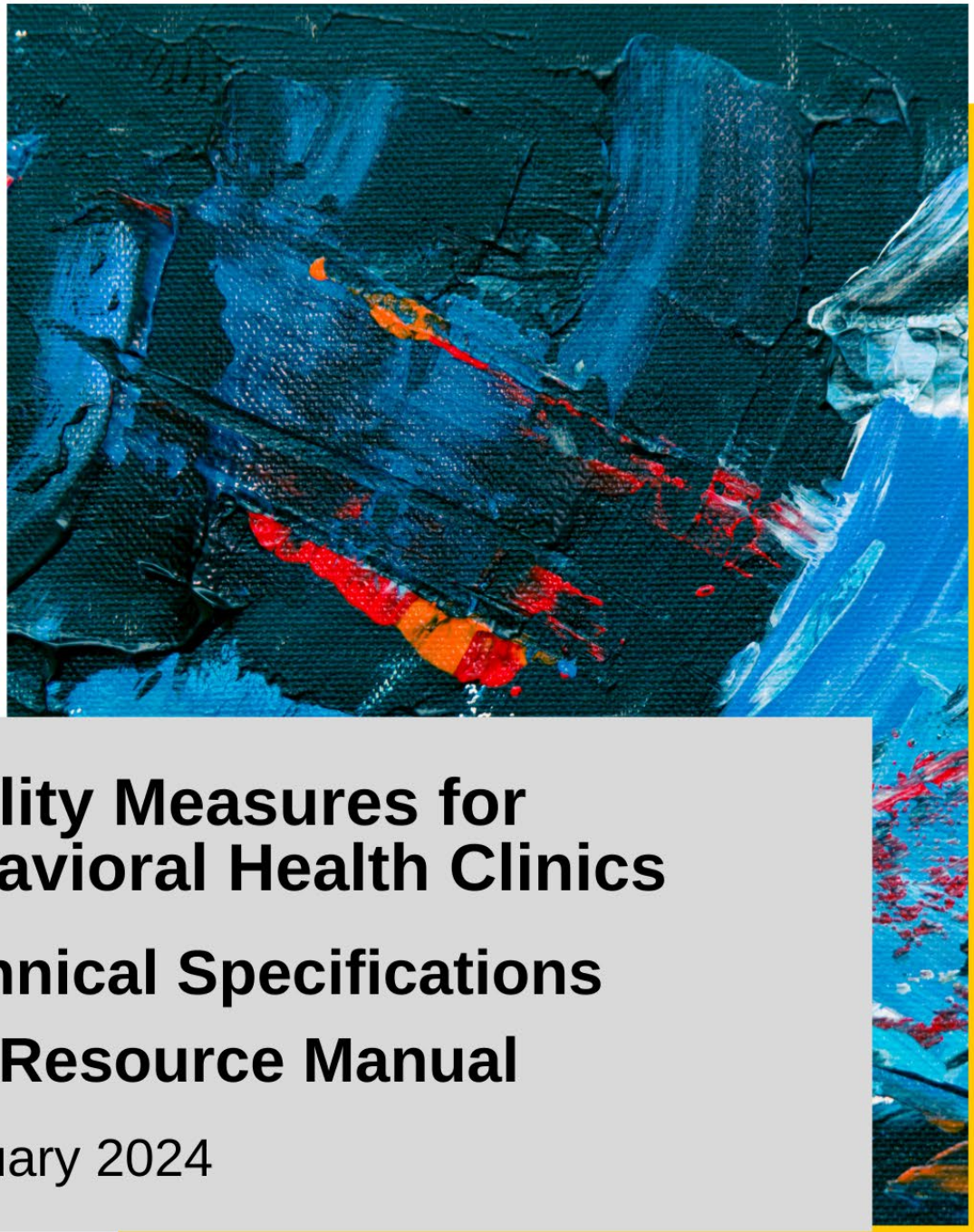

Quality Measures for Behavioral Health Clinics

Technical Specifications and Resource Manual

February 2024

SAMHSA
Substance Abuse and Mental Health Services Administration

Quality Measures for Behavioral Health Clinics: Technical Specifications and Resource Manual

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Controlling High Blood Pressure (CBP-AD)
Follow-Up After Hospitalization for Mental Illness, ages 18+ (adult) (FUH-AD)
Follow-Up After Hospitalization for Mental Illness, ages 6 to 17 (child/adolescent) (FUH-CH)
Initiation and Engagement of Substance Use Disorder Treatment (IET-AD)
Follow-Up After Emergency Department Visit for Mental Illness (FUM-CH and FUM-AD)
Follow-Up After Emergency Department Visit for Substance Use (FUA-CH and FUA-AD)
Plan All-Cause Readmissions Rate (PCR-AD)
Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder (ADHD) Medication (ADD-CH)
Antidepressant Medication Management (AMM-AD)
Hemoglobin A1c Control for Patients with Diabetes (HBD-AD)
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)

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Table of Contents

I. INTRODUCTION

Background

This manual provides technical specifications, guidance, and general information related to quality measures developed or adapted to be used at the Behavioral Health Clinic (BHC) provider level. This manual is organized as follows: Chapter I introduces and identifies the BHC quality measures; Chapter II provides general information on data collection for and reporting of the measures; Chapter III describes the components comprising the technical specification; and Chapters IV and V include the technical specifications for the clinic-collected and state-collected BHC measures, respectively. Appendices include: A. Glossary of Terms; B. Denominator and Numerator Measurement Periods for BHC Quality Measures; C. Guidance for Selecting Sample Sizes for Hybrid Measures; D. Definitions of Medicaid/Chip Core Set Practitioner Types; and E. Core Set Value Set Directory User Manual.

The measures included in this manual are rooted in the requirements placed on Certified Community Behavioral Health Clinics (CCBHCs) as part of the Demonstration Program to Improve Community Mental Health Services, found in Section 223 of the federal Protecting Access to Medicare Act of 2014 (PAMA), as amended by the Bipartisan Safer Communities Act of 2022 (BSCA). The measures in this manual are intended for use by:

- CCBHCs and states participating in the Section 223 Demonstration, which requires reporting of both clinic- and state-collected quality measures;
- CCBHCs and states involved in implementing independent state CCBHC initiatives (outside of the Section 223 Demonstration);
- CCBHC-Improvement and Advancement (IA) grantees and CCBHC-Planning, Development, and Implementation (PDI) grantees, that are recipients of grants from the Substance Abuse and Mental Health Services Administration (SAMHSA); and
- Other BHCs if they desire to report the clinic-reported quality measures.

For more information on the requirements for quality measure reporting applicable to the CCBHCs, see Program Requirement 5 of the CCBHC Certification Criteria (2023). A subset of these measures may be used by states to make Quality Bonus Payments (QBPs) under the Section 223 Demonstration.

Overview of updates to the BHC measures

The original BHC measures were developed by SAMHSA, with inputs from the Assistant Secretary for Planning and Evaluation (ASPE) and the Centers for Medicare and Medicaid Services (CMS) and published in April 2016. All Section 223 Demonstration CCBHCs were required to report nine measures annually; an additional five measures were not required of the CCBHCs. At that time, these clinic-reported measures were identified as “clinic-lead measures.” In addition, all Section 223 Demonstration states were required to report on 13 measures annually; five other state measures were prepared but not required to be used by the states. The latter 18 measures were identified as “state-lead measures.”

In 2022, SAMHSA, in consultation with its federal partners, undertook a lengthy review and assessment of the measures to determine which required updates, which should be removed, and what might be added, with the twin objectives of relieving some of the reporting burden on clinics and bringing the selection of measures up to date. This led to the selection of five measures to be required of Section 223 Demonstration CCBHCs, CCBHC-IAs, and CCBHC-PDIs, as well as five optional measures for clinic-level reporting. Furthermore, Section 223 Demonstration states are now required to report on twelve measures and may optionally report on two additional measures. Information on the time transition for existing reporting states and CCBHCs is provided in a separate document.

Purposes of quality measure reporting

Data and quality measure reporting has multiple purposes. Section 223(E) of PAMA, the authorizing statute for the Section 223 Demonstration, requires "reporting of encounter data, clinical data, quality data, and such other data as the Secretary [of HHS] requires." Collection and reporting of this information offers providers, states, and other stakeholders a method to assess the manner in which care is provided and accessed. Quality measures data can be used for BHC internal quality improvement (QI) to determine the progress of care delivery and areas for improvement. Some quality measure reporting also may be required as part of incentive programs, such as the Quality Bonus Measures (QBMs) and QBPs that are part of the Section 223 Demonstration Medicaid Prospective Payment System (PPS) methodology. The data and measures reported also may be used to supplement program evaluation, as with the national evaluation of the CCBHC Demonstration Program. In general, the data collected will help states and the federal government to better understand the quality of health care that clients at BHCs receive.

Quality Measures & Quality Improvement
Based on an evaluation of the original CCBHC Demonstration, we know that implementation of the original measures had positive effects on the quality of care provided, including improving access to and use of evidence-based practices.

Specification sources

This manual includes technical specifications and guidance for quality measures derived from multiple sources, including some developed specifically for BHCs by SAMHSA. In most cases, however, the measures are derived from other sources, such as original measures that were designed for reporting at the state or health plan level. Each such measure has been re-specified to enable reporting at the BHC level to capture performance by the BHC. This manual includes the most current version of the measure specifications available as of August 2023. For measures sourced from the Centers for Medicare and Medicaid (CMS) Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) or Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set), this manual follows the

Consensus-Based Entity (CBE)
The Consensus-Based Entity (CBE), as required by section 1890 of the Social Security Act, performs various duties related to health care performance measurement including endorsement and maintenance of quality measures. For additional information about endorsement and maintenance and other CBE work funded by CMS, see the Partnership for Quality Measurement website.

Adult or Child Core Set specifications for Federal Fiscal Year (FFY) 2023. For measures sourced from the Merit-based Incentive Payment System (MIPS), this manual follows the applicable MIPS measures for 2023. For the few measures derived from sources other than the Core Sets or MIPS, this manual includes the most applicable version of the technical specifications available from the measure steward for reporting 2023 data, re-specified where necessary at the BHC level. A few measures were developed by SAMHSA specifically for this manual rather than from existing measure sources, to address aspects of care important for BHCs in general and the CCBHCs specifically. For each measure included in this manual, the steward, and/or source, is noted at the top of the specification. Where relevant, information is also provided on Consensus-Based Entity (CBE) endorsement. Testing of measures that are not derived from CBE-endorsed measures is limited.

The Behavioral Health Clinic Quality Measures

Tables 1 and 2 identify the 2023 BHC measures. Table 1 comprises BHC-collected measures while Table 2 lists measures where data are collected by the state. The lists of measures in Tables 1 and 2 also identify whether they are required or optional for CCBHC or Demonstration state reporting. The technical specifications and other guidance in Chapters IV and V of this manual provide details for each measure. The measures that pertain to QBPs that are included in the CCBHC Demonstration will be identified in the CCBHC PPS Guidance on the CMS Section 223 website.

Table 1. Behavioral Health Clinic, Clinic-Collected Measures

Measure Name and Abbreviation	Measure Steward[2]	CBE ID	CMS Medicaid Core Set (2023)	MIPS Measure (2023)	Required or Optional for CCBHCs[3]
Time to Services (I-SERV)	SAMHSA	NA	NA	NA	**R**
Depression Remission at Six Months (DEP- REM-6)	Minnesota Community Measurement	0711	NA	NA	**R**
Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC)	NCQA	2152	NA	431	**R**
Screening for Social Drivers of Health (SDOH)	CMS	NA	NA	487	**R**
Screening for Clinical Depression and Follow-Up Plan (CDF-AD and CDF-CH)	CMS	0418 and 0418e	Adult and Child	134, cMS2v12	**R**
Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC)	NCQA	0028 and 0028e	NA	226, CMS138v11	O
Major Depressive Disorder: Suicide Risk Assessment (SRA-A)	MPR	0104e	NA	107, CMS161v11	O
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-C)	MPR	1365e	NA	382, CMS177v11	O
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-CH)	NCQA	0024	Child	239, CMS155v11	O
Controlling High Blood Pressure (CBP-AD)	NCQA	0018	Adult	236, CMS165v11	O

Abbreviations: CBE, Consensus-Based Entity; CMS, Centers for Medicare & Medicaid Services; MPR, Mathematica Policy Research; NA, not applicable; NCQA, National Committee for Quality Assurance; NR, Not required to be a QBM; O, Optional; PCPI, Physician Consortium for Performance Improvement; **R**, Required; SAMHSA, Substance Abuse and Mental Health Services Administration

[2]The measure steward is the organization responsible for maintaining a particular measure or measure set. Responsibilities of the measure steward include updating the codes that are tied to technical specifications and adjusting measures as the clinical evidence changes.

[3]The designation of required or optional for clinic-reported measures applies to CCBHCs in the Section 223 Demonstration and to any CCBHC-IAs or CCBHC-PDIs that are required to report measures. For CCBHCs that were part of the original Demonstration, and states with independent programs that may require reporting by non-Demonstration clinics, however, it must be determined by that state whether or not to require CCBHCs to report optional measures that formerly were required to be reported under the 2016 criteria.

Table 2. Behavioral Health Clinic State-Collected Measures

Measure Name and Abbreviation	Measure Steward[2]	CBE ID	CMS Medicaid Core Set (2023)	MIPS Measure (2023)	Required or Optional for CCBHCs[3]
Patient Experience of Care Survey (PEC)	SAMHSA	NA	No	NA	**R**
Youth/Family Experience of Care Survey (YFEC)	SAMHSA	NA	No	NA	**R**
Antidepressant Medication Management (AMM-AD)	NCQA	0105	Adult	009, CMS128v11	**R**
Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)	CMS	3400	Adult	NA	**R**
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)	CMS	1879	Adult	383	**R**
Plan All-Cause Readmissions Rate (PCR-AD)	NCQA	1768	Adult	NA	**R**
Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder (ADHD) Medication (ADD-CH)	NCQA	0108	Child	366, CMS136v12	**R**
Hemoglobin A1c Control for Patients with Diabetes (HBD-AD)	NCQA	0059/0575	Adult	NA	**R**
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD)	NCQA	0004	Adult	305, CMS137v11	**R**
Follow-Up After Hospitalization for Mental Illness (FUH-CH and FUH-AD)	NCQA	0576	Adult & Child	391	**R**
Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD and FUM-CH)	NCQA	3489	Adult & Child	391	**R**
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA-AD and FUA-CH)	NCQA	3488	Adult & Child	NA	**R**
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	NCQA	0717	Child	NA	O
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)	NCQA	2800	Child	NA	O

Abbreviations: CBE, Consensus-Based Entity; CMS, Centers for Medicare & Medicaid Services; NA, not applicable; NCQA, National Committee for Quality Assurance; NR, Not required to be a QBM; O, Optional; **R**, Required; SAMHSA, Substance Abuse and Mental Health Services Administration

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[3]The designation of required or optional for state-collected measures applies to states in the Section 223 Demonstration and to any CCBHC-IAs or CCBHC-PDIs that are required to report measures. For CCBHCs that were part of the original Demonstration, and states with independent programs that may require reporting by non-Demonstration clinics, however, it must be determined by that state whether or not to require CCBHCs to report optional measures that formerly were required to be reported under the 2016 criteria.

II. DATA COLLECTION AND REPORTING OF THE BEHAVIORAL HEALTH CLINIC QUALITY MEASURES

This chapter provides general guidelines for data collection, preparation, and reporting. Technical specifications and related guidance, with detailed information on how to calculate each measure, are presented in Chapters IV and V. For technical assistance with calculating and reporting these measures, please use the measure submission mailbox for the Section 223 Demonstration at CCBHCMeasuresSubmission@samhsa.hhs.gov.

Data Collection and Preparation for Reporting

Measurement years and measurement periods

Measurement Years. Measurement Years are the period of time that calculated quality measures assess. For reporting related to the Section 223 Demonstration, the Measurement Year **originally** was defined as the 12 month Demonstration Year (DY) (e.g., DY5). When the updated specifications are implemented, all reporting will transition to a Measurement Year that corresponds with the calendar year; for example, calendar year 2025 data.

Measurement Years
Beginning with the implementation of these updated technical specifications, CCBHCs will start using the calendar year as their Measurement Year. This replaces the Demonstration Year.

- ***Reporting:*** For all measures, reporters should indicate the Measurement Year using Section A (Measurement Year) of the data-reporting templates. The data-reporting templates are discussed in detail below.

Measurement Periods. Data collection also involves Measurement Periods, which identify the time periods for which data must be used to calculate a measure. Measurement Periods may correspond with the Measurement Year, but many Measurement Periods do not. Rather, they may be indexed to a specific date or event or may require some other modification to time periods for actual data collection (e.g., Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling (ASC), where the numerator measures whether alcohol use screening occurred in the past 12 months, requiring a numerator Measurement Period that includes both the Measurement Year and the prior 12 months to capture past year screening for individuals seen early in the Measurement Year). States and BHCs should adhere to the Measurement Periods identified in the technical specification for each measure. Measurement Periods also are summarized in Appendix B.

Measurement Periods
A measure is calculated using the data from a specific period of time, known as the Measurement Period. There may be distinct Measurement Periods for the numerator and denominator and they may or may not be the same as the Measurement Year.

- ***Reporting:*** For all measures, reporters should indicate start and end dates for the Measurement Period for the denominator and numerator in Section C (Date Range for Measurement Period) of the data-reporting templates.

Reporting at the BHC level

The unit or level of reporting for these measures is always the BHC. The measures are specified at the clinic/clinician office setting level. This means that both states and BHCs should collect data across all clients that are served by the BHC. In the case of the Section 223 Demonstration CCBHCs, the unit of reporting is determined at the CCBHC level regardless of how many clinics or entities comprise a single CCBHC. Depending on the data required for the measure and the structure of a Section 223 Demonstration CCBHC, data from Designated Collaborating Organizations (DCOs) also may be required (e.g., a DCO might be the entity undertaking screening for Hemoglobin A1c and the DCO data would be needed for computation of the related diabetes quality measure).

For state-collected measures in particular, reporting measures at the CCBHC level is different than the norm for most state reporting, as states tend to report numbers aggregated from multiple sources encompassing the state's Medicaid program or health plans. Therefore, the state must be able to identify and attribute data to specific clinics and their clients, for example, by assigning a unique identification number to each clinic.

Clinic Site Identifiers

Section 5.a.3 of the CCBHC certification criteria updated in 2023 require that "Medicaid claims and encounter data provided by the state to the national evaluation team, and to CMS through T-MSIS, should include a unique identifier for each person receiving services, unique clinic identifier, date of service, CCBHC-covered service provided, units of service provided and diagnosis. ***Clinic site identifiers are very strongly preferred***."

The population to be measured

Client attribution. States or other entities requiring reporting may decide how to attribute clients to BHCs depending on the specific impetus for data reporting. For the Section 223 Demonstration, attribution of clients for purposes of data reporting required by the CCBHC criteria requires only one visit by a person to the CCBHC during the Measurement Year. The state is responsible for providing guidance to clinics on what activities constitute a visit that should be enumerated (for example, a person seen only once for primary care services that are outside the scope of services required as part of the CCBHC certification criteria). Attribution to a CCBHC requires one enumerated visit that falls within the CCBHC scope of services (whether or not provided within the four walls of the clinic). It is possible that a client may visit more than one CCBHC during a year; in such cases, the client will be attributed to both unless one is a DCO for the other.

Population eligible for measurement. In the broadest sense, the eligible population for these measures is all clients served by a BHC provider. The denominator for a specific measure, however, includes only the BHC clients who satisfy measure-specific eligibility criteria. These may include requirements such as age or continuous Medicaid enrollment. The specifications in Chapters IV and V indicate the population eligible to be included in each measure.

Population stratification. The technical specifications also state what population stratifications are required for each measure. Stratification requirements might include race and/or ethnicity. However, except for the two state-collected patient experience of care measures (PEC and Y/FEC), there always will be a stratification by payer.

Stratification
Some stratification is required for all measures except the two state-collected patient experience of care measures (PEC and Y/FEC). Stratification details for each measure are included in the measure specification.

Stratification by payer serves two purposes: (1) for evaluation, ASPE needs information on the population served to the greatest extent possible; and (2) CMS uses this information to determine the population to which the Quality Bonus Payments may apply.

- For ***Section 223 Demonstration CCBHCs***, stratification by payer requires identification of clients as either: (1) Medicaid beneficiaries, including Title 19-eligible CHIP beneficiaries, or (2) Others, including those dually enrolled under Medicare and Medicaid, Title 21-eligible CHIP beneficiaries, those reliant on other payment sources, and people who lack insurance. The distinction between Title 21 and Title 19-eligible CHIP beneficiaries is based upon the restrictions found in PAMA Section 223 (d)(5)(A).
- ***Section 223 Demonstration states*** also are required to report data stratified for Medicaid beneficiaries, including Title 19-eligible CHIP beneficiaries, and, to the extent possible, clinic users who are dually eligible for Medicare and Medicaid. If a state cannot access the dual eligibility data, it should indicate in the data-reporting templates that it is excluding some or all data for the dually eligible group.

Continuous Medicaid enrollment requirements apply to determining the eligible population for some measures. If a measure specification does not include requirements for continuous enrollment, the insurance status at the time of the first visit during the Measurement Year will be applied for the entire year for purposes of stratification. For any measure with a continuous enrollment requirement that is clinic-collected, Medicaid and CHIP enrollees should be counted if applicable within those categories if they satisfy the continuous enrollment criteria. Those who do not satisfy those criteria are to be stratified into the "Other" category.

Implication of payer stratification for quality bonus measures (QBMs). For purposes of CCBHC QBM/QBP reporting and payment, only clients who are Medicaid beneficiaries, including Title 19-eligible Medicaid expansion CHIP beneficiaries, are counted towards payment. Data will be drawn from the stratified rates for those groups. Stratification by payer category is required for all non-experience of care measures.

- ***Reporting:*** Section E of the data-reporting template (Adherence to Measure Specifications) provides space for the state or BHC to report nonadherence to measure specification; for instance, if only certain client/payer categories are included in the measure calculation, including if the state lacks access to data for individuals dually enrolled in Medicare and Medicaid.

Representativeness of data. States and BHC providers should use the most complete data available and ensure that the rates reported are representative of the entire population served by the BHC. To achieve this with a measure based on administrative data, all BHC clients who meet the eligible population requirements for the measure should be included. For a measure based on a sampling methodology, states and BHC providers should ensure that the sample used to calculate the measure is representative of the entire BHC eligible population for the measure.

Population size requirements for reporting

For purposes of the CCBHC Demonstration Program, all measures must be reported to SAMHSA regardless of the size of the specified eligible population for a given measure in a CCBHC.

- However, if the eligible population and denominator exclusions for a given measure in a CCBHC result in a denominator less than 30, results should not be used for any public reporting or for purposes of the national evaluation
- For the Plan All-Cause Readmissions (PCR-AD) state-collected measure, the denominator is the Count of Index Hospital Stays among non-outlier members (outliers should not be considered). For that measure, a Count of Index Hospital Stays less than 150 should not be used for any public reporting or for purposes of the national evaluation.

For reporting that is **not** related to the CCBHC Demonstration Program, if a measure has a denominator less than 30 and the state and BHCs choose not to report the measure due to small numbers, this decision is to be noted in Section E of the data-reporting template (Adherence to Measure Specifications) and the denominator size should be provided.

Data sources or collection methods

The measures included in this manual have four possible data sources/collection methods: (1) administrative, (2) medical records (including electronic health records (EHRs)), (3) hybrid, and (4) survey. The specifications for each measure indicate which is to be used. If a measure includes a choice of sources or methods, any identified in the specification may be used.

Administrative data. The administrative method uses transaction data (for example, claims or encounters) or other administrative data sources to calculate the measure. Administrative data can be used in cases where such data are known to be complete, valid, and reliable. When administrative data are used, the entire eligible population, as specified for the measure, is included in the denominator.

Medical record data. The medical records method uses the BHC medical records or other clinic transaction data sources, such as electronic health records (EHRs), paper medical records, clinic registries, or scheduling software.

> ***EHR medical records:*** The electronic specification method uses EHR data to calculate the measure. A link to electronic specifications is included in the following measure specifications: ADD-CH, AMM-AD, CBP-AD, CDF-AD, CDF-CH, HBD-AD, IET-

AD, SRA-C, SRA-A, and WCC-CH. Use the version current for the year being reported.

- ***Reporting:*** States or BHCs that use electronic specifications should indicate this by selecting "Electronic Health Records" in the Data Source section (section B) of the Data Reporting Template.

Hybrid. The hybrid method uses data from both administrative sources and medical records (paper or EHRs or registry) determine the numerator. The denominator consists of a systematic sample of beneficiaries drawn from the measure's eligible population. Administrative data are reviewed to determine if clients in the sample received the service, and medical record data are reviewed for clients who do not meet the numerator criteria through administrative data. The hybrid method, when available, should be used when administrative data and EHR data are incomplete or may be of poor quality, or the data elements for the measure are not reliably captured in administrative data. Samples should be representative of the eligible population, including, when stratified by age, the relevant age groups. Only three BHC measures include an hybrid option: CBP-AD, HBD-AD, and WCC-CH. Only HBD-AD is a required measure; other options for calculation are available for each of these three measures.

Sampling: For measures that use the hybrid method and that require sampling, guidance is included in the technical specification and as described below. Sampling should be systematic and random to ensure that all eligible individuals have an equal chance of inclusion. The sample should be representative of the eligible population, and, in situations where reporting is by age group, random samples should be selected within each specified age group, to insure sufficient sample size of each age group.

Technical Assistance: Additional applicable guidance on sampling for hybrid measures is available in the following CMS technical assistance brief: "Approaches to Using the Hybrid Method to Calculate Measures from the Child and Adult Core Sets" (October 2014).[4]

- ***Reporting:*** States and BHC providers should describe the sampling approach used for each hybrid measure in Section F (Additional Notes) and the sample size and the size of the measure-eligible population in Section B (Data Source) in the data-reporting template.

Survey. The survey method uses data collected through a survey to calculate the measure. This data collection method applies only to the PEC and Y/FEC measures.

- ***Reporting:*** The method used should be reported in Section B of the data-reporting template (Data Source).

Alternative data collection methods and data sources. States and BHCs should report the measures

[4]Medicaid Core Measure Technical Assistance briefs can be found at the Adult and Child Health Care Quality Measures website.

using the methods listed in the specifications to the extent possible, but if that is not feasible, they may use an alternative method (e.g., medical record review without systematic sample) or data source.

- ***Reporting:*** Any deviations from the measure specifications should be explained in Section E of the data-reporting template (Adherence to Measure Specification) and, if necessary, in Section F (Additional Notes).

Includable claims

Inclusion of paid, suspended, pending, and denied claims. A key aspect of the assessment of quality for some measures is to capture whether or not a service was provided. For some measures, the Guidance for Reporting within each measure's technical specification indicates which claims (paid, suspended, pending, and/or denied) should be included. This applies to the following measures if administrative data sources are used: ADD-CH, AMM-AD, APP-CH, APM-CH, CBP-AD, CDF-AD, CDF-CH, FUA-AD, FUA-CH, FUH-AD, FUH-CH, FUM-AD, FUM-CH, HBD-AD, IET-AD, PCR-AD, SAA-AD, and WCC-CH.

Telehealth. Unless specifically stated otherwise, synchronous telehealth visits, which require real-time interactive audio and video telecommunications are to be treated as are in-person visits. Measures will specify if telephone-only or asynchronous telehealth are to be counted.

Code and medication lists

Value sets and codes. Many measures require the use of billing or diagnostic codes for calculation and many specifications list value sets to identify codes required for calculation. A value set is a separate and complete set of codes used to identify a service or condition included in a measure. Where required, either value set references or actual codes are included for all technical specifications in this manual. Value set references are underlined in the specifications (e.g., Schizophrenia Value Set).

ICD-9/ICD-10 Conversion. In compliance with the CMS mandate to use ICD-10 codes for services provided on or after October 1, 2015, measures should be calculated using ICD-10 codes for claims with a date of service or date of discharge on or after October 1, 2015. Pertinent ICD-10 codes are available in the specification or in the corresponding value set. ICD-9-CM and ICD-9-PCS codes are still included in measures where the lookback period plus one year prior includes services before October 1, 2015. ICD-9 codes are still referenced in the following measures: ADD-CH, CBP-AD, DEP-REM-6, PCR-AD, and SAA-AD.

Medication Lists. Several BHC measures derived from Medicaid Core Set measures reference medication lists, which are a list of codes and medications used to identify dispensed medications. The Medication List Directory is available to order free of charge in the NCQA Store. Once ordered, it can be downloaded from the NCQA Download Center. This applies to the following measures: ADD-CH, AMM-AD, APM-CH, APP-CH, CBP-AD, FUA-AD, FUA-CH, HBD-AD, IET-AD, and SAA-AD. Use the version that is current for the year being reported.

Risk adjustment

Among the measures that are part of the Medicaid Core Sets, one measure — the Plan All-Cause Readmissions (PCR-AD) — requires risk adjustment. Risk adjustment guidelines are included in the specification for the measure.

Reporting and Submission of Measures

Who collects and reports the data

Level of Data Collected and Reported
Regardless of whether it is a clinic or state collecting and reporting the BHC measure data, the measures are always calculated at the BHC level, not at the state level.

Measures included in this technical specification manual are designed to be calculated and reported by either the BHC or the state, but all of them are specified to capture information at the BHC level rather than at a higher level of aggregation. For the Section 223 Demonstration, the responsibility for calculation and reporting reflects the fact that some measures require access to data that the clinics may not have (e.g., Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD and FUM-CH)).

- ***Clinic responsibilities:*** For clinic-collected measures (Table 1), the BHC should report the measures to the entity that requested it. In the case of the Section 223 Demonstration, CCBHCs report the required measures to their designated state agency and the state agency reports them to SAMHSA. This is true for all required measures, including the QBMs, although QBPs based on those measures will be calculated only from clients who are Medicaid eligible, including Title 19-eligible Medicaid expansion CHIP program beneficiaries (but not Title 21-eligible CHIP beneficiaries).

- ***State responsibilities:*** The state should report the measures that it collects and/or calculates (whether received from the BHCs (Table 1) or calculated by the state using administrative or other data (Table 2)) to the entity that requested it. In the case of the Section 223 Demonstration, any data that the state is required to report (either on its own or as a conduit for the CCBHCs) should be reported to SAMHSA. The data submitted to SAMHSA will be reported for each CCBHC separately using the data-reporting templates.

Data-reporting templates

Data-reporting templates have been developed for each measure. For the Section 223 Demonstration, CCBHCs and states reporting the measures must use the templates to submit the measure results. The templates are not part of an automated electronic system. Rather, the templates are worksheets that are to be completed and submitted by email to CCBHCMeasuresSubmission@samhsa.hhs.gov.

In addition to guidance and technical specifications provided in this manual, instructions for completion of the templates are included in the template document. For purposes of the Section

223 Demonstration, CCBHCs and states should complete every field for each measure to meet reporting requirements and to ensure consistent reporting across CCBHCs and states. The templates are separated into clinic-collected and state-collected measures; both have the same fields. Clinics also are provided a worksheet to report on caseload characteristics. A final roll-up worksheet automatically includes the results for all measures.

- ***Reporting:*** States and BHC providers are strongly encouraged to use the methods and data sources listed in the specification for each measure; however, if states or BHC providers use alternative methods or data sources, the deviations should be indicated in Section E (Adherence to Measure Specification) of the pertinent data-reporting template.

Data auditing

Individual states may have specific data auditing requirements.

- ***Reporting:*** If the state has current mechanisms for external quality review reporting, or if the state validates its measures, the states should note these processes in Section F (Additional Notes) of the data-reporting template.

Changes to aspects of Quality Bonus Programs

If a Section 223 Demonstration state makes any changes to factors surrounding its QBP, such as any change that may differ from descriptions provided in the state's original CCBHC Demonstration application regarding the methodology by which QBPs are made, factors that trigger payment, amount of payment, or how often payment is made, the state should report that with their submission.

- ***Reporting:*** Changes related to the QBP must be reported as part of quality measure reporting, either in Section F (Additional Notes) of the data-reporting template, or by providing a separate attachment to the submission.

Submission deadlines

For non-CCBHC reporting, data must be submitted to the state or other entity that requires it.

State and Clinic CCBHC Submission Deadlines

For purposes of the CCBHC Section 223 Demonstration, ***CCBHCs*** report their measures to their state nine months after the end of the Measurement Year. ***States***, in turn, report both those clinic-collected measures and their state-collected measures to SAMHSA 12 months after the end of the Measurement Year.

For the Section 223 Demonstration Program, results for the clinic-collected measures must be submitted to the state no later than nine months after the end of the Measurement Year. In turn, the state must submit both its state-collected measures and the previously received clinic-collected measures for that Measurement Year to SAMHSA no later than 12 months after the end of the Measurement Year. The completed reporting templates from the Section 223 Demonstration states should be submitted to SAMHSA using the following email address: CCBHCMeasuresSubmission@samhsa.hhs.gov. Submitted data should be complete and final at the submission deadline. The state may set separate timeframes for the submission of data by CCBHCs that support the Quality Bonus Payments.

Data Collection and Reporting

For CCBHC-IAs and CCBHC-PDIs that are part of the Section 223 Demonstration, measures must be reported as required for all Demonstration CCBHCs. Additionally, those CCBHC-IAs and CCBHC-PDIs that are required by the terms of their SAMHSA grants to report measures (whether in the Section 223 Demonstration or not), must report to SAMHSA their most recent complete data no later than 90 days after the end of each 12-month grant budget period.

III. TECHNICAL SPECIFICATION COMPONENTS

This chapter presents the technical specification components for the BHC measures. Each specification includes a description of the measure and information about the eligible population, key definitions, data collection method(s), instructions for calculating the measure, and other relevant information. A brief introduction to each component of the specifications follows this paragraph, with the technical specifications themselves found in Chapters IV (Clinic-Collected) and V (State-Collected).

Important Information
For measures derived from the CMS Medicaid Adult and Child Core Sets, this manual incorporates:
(1) the actual technical specification generated by CMS with minor annotations in that specification, and
(2) supplemental information that we believe will be useful to reporters, including very critical information such as additional required stratifications beyond those in the CMS document.

Description

The description section in each specification includes a narrative description of the measure, the applicable data source or collection method, guidance on reporting, and an explanation of the Measurement Period. Topics included in guidance on reporting vary by measure, but they typically address the following information on: 1) stratifications required for the measure; 2) the multiple rates included in the measure, if applicable; 3) potential sources of data for clinic-reported measures (i.e., administrative, hybrid, medical records, survey); 4) value sets if the measure relies on administrative data; 5) a reminder to refer to the data-reporting template pertinent to the measure; and 6) any additional information. The explanation of the Measurement Period provides information on the time period(s) for data used to compute the denominator and numerator, respectively.

Definitions

This section of each specification defines key terms relevant to the measure.

Eligible Population

The section defining the eligible population provides information needed for computation of the denominator, including requirements regarding the client's relationship to the clinic, age, and insurance (the latter for claims-based data), and a step-by-step guide for determining the eligible population.

- ***Age requirements:*** The age criteria vary by measure. States and BHCs should calculate and report rates for the total age-eligible population.
- ***Insurance requirements:*** Some measures include requirements related to

continuous enrollment in Medicaid or dual enrollment in Medicare and Medicaid, allowable insurance gaps, and an anchor date.

- ***Continuous enrollment:*** This requirement refers to the period of time during which a client must be enrolled for Medicaid or CHIP benefits or dually eligible for Medicare and Medicaid benefits to be included in the eligible population for certain measures using administrative data. It ensures that the provider has enough time to render services during the Measurement Period. If applicable, the technical specifications provide the continuous enrollment requirement for the measure. To be considered continuously enrolled, a client must also be continuously enrolled with the benefit specified for each measure (e.g., pharmacy or mental health), accounting for any allowable gap. States should combine data across programs (e.g., Medicaid and CHIP), delivery systems (e.g., managed care and fee-for-service), and managed care plans when analyzing continuous enrollment for a client. For example, a client might switch between Medicaid programs or between managed care plans, and should be counted for the measure as long as the continuous enrollment criteria in the measure specification are met.

- ***Allowable gap:*** Some measures specify an allowable gap that can occur during continuous enrollment for Medicaid or CHIP, or for dually eligible Medicare and Medicaid enrollment. For example, the CBP-AD measure requires continuous enrollment throughout the Measurement Year (January 1–December 31) and allows one gap in Medicaid and CHIP enrollment of up to 45 days. Thus, a client who enrolls for the first time on February 8 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 client has one 38-day gap (January 1–February 7). A client 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 Medicaid or CHIP and have the required benefit to be eligible for the measure. If a measure requires a Medicaid beneficiary, or a dually eligible Medicare and Medicaid beneficiary, to be enrolled and to have a benefit on a specific date, the allowable gap must not include the anchor date.

- ***Reporting:*** States and BHCs should note any deviations from the specifications in Section E of the data-reporting template (Adherence to Measure Specifications) and, if necessary, Section F (Additional Notes).

Measure Specification

The measure specification explains how to compute: 1) the denominator (the eligible population with any relevant exclusions) and 2) the numerator (some subset of the denominator that typically has received the service or achieved the outcome being measured). If the measure requires reporting of multiple rates or other types of measures, specifications for each are included. Relevant Measurement Periods also are addressed within the specification.

- ***Required and optional exclusions:*** Some measure specifications contain required or optional exclusions. A BHC client who meets required exclusion criteria should be removed from the eligible population as stated in the technical specification. Most exclusions are to the denominator and numerator, but some apply only to the numerator.
    - ***Reporting:*** If an optional exclusion is used, this fact should be so stated in Section E (Adherence to Measure Specification) of the data-reporting template.

- ***Hospice exclusion:*** Some measures include a required hospice exclusion: ADD-CH, AMM-AD, APM-CH, APP-CH, ASC, CBP-AD, DEP-REM-6, FUA-AD, FUA-CH, FUH-AD, FUH-CH, FUM-AD, FUM-CH, HBD-AD, IET-AD, PCR-AD, SAA-AD, TSC, and WCC-CH. For these measures, states should exclude BHC clients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. These clients may be identified using various methods, which may include but are not limited to, enrollment data, medical record, or claims/encounter data, or supplemental data for this required exclusion.

  States should remove BHC clients under the hospice exclusion while they are determining the measure's eligible population. For measures calculated using the hybrid process, states should remove these clients before drawing the sample. If a client is found to be in hospice or using hospice services during the medical record review portion if using the hybrid approach, the client is removed from the sample and replaced by a client from the oversample. If the documentation shows that a client is near the end of life (e.g., comfort care, Do Not Resuscitate [DNR], Do Not Intubate [DNI]), or is in palliative care, but is

not in hospice, the client does not meet criteria for the hospice exclusion and therefore must not be removed from the sample on that basis.

Supplemental data can be used for the hospice exclusion for all applicable measures, including for the PCR-AD measure which otherwise says "supplemental data may not be used for the measure."

- ***Deceased client exclusion:*** Some measures include a deceased client exclusion: ADD-CH, AMM-AD, APM-CH, APP-CH, CBP-AD, FUA-AD, FUA-CH, FUH-AD, FUH-CH, FUM-AD, FUM-CH, HBD-AD, IET-AD, SAA-AD, and WCC-CH. For these measures, if a state can identify BHC clients who die during the Measurement Year, these clients should be excluded consistently from the measures. Deceased clients may be identified using various methods that include, but are not limited to, enrollment data, medical record review, claims/encounter data, or supplemental data.

  For a measure where hybrid data are being used, if a state excludes deceased clients, it should attempt to remove them while it is determining the eligible population and before drawing the sample for hybrid measures. If, during medical record review, a client is found to be deceased, the client can be removed from the sample and replaced by a client from the oversample.

  The deceased client exclusion is a client-level exclusion. For episode-based measures, if one event does not meet numerator criteria and the state chooses to use this optional exclusion, remove all client events/episodes from the measure.

Additional Notes

This section contains additional information relevant to the measure.

Frequently Asked Questions

These are questions that have been asked in the past and potential future questions with their answers.

IV. CLINIC-COLLECTED MEASURE TECHNICAL SPECIFICATIONS

Section IV contains the technical specifications and other guidance for the Clinic-Collected BHC measures, including five measures that are required as part of the Section 223 CCBHC Demonstration and for SAMHSA CCBHC-IA and CCBHC-PDI grantees, and five measures that are optional. These are:

Required Measures:

1. Time to Services (I-SERV)
2. Depression Remission at Six Months (DEP- REM-6)
3. Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC)
4. Screening for Social Drivers of Health (SDOH)
5. Screening for Clinical Depression and Follow-Up Plan (CDF-AD and CDF-CH)

Optional Measures:

1. Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC)
2. Major Depressive Disorder: Suicide Risk Assessment (SRA-A)
3. Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-C)
4. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-CH)
5. Controlling High Blood Pressure (CBP-AD)

Clinic-Collected Measures Required for Submission as Part of CCBHC Demonstration

This section of Chapter IV includes the following Clinic-Collected required measures:

1. Time to Services (I-SERV)
2. Depression Remission at Six Months (DEP- REM-6)
3. Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC)
4. Screening for Social Drivers of Health (SDOH)
5. Screening for Clinical Depression and Follow-Up Plan (CDF-AD and CDF-CH) — including supplemental materials

Time to Services (I-SERV)[5]

SAMHSA-Developed Measure

A. DESCRIPTION

The I-SERV measure calculates the Average time for clients to access three different types of services at Behavioral Health Clinics (BHCs) reporting the measure. The I-SERV measure is comprised of three sub-measures of time until provision of: (1) initial evaluation, (2) initial clinical services, and (3) crisis services.

Data Source: Medical Records

Important Reporting Guidance:

This section of the specification includes important guidance for reporting the I-SERV measure. Also refer to section I for Frequently Asked Questions.

- I-SERV is a three-part measure. Each submeasure requires a separate calculation.
- Providers will rely on medical records to compile the submeasures. There are several potential data sources that may be used individually or together to compile the submeasures:
    - An electronic scheduling or case management system that is used to schedule and monitor appointments and critical time frames
    - Electronic health records (including billing records)
    - Paper health records
    - A registry
- I-SERV is stratified separately based on whether the client is:
    - an adolescent (12–17 years of age) or an adult (18 years of age and older)

    AND
    - Medicaid only or Other (including those dually eligible for Medicare and Medicaid)

    AND
    - a member of which of the following ethnic groups: Not Hispanic or Latino, Hispanic or Latino, or Unknown

    AND

[5]This measure differs from the previous I-EVAL measure. It incorporates part of that measure and adds submeasures related to time to Initial Clinical Services and time until provision of Crisis Services.

- a member of which of the following racial groups: White or Caucasian, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or Pacific Islander, More than one race, or Unknown

- Refer to the specific data-reporting template for the reporting requirements applicable to each measure.

Measurement Period: The Measurement Period is the period for which data are required for reporting purposes.

For Submeasures 1 and 2: The Measurement Period for the **denominator** is the Measurement Year, excluding the final month of that year, and including the 6 months preceding the Measurement Year. The Measurement Period for the **numerator** is the Measurement Year. See Figure 1 for visual depiction of Measurement Year and Measurement Periods for Submeasures 1 and 2.

Figure 1. Visual of Measurement Year and Measurement Periods for Submeasures 1 and 2

6 Months	**First Eleven Months of MY**	**Last 30 Days of MY**
	Measurement Year (MY): 12-month reporting period	
Denominator Measurement Period: First 11 months of MY + 6 months before the MY		
	Numerator Measurement Period: The MY	

Key: MY: Measurement Year.

For Submeasure 3: The Measurement Period for the **denominator** is the Measurement Year, excluding the last 24 hours, and including the 24 hours immediately preceding the Measurement Year. The Measurement Period for the **numerator** is the Measurement Year. See Figure 2 for visual depiction of Measurement Year and Measurement Periods for Submeasure 3.

Figure 2. Visual of Measurement Year and Measurement Periods for Submeasure 3

24 H	**One Year (excluding final 24 H)**	**24 H**
	Measurement Year (MY): 12 month reporting period	
Denominator Measurement Period: 24 hours before MY and MY (excluding last 24 hours)		
	Numerator Measurement Period: The MY	

Key: H: Hours; MY: Measurement Year

B. DEFINITIONS

TERM	DEFINITION
Average	The Average in this measure is calculated by dividing the sum of observations in the numerator by the number of observations in the denominator (N/D).
Business Days	Monday through Friday, excluding state and federal holidays (regardless of days of operation)
Crisis Episode or Crisis Service Episode	A Crisis Service Episode begins when an individual or someone acting on their behalf contacts the Crisis Service provider (whether a CCBHC or its crisis Designated

Time to Services (I-SERV)

TERM	DEFINITION
	Collaborating Organization (DCO)) requesting Crisis Services for the first time in a 24-hour period.
Crisis Service or Crisis Management Service	Crisis Services such as those provided by CCBHCs in accordance with CCBHC certification criteria 2.C.
Designated Collaborating Organization (DCO)	A Designated Collaborating Organization is an entity that is not under the direct supervision of the CCBHC but is engaged in a formal relationship with the CCBHC and delivers services under the same requirements as the CCBHC. See Appendix A of CCBHC Certification Criteria for further information.
First Contact (for Purposes of Initial Evaluation or Clinical Service)	First Contact represents the first time that an individual or guardian contacts a BHC to obtain services for the individual in a six-month period. First Contact may be by telephone. First Contact for a CCBHC should include the required preliminary screening and risk assessment and collection of basic data about the person that includes insurance information. A referral from a primary care physician or other provider is not a First Contact (contact must be between the prospective client and the CCBHC).Only one contact in a six-month period will count (with six months being used to determine if the person is a New Client). ***Note:*** The idea of First Contact does not apply to submeasure 3 regarding Crisis Services.
Initial Clinical Service	Some certification standards, such as the CCBHC certification criteria, require that Initial Clinical Services be carried out for New Clients within a specified time frame based on the acuity of needs. In the case of a CCBHC, Initial Clinical Services occur after a preliminary screening and risk assessment to determine acuity of needs and after or at the time of an Initial Evaluation. CCBHC criteria require the Initial Clinical Services to occur within 10 Business Days of First Contact for those who present with "routine" non-emergency or non-urgent needs. That standard is used in this specification. Other standards may exist for other entities and this specification can be adapted accordingly.
Initial Evaluation	Some certification standards, such as the CCBHC certification criteria, require that an Initial Evaluation be carried out for New Clients within a specified time frame based on the acuity of needs. In the case of a CCBHC, the Initial Evaluation is due within 10 Business Days of First Contact for those who present with "routine" non-emergency or non-urgent needs. That standard is used in

TERM	DEFINITION
	this specification. Other standards may exist for other entities and this specification can be adapted accordingly.
Measurement Period	The specific time period for which data are needed for the numerator and denominator of a given measure. The Measurement Period may differ for the numerator and denominator and for each measure and is specified in section A above.
Measurement Year	The standard 12-month reporting period common to all measures being reported by the Provider Entity.
New Client	An individual not seen at the clinic in the past 6 months
Provided	As used in the context of the measured services being "Provided" by the clinic, the word "Provided" means "received."
Provider Entity	The Provider Entity that is being measured (i.e., BHC)
Seeking Crisis Services	Seeking Crisis Services includes instances when a client actively seeks crisis services or when others seek services on a client's behalf.
Submeasure	I-SERV is comprised of calculations for three different services, with each calculated average time to service being a submeasure.

C. ELIGIBLE POPULATION FOR SUBMEASURES 1 AND 2

CRITERIA	REQUIREMENTS
Event/Age	Follow the steps below to identify the eligible population: *Step 1* Identify New Clients who contacted the Provider Entity seeking services during the Measurement Year. *Note:* New Clients are those who have not been served at the clinic in the past six months. *Step 2* Identify clients from step 1 of ages 12 years and older as of the end of the Measurement Year.

D. ELIGIBLE POPULATION FOR SUBMEASURE 3

CRITERIA	REQUIREMENTS
Event/Age	Follow the steps below to identify the eligible population: *Step 1* Identify clients who contacted the Provider Entity or its crisis DCO Seeking Crisis Services for a new Crisis Episode during the Measurement Year.

CRITERIA	REQUIREMENTS
	Note: A Crisis Service Episode begins when the Crisis Service provider (whether a CCBHC or its crisis DCO) receives a contact related to needed Crisis Services for a client for the first time in 24 hours. ***Note:*** A single individual may have multiple Crisis Service Episodes over the course of the Measurement Year and each such episode is counted. *Step 2* Identify clients from step 1 of ages 12 years and older as of the end of the Measurement Year.

E. SUBMEASURE SPECIFICATION #1

The Average number of days until Initial Evaluation for New Clients (see Figure 3 for visual)

Denominator

The number of clients in the eligible population (Section C).

Denominator Exclusions

Exclude from the Submeasure #1 denominator all eligible New Clients who never received an Initial Evaluation. Indicate in Additional Notes in the data reporting template the number so excluded.

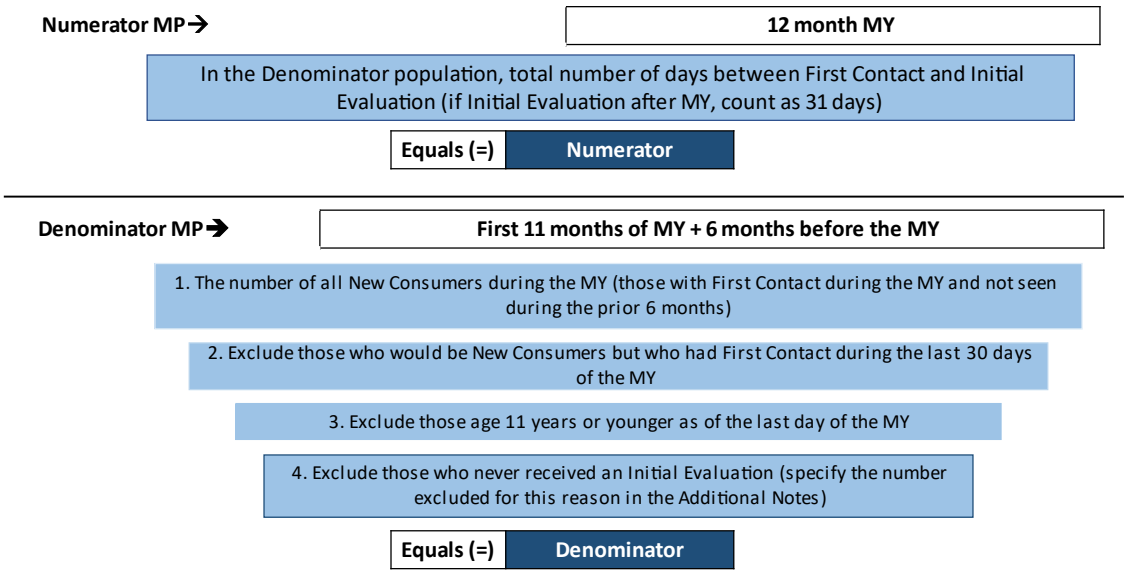
Note: The Measurement Period for the denominator is the Measurement Year excluding the last month of the Measurement Year and including the 6 months preceding the Measurement Year.

Numerator

The total number of days between First Contact and Initial Evaluation for all members of the Section E denominator population (after exclusions)

Note: The Measurement Period for the numerator is the Measurement Year. Any who received an Initial Evaluation after the last day of the Measurement Year are treated as having been evaluated 31 days after First Contact.

Figure 3. Visual of Submeasure 1 Specification



Key: MP: Measurement Period; MY: Measurement Year.

F. SUBMEASURE SPECIFICATION #2

The Average number of days until Initial Clinical Service for New Clients (see Figure 4 for visual)

Denominator

The number of clients in the eligible population (Section C).

Denominator Exclusions

Exclude from the Submeasure #2 denominator all eligible New Clients who never received a clinical service. Indicate in Additional Notes in the data reporting template the number excluded.

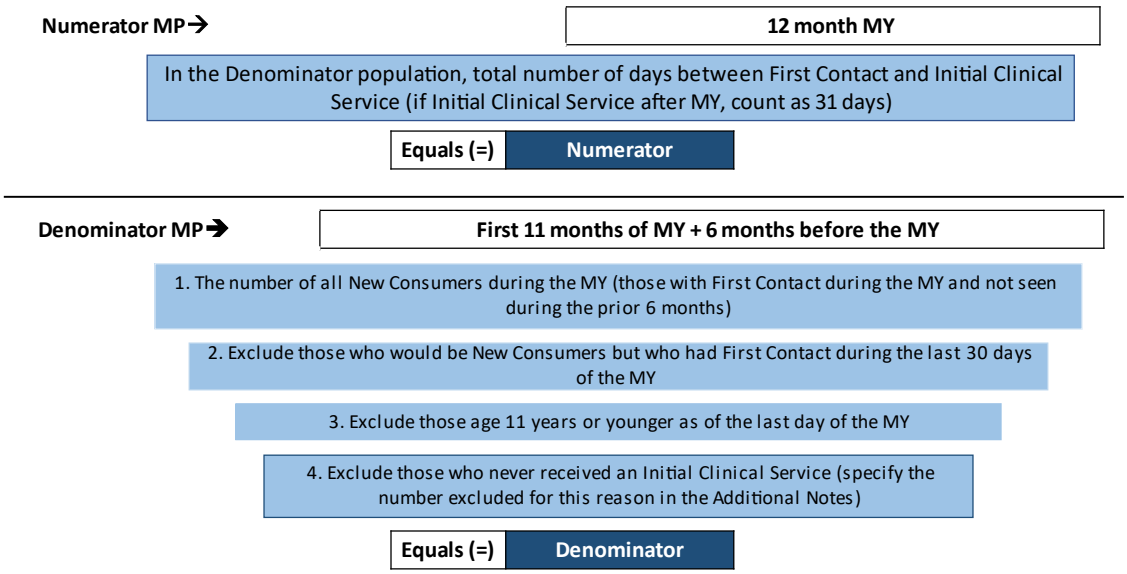
Note: The Measurement Period for the denominator is the Measurement Year excluding the last month of the Measurement Year and including the 6 months preceding the Measurement Year.

Numerator

The total number of days between First Contact and Initial Clinical Service for all members of the Section F denominator population (after exclusions)

Note: The Measurement Period for the numerator is the Measurement Year. Any who received an Initial Clinical Service after the last day of the Measurement Year are treated as having been served 31 days after First Contact.

Figure 4. Visual of Submeasure 2 Specification



Key: MP: Measurement Period; MY: Measurement Year.

G. SUBMEASURE SPECIFICATION #3

The Average number of hours until provision of Crisis Services following a first Crisis Episode contact (see Figure 5 for visual).

Note: This submeasure applies to face to face crisis services (e.g. mobile crisis) but not to crisis hotlines.

Denominator

The number of clients in the eligible population (Section D).

Note: A single individual may have multiple Crisis Service Episodes over the course of the Measurement Year and each such episode is counted. Additionally, the concept and definition of First Contact do not apply to submeasure 3.

Denominator Exclusions

Exclude from the Submeasure #3 denominator all clients who never received a Crisis Service in response to a Crisis Episode contact. Indicate in Additional Notes in the data reporting template the number so excluded.

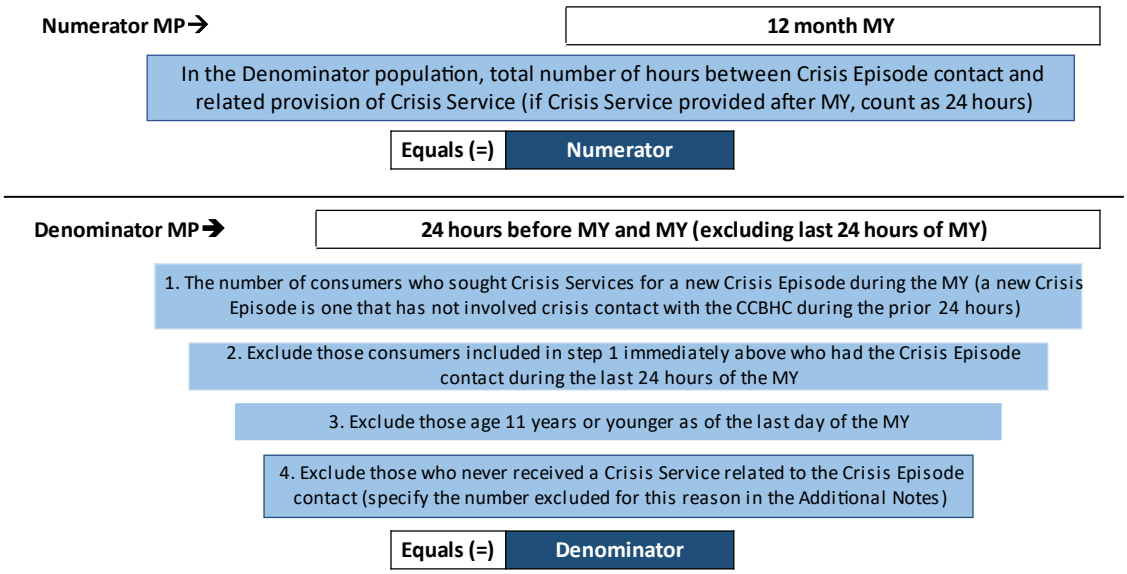
Note: The Measurement Period for the denominator is the Measurement Year excluding the last 24 hours of the Measurement Year and including the 24 hours immediately preceding the Measurement Year.

Numerator

The total number of hours between Crisis Episode contact and related provision of a Crisis Service for all members of the Section G denominator population (after exclusions)

Note: The Measurement Period for the numerator is the Measurement Year. Any who received a Crisis Service after the last day of the Measurement Year in response to a Crisis Episode contact during the Measurement Year are treated as having been served 24 hours after the Crisis Episode contact.

Figure 5. Visual of Submeasure 3 Specification



Key: MP: Measurement Period; MY: Measurement Year.

H. ADDITIONAL NOTES

This measure is designed to require provider-level reporting.

Interpretation of scores:

Mean number of days until Initial Evaluation or Initial Clinical Services for New Clients: Better quality = Lower number

Mean number of hours until receipt of Crisis Service**s after a** Crisis Episode **contact:** Better quality = Lower number

I. FREQUENTLY ASKED QUESTIONS

Questions Regarding Age:

Q: Why is this measure not reported for children younger than 12 years of age?
A: Ensuring timely access for younger children is important. If BHCs wish, they may report this measure for children younger than age 12 years of age but that information should be included in the additional notes in the bottom of the I-SERV data reporting template.

Questions Regarding Clients Who Do Not Attend Appointments within 10 Days:

Q: Why should we be penalized for clients who do not attend appointments within 10 days of First Contact?
A: For Submeasures 1 and 2, it is likely that some New Clients will not have an appointment within 10 days because of their own schedules, non-urgent needs, and/or rescheduling. This situation is a recognized limitation of this measure that will affect all clinics. Trying to adjust for New Clients who are offered but do not accept an appointment within 10 Business Days complicates the calculation. The same is true for clients who are referred only for forensic evaluation or who only seek service during a crisis but may go elsewhere for additional services. We suggest that, if you see patterns over time, you report in the space for additional notes in the bottom of the I-SERV data reporting template.

Questions Regarding Clients Who Do Not Receive Crisis Services within 24 Hours of Contact:

Q: Why should we be penalized for clients who contact us in crisis but are not seen within 24 hours of a Crisis Episode contact for no fault of ours?
A: Submeasure 3 is just a measure of your average time to provision of Crisis Services. The 24-hour time period is used only to indicate a new crisis episode and for no other reason. Moreover, for a variety of reasons, it is likely that some clients will not receive Crisis Services as promptly as others, which is why we are using an average over the course of a year.

Questions regarding multiple Crisis Episodes:

Q: If a client has multiple Crisis Episodes during the Measurement Year, is each episode counted in submeasure 3?
A: Yes, each episode is counted, provided there are more than 24 hours between episodes.

Depression Remission at Six Months (DEP-REM-6)[6]

Based on CMS MIPS CQMS #370 (2023), stewarded by MN Community Measurement (CBE #0710), modified for Depression Remission at Six Months (CBE #0711)

A. DESCRIPTION

The DEP-REM-6 measure calculates the Percentage of clients (12 years of age or older) with Major Depression or Dysthymia who reach Remission Six Months (+/- 60 days) after an Index Event Date.

Data Source: Medical Records

Important Reporting Guidance:

This section of the specification includes important guidance for reporting the DEP-REM-6 measure. Also refer to section (F) on Frequently Asked Questions.

- This measure is to be reported once per Measurement Year for clients seen during the Measurement Year with a diagnosis of Major Depression or Dysthymia **and** an initial Patient Health Questionnaire – 9 item version (PHQ-9) or Patient Health Questionnaire – 9 Modified for Teens and Adolescents (PHQ-9M) greater than nine (Index Event).
- Providers will rely on medical records to compile this information. There are several potential sources of information that may be used individually or together:
    - Electronic health records (including billing records)
    - Paper health records
    - A registry
- G or M codes are not available for this measure. Instead, a Provider may rely on an equally reliable source of information to indicate numerator compliance.
- DEP-REM-6 is stratified separately based on whether the client is:
    - an adolescent (12-17 years of age) or an adult (18 years of age and older,

      AND
        - Medicaid only or Other (including those dually eligible for Medicare and Medicaid)

      AND
        - a member of which of the following ethnic groups: Not Hispanic or Latino, Hispanic or Latino, or Unknown

      AND

[6]This measure differs from the 2016 Behavioral Health Clinic measure (DEP-REM-12) which looked at remission at 12 months. This measure only requires measurement of remission at six months.

- a member of which of the following racial groups: White or Caucasian, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or Pacific Islander, More than one race, or Unknown

- Refer to the specific data-reporting template for the reporting requirements applicable to each measure.

Measurement Period: The Measurement Period is the period for which data are required for reporting purposes. The Measurement Period for the **denominator** is the Measurement Year. The Measurement Period for the **numerator** begins four months after the beginning of the Measurement Year and extends eight (8) months past the end of the Measurement Year; this allows capture of Remission in the period 4 to 8 months after an Index Event Date that may occur at any point during the Measurement Year (6 months (+/- 60 days)). This equates to a four month window around the six month calendar date from the Index Event Date (+/- 60 days). See Figure 1 for visual depiction of Measurement Year, Measurement Periods, Index Event Dates and Measure Assessment Period.

Figure 1. Visual of Measurement Year, Measurement Periods, and Index Event Dates for Remission at Six Months

	Index screening may be 7 days before first possible IED																		
Months:	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
	MY																			
	Denominator MP: 12 mo MY																			
					Numerator MP: 6 mo +/- 60 days after IED															
If IED=x, R may be measured:	x				R	R	R	R	R											
If IED=x, R may be measured:		x				R	R	R	R	R										
If IED=x, R may be measured:			x				R	R	R	R	R									
If IED=x, R may be measured:				x				R	R	R	R	R								
If IED=x, R may be measured:					x				R	R	R	R	R							
If IED=x, R may be measured:						x				R	R	R	R	R						
If IED=x, R may be measured:							x				R	R	R	R	R					
If IED=x, R may be measured:								x				R	R	R	R	R				
If IED=x, R may be measured:									x				R	R	R	R	R			
If IED=x, R may be measured:										x				R	R	R	R	R		
If IED=x, R may be measured:											x				R	R	R	R	R	
If IED=x, R may be measured:												x				R	R	R	R	R

Key: IED: Index Event Date; MY: Measurement Year; MP: Measurement Period; R: Six Month Remission may be measured, depending on date, 4-8 months after IED (6 months (+/- 60 days)).

B. DEFINITIONS

TERM	DEFINITION
Index Event Date	The date on which the first instance of elevated PHQ-9 or PHQ-9M greater than nine **AND** diagnosis of Depression or Dysthymia occurs during the Measurement Year. Clients may be screened using PHQ-9 or PHQ-9M up to seven days prior to the encounter (including the day of the encounter).

Depression Remission at Six Months (DEP-REM-6)

TERM	DEFINITION
Measure Assessment Period[7]	The Index Event Date marks the start of the Measure Assessment Period for each client, which is 14 months (12 months +/- 60 days). This period is fixed and does not "start over" with a higher PHQ-9 or PHQ-9M that may occur after the Index Event Date. The Measure Assessment Period is held constant to accommodate both the six and twelve month depression outcome measures, if both are being used, so that the client does not re-index after the Six Month assessment. The window for assessing the Six Month measure, however, is at 6 months (+/- 60 days) or 4 to 8 months after Index Event Date.
Measurement Period	The specific time period for which data are needed for the numerator and denominator of a given measure. The Measurement Period may differ for the numerator and denominator and for each measure and is specified in section A above.
Measurement Year	The standard 12-month reporting period common to all measures being reported by the Provider.
Percentage	A Percentage is calculated as follows: numerator divided by denominator (n/d).
PHQ-9	The Patient Health Questionnaire (PHQ-9) tool is a widely accepted, standardized patient reported outcome tool that is completed by the client, ideally at each visit, and utilized by the provider to monitor treatment progress. It is available in many languages and was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, et al. It is in the public domain and can be obtained for free use on the Patient Health Questionnaire (PHQ) Screeners website at Link to PHQ-9. More than 75 language versions are available.
PHQ-9M	The PHQ-9M is a modification of the PHQ-9 geared for use with adolescents and, although it has not been validated, is widely used. This tool is similar to the PHQ-9 with only a few minor age-related wording modifications (e.g., schoolwork instead of newspaper) and scores with the same cut-points as the PHQ-9. The tool developer approved the minor wording changes. According to the measure developer, the American Psychiatric Association (APA) recommends using the PHQ-9M for children ages 11 to 17 to assess depression symptom severity (APA, 2015. Online Assessment Measures. Severity Measure for Depression, Child Age 11 to 17 (PHQ-9 modified for Adolescents [PHQ-A], Adapted) at Link to PHQ-9M.
Provider	The Provider entity that is being measured (i.e., BHC)
Remission	A PHQ-9 or PHQ-9M score of less than five
Six Months	The point in time from the Index Event Date extending out "Six Months" and then allowing a grace period of sixty days prior to and sixty days after this date. The most recent PHQ-9 or PHQ-9-M score less than five obtained during this four-month period is deemed Remission at Six Months; values obtained prior to or after this period are not counted as numerator compliant (Remission).

C. ELIGIBLE POPULATION

CRITERIA	REQUIREMENTS
Event/Age	Follow the steps below to identify the eligible population: ***Step 1***

[7]The Measure Assessment Period is only applicable to Providers reporting both a Six Month and Twelve Month Depression Remission outcome measure.

Depression Remission at Six Months (DEP-REM-6)

CRITERIA	REQUIREMENTS
	Identify clients seen at the Provider during the Measurement Year. ***Step 2*** Identify clients from step 1 who were aged 12 years or older at the Index Event Date. ***Step 3*** Identify clients from step 2 who: • Have an active diagnosis of Major Depression or Dysthymia (ICD-10-CM): F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F32.9, F33.0, F33.1, F33.2, F33.3, F33.40, F33.41, F33.42, F33.9, F34.1 • **At a client encounter** during the Measurement Year (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, G0402, G0438, G0439, 99384*, 99394*, 99421, 99422, 99423, 99441, 99442, 99443, 96156, 96158, 96159 ***NOTE #1:*** The diagnosis of Major Depression or Dysthymia may be in any diagnostic field and need not be the primary diagnosis. ***NOTE #2:*** Client encounters for this measure conducted via telehealth (e.g., encounters coded with GQ, GT, 95, or POS 02 modifiers) are allowable. ***NOTE #3:*** *Signifies that this CPT Category I code is a non-covered service under the Medicare Part B Physician Fee Schedule (PFS). These non-covered services should be counted in the eligible population. ***Step 4*** Identify clients from step 3 who have an Index Event Date PHQ-9 or PHQ-9M score greater than nine (9) documented during the denominator Measurement Period (as specified in Section A). ***NOTE #1:*** To be considered denominator eligible for this measure, the client must have both the diagnosis of Depression or Dysthymia and a PHQ-9 or PHQ-9M score greater than nine (9) documented on the same date or up to seven (7) days prior to encounter (Index Event) and this date occurs during denominator Measurement Period (as specified in Section A).

D. MEDICAL RECORD SPECIFICATION

DENOMINATOR:
All clients (aged 12 years or older with Major Depression or Dysthymia and an initial PHQ-9 or PHQ-9M score greater than nine on the Index Event Date (see Figure 2 for visual).

NOTE #1: The diagnosis of Major Depression or Dysthymia may be in any diagnostic field and need not be the primary diagnosis.

Depression Remission at Six Months (DEP-REM-6)

Denominator Criteria:
All clients in the Eligible Population (section C)

AND NOT
Denominator Exclusions:
Clients with an active diagnosis of Bipolar Disorder any time prior to the end of their numerator Measurement Period or, if the Provider also is reporting the Twelve Month Remission measure, their Measure Assessment Period:

- The following codes would be sufficient to define the Denominator Exclusion of Bipolar Disorder: F30.10, F30.11, F30.12, F30.13, F30.2, F30.3, F30.4, F30.8, F30.9, F31.0, F31.10, F31.11, F31.12, F31.13, F31.2, F31.30, F31.31, F31.32, F31.4, F31.5, F31.60, F31.61, F31.62, F31.63, F31.64, F31.70, F31.71, F31.72, F31.73, F31.74, F31.75, F31.76, F31.77, F31.78, F31.81, F31.89 or F31.9
- For historical reference purposes, these ICD-9 codes, if documented, would be sufficient to define the Denominator Exclusion of Bipolar Disorder: 296.00, 296.01, 296.02, 296.03, 296.04, 296.05, 296.06, 296.10, 296.11, 296.12, 296.13, 296.14, 296.15, 296.16, 296.40, 296.41, 296.42, 296.43, 296.44, 296.45, 296.46, 296.50, 296.51, 296.52, 296.53, 296.54, 296.55, 296.56, 296.60, 296.61, 296.62, 296.63, 296.64, 296.65, 296.66, 296.7, 296.80, 296.81, 296.82 or 296. 89

OR
Clients with an active diagnosis of Personality Disorder any time prior to the end of their numerator Measurement Period or, if the Provider also is reporting the Twelve Month Remission measure, their Measure Assessment Period:

- The following codes would be sufficient to define the Denominator Exclusion of Personality Disorder: F34.0, F60.3, F60.4, F68.10, F68.11, F68.12 or F68.13
- For historical reference purposes, these ICD-9 codes, if documented, would be sufficient to define the Denominator Exclusion of Personality Disorder: 301.13, 301.50, 301.51 or 301.83

OR
Clients with an active diagnosis of Schizophrenia or Psychotic Disorder any time prior to the end of their numerator Measurement Period or, if the Provider also is reporting the Twelve Month Remission measure, their Measure Assessment Period:

- The following codes would be sufficient to define the Denominator Exclusion of Schizophrenia or Psychotic Disorder: F20.0, F20.1, F20.2, F20.3, F20.5, F20.81, F20.89, F20.9, F21, F23, F25.0, F25.1, F25.8, F25.9, F28 or F29
- For historical reference purposes, these ICD-9 codes, if documented, would be sufficient to define the Denominator Exclusion of Schizophrenia or Psychotic Disorder: 295.00, 295.01, 295.02, 295.03, 295.04, 295.05, 295.10, 295.11,

295.12, 295.13, 295.14, 295.15, 295.20, 295.21, 295.22, 295.23, 295.24, 295.25, 295.30, 295.31, 295.32, 295.33, 295.34, 295.35, 295.40, 295.41, 295.42, 295.43, 295.44, 295.45, 295.50, 295.51, 295.52, 295.53, 295.54, 295.55, 295.60, 295.61, 295.62, 295.63, 295.64, 295.65, 295.70, 295.71, 295.72, 295.73, 295.74, 295.75, 295.80, 295.81, 295.82, 295.83, 295.84, 295.85, 295.90, 295.91, 295.92, 295.93, 295.94, 295.95, 298.0, 298.1, 298.4, 298.8 or 298.9

OR

Clients with an active diagnosis of Pervasive Developmental Disorder any time prior to the end of their numerator Measurement Period or, if the Provider also is reporting the Twelve Month Remission measure, their Measure Assessment Period:

- The following codes would be sufficient to define the Denominator Exclusion of Pervasive Developmental Disorder: F84.0, F84.3, F84.8 or F84.9
- For historical reference purposes, these ICD-9 codes, if documented, would be sufficient to define the Denominator Exclusion of Pervasive Developmental Disorder: 299.00, 299.01, 299.10, 299.11, 299.80, 299.81, 299.90 or 299.91

OR

Clients who died any time prior to the end of their numerator Measurement Period or, if the Provider also is reporting the Twelve Month Remission measure, their Measure Assessment Period

OR

Clients who received hospice or palliative care service any time during the numerator Measurement Period or, if the Provider also is reporting the Twelve Month Remission measure, their Measure Assessment Period:

- The following code would be sufficient to define the Denominator Exclusion of hospice or palliative care: Z51.5

NUMERATOR:

All clients in the denominator who achieved Remission at Six Months as demonstrated by a Six Month (+/- 60 days) PHQ-9 or PHQ-9M score of less than five (5) (see Figure 2 for visual)

Numerator Options:

Performance Met: Client identified as achieving Remission at Six Months as demonstrated by a Six Month (+/- 60 days) PHQ-9 or PHQ-9M score of less than 5

OR

Performance Not Met: Remission at Six Months **NOT** demonstrated by:

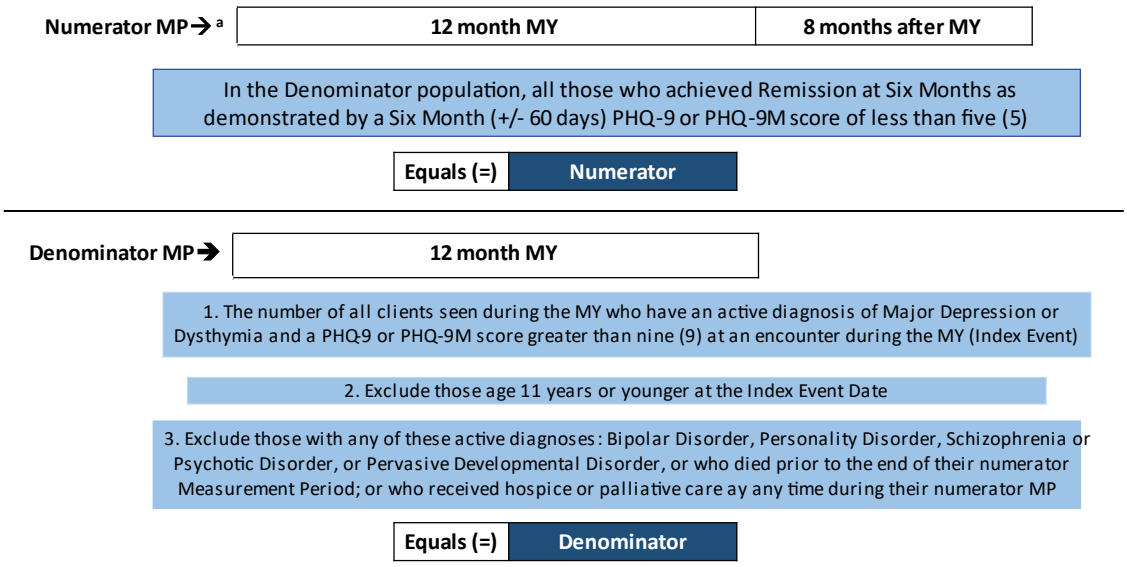
- A Six Month (+/- 60 days) PHQ-9 or PHQ-9M score of less than five
  OR
- PHQ-9 or PHQ-9M score was not assessed during the allowed time period

Depression Remission at Six Months (DEP-REM-6)

NOTE #1: The Measurement Period for the **numerator** begins four months after the beginning of the Measurement Year and extends eight (8) months past the end of the Measurement Year; this allows capture of Remission in the period 4 to 8 months after an Index Event Date (6 months (+/- 60 days)), as the Index Event Date may occur at any point during the Measurement Year. The Measure Assessment Period is held constant to accommodate both six and twelve month depression outcome measures for those who choose or are required to use both. Thus, the total Measure Assessment Period is 14 months so that the client does not re-index after the six month assessment.

NOTE #2: If more than one PHQ-9 or PHQ-9M is administered during the Measurement Period for the numerator, the most recent (latest) occurring within the Measurement Period is used.

Figure 2. Visual of DEP-REM-6 Specification



Key: MP: Measurement Period; MY: Measurement Year.
[a] The Numerator MP is the total potential time for which data must be available to compute the numerator. The reporter does not have 20 months to meet remission for Clients. Rather, this MP is for the entire group of Clients in the denominator, with the individual's remission measured depending on when the Index Event occurred in the 12 month MY.

E. ADDITIONAL NOTES

Both this and the source measure were specified at the provider level. This measure is not risk adjusted, although the source measure when reported to the state of Minnesota is. The source measure was assessed for reliability and validity for clinics with ≥ 30 clients in the denominator. This measure is modified from the source measure to provide a specification consistent in format to other measures in this set of BHC measures. The substance of the measure is unchanged.

Interpretation of scores: Better quality = Higher Percentage

F. FREQUENTLY ASKED QUESTIONS

Questions Related to Screening Tools Required to be Used:

Q: Must we use the PHQ-9 or PHQ-9M?
A: Yes, you must use one of those two instruments/screening tools. The developers of the source measure reviewed 21 additional tools against standardized criteria and concluded very few had cut-points for severity levels of depression or Remission. Further, using patient-reported outcome tools with significantly different numbers of questions could impact the response measures in addition to adversely affecting denominator comparability.

Q: Do we have to pay for the PHQ-9 or PHQ-9M?
A: No, these tools are in the public domain and require no further permission for use. More information can be obtained from the tool developer. To obtain a copy of the PHQ-9 tool or additional language translations, please visit www.phqscreeners.com.

Q: Is the PHQ-9M required to be used for adolescents?
A: No. Providers may elect to use either tool (the PHQ-9 or PHQ-9M); there is no measure construct restriction for age. According to MN Community Measurement, the PHQ-9 is validated for use for ages 13 years and older, however a provider group can elect to administer this tool for twelve-year-old clients as well. The depression measure development workgroup decided not to restrict the measure construct by age and supports the most efficient use of tools depending on the population of clients in each clinic.

Questions Related to How and When Screening Tools are Used and Scored:

Q: Some of our clinics have not used the PHQ-9 in the past, so clients currently being seen by the clinics for Major Depressive Disorder/Dysthymia do not have PHQ-9 or PHQ-9M scores. Do these clinics need to screen all their current clients using the PHQ-9 or PHQ-9M at the first visit during the DY?
A: The measure requires that BHC include in the denominator clients who (1) were seen at the BHC during the MY; (2) had a diagnosis of Major Depressive Disorder/Dysthymia; (3) were age 12 years or older, and (4) had a PHQ-9 or PHQ-9M score greater than 9 on the day they presented (or up to seven days prior). Careful examination of the metric indicates that the measure does not require universal population screening with a PHQ-9/PHQ-9M of all patients, however, when screening does occur and results in a score greater than nine, indicating a need for treatment, the patient is included in the denominator with an expectation for assessing for the outcome of remission at six months.

Q: Can someone other than the client complete the PHQ-9 or PHQ-9M (i.e., a proxy)?
A: No, the client must complete it themselves.

Q: Must the PHQ-9 or PHQ-9M be collected in a face to face office visit?
A: According to MN Community Measurement, acceptable methods for obtaining PHQ-9/PHQ-9M scores include traditional paper or electronic versions and they can be collected via:

- Office visit/in-person
- Telephone encounter
- E-visit
- Mail (post)
- Electronic administration (email, client portal, iPad/tablet, client kiosk)

Q: Who can administer the PHQ-9 or PHQ-9M?
A: According to MN Community Measurement, anyone can administer these tools, including office staff, the care team, receptionists, medical assistants, etc. For purposes of insurance billing, however, the Index Visit must be with an insurance-eligible provider.

Depression Remission at Six Months (DEP-REM-6)

Q: Can the PHQ-9 or PHQ-9M be changed to better fit our practice?
A: Regardless of mode of administration, the content of all tools must be kept intact including question text, order, and scoring. Tools that are altered from their original form are invalid.

Q: What if a client does not complete all nine questions or provides multiple responses? How should we score the PHQ-9 or PHQ-9M?
A: According to MN Community Measurement, the PHQ-9/9M tool contains nine items, each item earning a score from zero to three, providing a zero to 27 total severity score. Valid scores are whole numbers 0 – 27. If a client chooses more than one answer, select the "worst" of the answers which will be the higher score. The client must answer ALL nine questions for the score to be valid. If the PHQ-9/ 9M result is missing, invalid or incomplete, do NOT submit zero for these encounters. Tools that are not complete are invalid.

Questions Related to Diagnoses:

Q: In the past, the Depression or Dysthymia diagnosis had to be the primary diagnosis. Is that still true?
A: No, the diagnosis may be in any diagnostic field or order if a client has multiple diagnoses.

Questions Related to Index Event Dates:

Q: Is the Index Event Date for the measure the date of the first PHQ-9 or PHQ9M screening that resulted in a diagnosis of depression in the MY (or the seven (7) days prior)?
A: Yes.

Q: What if a client comes to intake and Major Depressive Disorder is diagnosed based on previous history, previous psychiatric hospitalization, or transfer from one CCBHC to our CCBHC, etc, and the current PHQ score is 9 or less. Then several weeks later, the client completes the PHQ9 and the score is greater than 9. Would this count as the Index Event Date even though the MDD diagnosis was not diagnosed on the same date the PHQ-9 score was greater than 9?
A: The point at which there is the first (in this case first known) PHQ-9 greater than 9 and a documented dx of MDD (not necessarily a new diagnosis, but an active diagnosis) is when the Index Event Date occurs. So, in this example, it will be at the point "several weeks later."

Questions Related to Multiple Visits:

Q: If there are multiple PHQ-9 scores submitted for an indexed client that fall within that client's Remission at Six Months "window" (the period 6 months after the Index Event Date (+/- 60 days), which score is evaluated for numerator compliance?
A: The most recent PHQ-9 or PHQ-9-M score less than five obtained during this four-month period is deemed Remission at Six Months for the numerator.

Depression Remission at Six Months (DEP-REM-6)

Questions Related to Capturing Remission at Six Months:

Q: How do you recommend clinics handle the situation where a client has finished treatment prior to the Remission at Six Months "window" and is no longer being seen by the clinic because they are in Remission? Should a follow-up appointment around 6 months be scheduled, even though the client is finished with treatment? Should the clinic note the number of people who achieved Remission prior to 6 months?
A: The measure does require such an appointment. We know it may be difficult to get people in if they do not otherwise need service. However, we ask that BHCs try, and, if they do not succeed, to treat failure to do so as not satisfying the numerator. Although it is not necessary, BHCs are free to indicate in the additional notes of the reporting template, the number of clients who do not appear in the Six-Month "window" but who are known to have achieved Remission prior to that point.

Questions Related to Measure Calculation:

Q: How do we handle missing data when we cannot assess someone at Six Months (± 60 days)?
A: According to MN Community Measurement, missing data (in this case follow-up PHQ-9/9M assessment) is not an issue as those clients who are not reassessed in follow-up remain in the denominator and are treated as if they are not in Remission.

Q: The DEP-REM-6 measure indicates that the **numerator** Measurement Period spans MY1 and 8 months into MY2 and the **denominator** Measurement Period encompasses MY1 only. Is this measure not required to be reported annually? If not, when will we be required to report on this measure?
A: For purposes of the CCBHC demonstration program, this measure is to be reported annually and, because it is a clinic-collected measure, it is reported by CCBHCs within 9 months of the end of the demonstration year (DY) for their state. This means that the data included in the numerator would, at the latest, end one month before the reporting due date.

Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling (ASC)

Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling (ASC)[9]

Based on CMS MIPS CQMS #431 (2023), which is derived from a measure stewarded by the National Committee for Quality Assurance (NCQA)[8]

A. DESCRIPTION

The ASC measure calculates the Percentage of clients aged 18 years and older who were screened for unhealthy alcohol use using a Systematic Screening Method at least once within the last 12 months AND who received brief counseling if identified as an unhealthy alcohol user.

Data Source: Medical Records

Important Reporting Guidance:

This section of the specification includes important guidance for reporting the ASC measure. Also refer to section F for Frequently Asked Questions.

- The MIPS CQMS measure 431 on which this measure is based contains three submeasures or submission criteria, with the third designed to allow comparison of performance to published versions of the measure prior to the MIPS 2021 performance year, when the measure had a single performance rate. ***We include all three but submeasure 3 is optional for newer reporters who are not also reporting MIPS.***
- This measure is to be reported once per Measurement Year for clients seen during the Measurement Year.
- Providers will rely on medical records to compile this information. There are several potential sources of information that may be used individually or together:
    - Electronic health records (including billing records)
    - Paper health records
    - A registry
- A Provider that does not use the G or M codes noted in the specifications below may rely on an equally reliable source of information (designated as "equivalent information source" in the specifications).

[8]The NCQA HEDIS® measure specification has been adjusted pursuant to NCQA's Rules for Allowable Adjustments of HEDIS.

[9]Note: The National Quality Forum (NQF) endorsed version of ASC (#2152) contains different requirements, including screening only every 24 months and different AUDIT and Single Question Screening scores for unhealthy alcohol use. The 2016 version of this Behavioral Health Clinic (BHC) measure relied on the NQF version of the measure. This 2023 version aligns, instead, with the MIPS version which requires screening and brief counseling services during the Measurement Year or within the prior 12 months.

- For the purposes of the measure, the most recent denominator eligible encounter should be used to determine if the numerator action for the submeasure was performed within the 12-month look back period.
- ASC is stratified separately based on whether the client is:
    - Medicaid only or Other (including those dually eligible for Medicare and Medicaid)

    AND
    - A member of which of the following ethnic groups: Not Hispanic or Latino, Hispanic or Latino, or Unknown

    AND
    - A member of which of the following racial groups: White or Caucasian, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or Pacific Islander, More than one race, or Unknown
- Refer to the specific data-reporting template for the reporting requirements applicable to each measure.

Measurement Period: The Measurement Period is the period for which data are required for reporting purposes. The Measurement Period for the **denominator** is the Measurement Year and, for the **numerator**, is the Measurement Year and the prior year. See Figure 1 for visual depiction of Measurement Year and Measurement Periods.

Figure 1. Visual of Measurement Year and Measurement Periods

Year before Measurement Year	Measurement Year
[redacted]	**Measurement Year (MY): 12 month reporting period**
	Denominator Measurement Period (MP): 12 month MY
Numerator Measurement Period: MY and previous year	

Key: MY: Measurement Year; MP: Measurement Period.

B. DEFINITIONS

TERM	DEFINITION
AUDIT and AUDIT-C	The AUDIT is the Alcohol Use Disorders Identification Test, and the AUDIT-C is an abbreviated version of the AUDIT. Both were developed by the World Health Organization.
Brief Counseling	Brief Counseling for unhealthy alcohol use refers to one or more counseling sessions, a minimum of 5-15 minutes, which may include: feedback on alcohol use and harms; identification of high-risk situations for drinking and coping strategies; increased motivation and the development of a personal plan to reduce drinking.
Measurement Period	The specific time period for which data are needed for the numerator and denominator of a given measure. The Measurement

TERM	DEFINITION
	Period may differ for the numerator and denominator and for each measure and is specified in section A above.
Measurement Year	The standard 12-month reporting period common to all measures being reported by the Provider.
Percentage	A Percentage is calculated as follows: numerator divided by denominator (n/d).
Provider	The Provider entity that is being measured (i.e., BHC)
Submeasure	ASC is comprised of calculations for three different approaches to assessing rates of screening and brief counseling.
Systematic Screening Method[10]	For purposes of this measure, one of the following systematic methods to assess unhealthy alcohol use must be utilized. Systematic Screening Methods and thresholds for defining unhealthy alcohol use include: • AUDIT Screening Instrument (score ≥ 8) • AUDIT-C Screening Instrument (score ≥4 for men; score ≥3 for women) • Single Question Screening - How many times in the past year have you had 5 (for men) or 4 (for women and all adults older than 65 years) or more drinks in a day? (response ≥1)

C. ELIGIBLE POPULATION

CRITERIA	REQUIREMENTS
Event/Age	Follow the steps below to identify the eligible population: ***Step 1*** Identify clients seen at the Provider during the Measurement Year. ***Step 2*** Identify clients from step 1 who were aged 18 years and older on the date of service during the Measurement Year. ***Step 3*** 1. Had at least two encounters at the Provider during the Measurement Year. Relevant codes (Current Procedural Terminology [CPT®] or Healthcare Common Procedure Coding System [HCPCS]) include: 90791, 90792, 90832, 90834, 90837, 90845, 92002, 92004, 92012, 92014, 92521, 92522, 92523, 92524, 92540, 92557, 92625, 96156, 96158,

[10]Please note that the scores for the third bullet has changed in the source measure since the 2016 BHC measures were published. The response for the Single Question Screening for women and adults older than 65 years decreased from ≥2 to ≥1.

Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling (ASC)

CRITERIA	REQUIREMENTS
	97161, 97162, 97163, 97165, 97166, 97167, 97168, 97802, 97803, 97804, 99024, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, G0270, G0271 **OR** 2. Had one preventive care visit. Relevant codes (Current Procedural Terminology [CPT®] or Healthcare Common Procedure Coding System [HCPCS]) include: 99385*, 99386*, 99387*, 99395*, 99396*, 99397*, 99401*, 99402*, 99403*, 99404*, 99411*, 99412*, 99429*, G0438, G0439 ***NOTE #1:*** *Signifies that this CPT Category I code is a non-covered service under the Medicare Part B Physician Fee Schedule (PFS). These non-covered services should be counted in the eligible population. ***NOTE #2:*** Client encounters for this measure conducted via telehealth (e.g., encounters coded with GQ, GT, 95, or POS 02 modifiers) are allowable.

D. MEDICAL RECORD SPECIFICATION

There are three submeasures for the ASC measure:

1) Percentage of clients aged 18 years and older who were screened for unhealthy alcohol use using a Systematic Screening Method at least once within the last 12 months

AND

2) Percentage of clients aged 18 years and older who were identified as unhealthy alcohol users (in submeasure #1) who received Brief Counseling

AND

3) Percentage of clients aged 18 years and older who were screened for unhealthy alcohol use using a Systematic Screening Method at least once within the last 12 months AND who received Brief Counseling if identified as unhealthy alcohol users, or were not identified as an unhealthy alcohol user ***(Providers should use only submeasures 1 and 2 unless they were reporting this measure as part of MIPS before 2017).***

Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling (ASC)

SUBMEASURE 1: ALL CLIENTS WHO WERE SCREENED FOR UNHEALTHY ALCOHOL USE

DENOMINATOR (SUBMEASURE 1):
All clients aged 18 years and older seen for at least two visits or at least one preventive visit during the Measurement Year (see MIPS source measure for 2023, or more current in later years, for visual example).

Denominator Criteria:
All clients in the Eligible Population (section C)

AND NOT
Denominator Exclusions:
Clients with dementia at any time during the patient's history through the end of the Measurement Year **(M1164 or equivalent information source)**

OR
Clients who use hospice services any time during the Measurement Year **(M1165 or equivalent information source)**

NOTE: If documented, an individual already diagnosed with an alcohol use disorder prior to the Measurement Year also may be excluded from the denominator. This is determined on the date of the most recent denominator eligible encounter for all submeasures.

NUMERATOR (SUBMEASURE 1):
All clients in the denominator who were screened for unhealthy alcohol use using a Systematic Screening Method at least once within the last 12 months

NUMERATOR NOTE: *To satisfy the intent of this measure, a client must have at least one screening for unhealthy alcohol use during the 12-month period. If a client has multiple screenings for unhealthy alcohol use during the 12-month period, only the most recent denominator eligible screening, which has a documented status of unhealthy alcohol user or unhealthy alcohol non-user, will be used to satisfy the measure requirements.*

Numerator Options:

Performance Met:

- Client identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a Systematic Screening Method **(G2196 or equivalent information source),**
  OR

- Client screened for unhealthy alcohol use using a Systematic Screening Method and not identified as an unhealthy alcohol user **(G2197 or equivalent information source)**

OR
Performance Not Met: Client not screened for unhealthy alcohol use using a Systematic Screening Method **(G2199 or equivalent information source)**

SUBMEASURE 2: ALL CLIENTS WHO WERE IDENTIFIED AS UNHEALTHY ALCOHOL USERS AND WHO RECEIVED BRIEF COUNSELING

DENOMINATOR (SUBMEASURE 2):
All clients aged 18 years and older seen for at least two visits or at least one preventive visit during the Measurement Year who were screened for unhealthy alcohol use and identified as an unhealthy alcohol user (see MIPS source measure for 2023, or more current in later years, for visual example).

Denominator Criteria:
All clients in the Eligible Population (section C)
AND
All eligible instances when **G2196 (or equivalent information source)** is submitted for Performance Met (client identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a Systematic Screening Method) in the numerator of Submeasure 1

AND NOT
Denominator Exclusions:
Clients with dementia at any time during the patient's history through the end of the Measurement Year **(M1164 or equivalent information source)**

OR
Clients who use hospice services any time during the Measurement Year **(M1165 or equivalent information source)**

NUMERATOR (SUBMEASURE 2):
All clients in the denominator who received Brief Counseling

Numerator Options:

Performance Met: Client identified as an unhealthy alcohol user received Brief Counseling **(G2200 or equivalent information source)**

OR
Performance Not Met: Client did not receive Brief Counseling if identified as an unhealthy alcohol user, reason not given **(G2202 or equivalent information source)**

Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling (ASC)

SUBMEASURE 3: ALL CLIENTS WHO WERE SCREENED FOR UNHEALTHY ALCOHOL USE AND, IF IDENTIFIED AS AN UNHEALTHY ALCOHOL USER, RECEIVED BRIEF COUNSELING, OR WERE NOT IDENTIFIED AS AN UNHEALTHY ALCOHOL USER (*Providers should not use submeasure 3 unless they were reporting TSC as part of MIPS before 2017.*)

DENOMINATOR (SUBMEASURE 3):
All clients aged 18 years and older seen for at least two visits or at least one preventive visit during the Measurement Year (see MIPS source measure for 2023, or more current in later years, for visual example).

Denominator Criteria:
All clients in the Eligible Population (section C)

AND NOT
Denominator Exclusions:
Clients with dementia at any time during the patient's history through the end of the Measurement Year **(M1164 or equivalent information source)**

OR
Clients who use hospice services any time during the Measurement Year **(M1165 or equivalent information source)**

NOTE: If documented, an individual already diagnosed with an alcohol use disorder prior to the Measurement Year also may be excluded from the denominator. This is determined on the date of the most recent denominator eligible encounter for all submeasures.

NUMERATOR (SUBMEASURE 3):
All clients in the denominator who were screened for unhealthy alcohol use using a Systematic Screening Method at least once within 12 months **AND** who received Brief Counseling if identified as an unhealthy alcohol user

NUMERATOR NOTE: *To satisfy the intent of this measure, a client must have at least one unhealthy alcohol use screening during the 12-month period. If a client has multiple unhealthy alcohol use screenings during the 12-month period, only the most recent denominator eligible screening, which has a documented status of unhealthy alcohol user or unhealthy alcohol non-user, will be used to satisfy the measure requirements.*

Numerator Options:

Performance Met: Client identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a Systematic Screening Method and received Brief Counseling **(G9621 or equivalent information source)**
OR

Performance Met: Client not identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a Systematic Screening Method **(G9622 or equivalent information source)**

OR

Performance Not Met: Client not screened for unhealthy alcohol use using a Systematic Screening Method or client did not receive Brief Counseling if identified as an unhealthy alcohol user, reason not given **(G9624 or equivalent information source)**

E. ADDITIONAL NOTES

Both this and the source measure were specified at the provider level. Neither is risk adjusted. This measure is modified from the source measure to provide a specification consistent in format to other measures in this set of BHC measures. The substance of the measure is unchanged.

Interpretation of scores: Better quality = Higher Percentage

F. FREQUENTLY ASKED QUESTIONS

Questions Related to Screening Tools:

Q: Do all BHCs in a state have to use the same screening tool?
A: No, all BHCs do not have to use the same screening tool. They should, however, all use an approach that is "systematic" as that is defined in the Technical Specification for the measure (i.e., AUDIT, AUDIT-C, single question screening).

Q: Is it the case that the AUDIT and AUDIT-C are the only tools to use for unhealthy alcohol use?
A: No. There is one other option: the brief screening tool that is included in the Technical Specification definitions and which contains a single-question screen about number of drinks, which differs for men, women, and older adults. Information also is available about what cut-off score a client needs to obtain on any of the 3 allowable screens to be considered as having unhealthy alcohol use.

Q: For the measure of screening and intervention for unhealthy alcohol use, if we have other screens already embedded in our EHR, can we use those instead of the AUDIT?
A: Only the AUDIT, AUDIT-C, and the single-question screen specified in the ASC measure are permissible. Those are the only screens you can use to satisfy the numerator.

Q: For the measure of screening and intervention for unhealthy alcohol use, is the AUDIT tool in the public domain?
A: The AUDIT is freely available from a variety of sources, including the World Health Organization (WHO) that developed the AUDIT. You can access it on the WHO website at: WHO AUDIT Guidelines. However, it may not be sold or used for commercial purposes. The AUDIT has been validated across sex, age, and cultures and is available in more than 50 languages.

Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling (ASC)

Q: For the measure of screening and intervention for unhealthy alcohol use, is the CAGE appropriate given that we have that in our EHR?
A: The CAGE is not one of the three allowed screening tools. It is important to note that the CAGE is only validated for adults, so it is not appropriate for use with adolescents. It also is less valid than alternative screening tools with some other client groups such as pregnant women. The CAGE is often included as a default screen in EHRs, but that does not mean it is always appropriate for all ages or segments of the population. You should determine how to include other screens in the EHR to make sure you have what you need to satisfy the measure and what you need for a particular population segment.

Questions Related to Screening Clients with a Diagnosed Alcohol Use Disorder:

Q: Is screening required for individuals with a diagnosed alcohol use disorder?
A: No, those with an existing active diagnosis of an alcohol use disorder prior to the Measurement Year would be omitted from the denominator.

Questions Related to Frequency of Screening:

Q: Can BHCs screen more frequently than once a year?
A: Yes, BHCs can screen more frequently. The measure, however, only looks at the last screen in the Measurement Year. ***Note:*** The earlier version of this measure only looked at screening at least every 24 months. This revision changes that and makes the BHC measure consistent with the current MIPS measure.

Questions Related to Screening Provider:

Q: Which staff is required to screen?
A: The measure does not specify which staff should do the screening other than by inclusion of specific codes designating an eligible encounter. The BHC should follow any state or other requirements for licensure and training that would otherwise apply.

Questions Related to Timing of Screening and Brief Intervention:

Q: Do the screening and brief intervention need to happen in the same session/encounter?
A: If you are screening someone for alcohol use, however, the time for a brief intervention is when they are screened. It should happen at the same encounter.

Questions Related to Client Age:

Q: Can the measure be reported for clients younger than age 18 years?
A: It is only required in the measure for those ages 18 year or older but BHCs may also report this submeasure for individuals younger than age 18 years of age if they wish but that information should be included in the additional notes in the bottom of the ASC data reporting template. If you are screening adolescents, however, you will need to use standardized tools that

have been validated for that age group. Both the AUDIT and AUDIT-C are validated for adolescents, but cut-offs may need to be lower. See Liskola et al. (2018).

Questions Related to Coding:

Q: Our system does not support the G or M codes needed to calculate the denominator exclusions or numerators. What should we do?
A: Although we recommend using the G or M codes, a provider that does not use the G or M codes noted in the specifications may rely on an **equally reliable** source of information (designated as "equivalent information source" in the specifications).

Screening for Social Drivers of Health (SDOH)

Based on MIPS CQMS #487 (2023), stewarded by CMS

A. DESCRIPTION

The SDOH measure calculates the Percentage of clients 18 years and older screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety.

Data Source: Medical Records

Important Reporting Guidance:

This section of the specification includes important guidance for reporting the SDOH measure. Also refer to section F for Frequently Asked Questions.

- This measure is to be reported once per Measurement Year for clients seen during the Measurement Year.
- Providers will rely on medical records to compile this information. There are several potential sources of information that may be used individually or together:
    - Electronic health records (including billing records)
    - Paper health records
    - A registry
- A Provider that does not use the M codes noted in the numerator specifications below may rely on an equally reliable source of information (designated as "equivalent information source" in the numerator specifications).
- SDOH is stratified separately based on whether the client is:
    - Medicaid only or Other (including those dually eligible for Medicare and Medicaid)

    AND
    - a member of which of the following ethnic groups: Not Hispanic or Latino, Hispanic or Latino, or Unknown

    AND
    - a member of which of the following racial groups: White or Caucasian, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or Pacific Islander, More than one race, or Unknown
- Refer to the specific data-reporting template for the reporting requirements applicable to each measure.

Measurement Period: The Measurement Period is the period for which data are required for reporting purposes. The Measurement Period for both the **denominator and the numerator** is the Measurement Year.

B. DEFINITIONS

TERM	DEFINITION
Measurement Period	The specific time period for which data are needed for the numerator and denominator of a given measure. The Measurement Period may differ for the numerator and denominator and for each measure and is specified in section A above.
Measurement Year	The standard 12-month reporting period common to all measures being reported by the Provider.
Percentage	A Percentage is calculated as follows: numerator divided by denominator (n/d).
Provider	The Provider entity that is being measured (i.e., BHC)
Social Drivers of Health (SDOH)	Also referred to as Social Determinants of Health, SDOH "are the nonmedical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life." (CDC, 2022).
Standardized Health-Related Social Needs (HRSN) Screening	HRSN is the term used by HHS to refer to an individual's unmet, adverse social conditions that contribute to poor health as a result of the community's underlying SDOH. Examples of standardized HRSN screening tools include but are not limited to: • Accountable Health Communities Health-Related Social Needs Screening Tool (2017) • Accountable Health Communities Health-Related Social Needs Screening Tool (2022) • The Protocol for Responding to and Assessing Patients' Risks and Experiences (PRAPARE) Tool (2016) • WellRx Questionnaire (2014) • American Academy of Family Physicians (AAFP) Screening Tool (2018)

C. ELIGIBLE POPULATION

CRITERIA	REQUIREMENTS
Event/Age	Follow the steps below to identify the eligible population: ***Step 1***

CRITERIA	REQUIREMENTS
	Identify clients seen at the Provider during the Measurement Year. ***Step 2*** Identify clients from step 1 who were aged 18 years and older on the date of service during the Measurement Year. ***Step 3*** Identify clients from step 2 who had at least one of the following encounters at the Provider during the Measurement Year (CPT): 59400, 59510, 59610, 59618, 78012, 78070, 78075, 78102, 78140, 78185, 78195, 78202, 78215, 78261, 78290, 78300, 78305, 78315, 78414, 78428, 78456, 78458, 78579, 78580, 78582, 78597, 78601, 78630, 78699, 78708, 78725, 78740, 78801, 78803, 78999, 90791, 90792, 90832, 90834, 90837, 90839, 90845, 90945, 90947, 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90960, 90961, 90962, 90963, 90964, 90965, 90966, 90967, 90968, 90969, 90970, 92002, 92004, 92012, 92014, 92507, 92508, 92521, 92522, 92523, 92524, 92526, 92537, 92538, 92540, 92541, 92542, 92544, 92545, 92548, 92549, 92550, 92557, 92567, 92568, 92570, 92588, 92625, 92626, 92650*, 92651, 92652, 92653, 96116, 96156, 96158, 97129, 97161, 97162, 97163, 97164, 97802, 97803, 97804, 98960, 98961, 98962, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99221, 99222, 99223, 99231, 99232, 99233, 99236, 99242*, 99243*, 99244*, 99245*, 99281, 99282, 99283, 99284, 99285, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99381*, 99382*, 99383*, 99384*, 99385*, 99386*, 99387*, 99391*, 99392*, 99393*, 99394*, 99395*, 99396*, 99397*, 99401*, 99402*, 99403*, 99404*, 99411*, 99412*, 99429*, 99495, 99496, 99512*, D0120*, D0140*, D0145*, D0150, D0160*, D0170*, D0180*, D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7251, G0101, G0108, G0270, G0271, G0402, G0438, G0439, G0447, G0473, G9054

D. MEDICAL RECORD SPECIFICATION

DENOMINATOR:
All clients in the Eligible Population (section C) (see MIPS source measure for 2023, or more current in later years, for visual example).

> ***DENOMINATOR NOTE:*** **Signifies that this CPT Category I code is a non-covered service under the Medicare Part B Physician Fee Schedule (PFS). These non-covered services should be counted in the denominator population.*

NOTE: Client encounters for this measure conducted via telehealth (e.g., encounters coded with GQ, GT, 95, or POS 02 modifiers) are allowable.

NUMERATOR:
Number of patients 18 years and older screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety.

NUMERATOR NOTE: The patient is required to have a standardized health-related social needs (HRSN) screening done once per performance period. Documentation that a review of a previous performed standardized HRSN screening during the performance period is acceptable for meeting the numerator criteria. See definitions for examples of standardized HRSN screening tools.

Numerator Options:

Performance Met:
Number of patients screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety **(M1207 or equivalent information source)**

OR

Performance Not Met:
Number of patients not screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety. **(M1208 or equivalent information source)**

E. ADDITIONAL NOTES

Both this and the source measure were specified at the provider level. Neither is risk adjusted. This measure is modified from the source measure to provide a specification consistent in format to other measures in this set of BHC measures. The substance of the measure is unchanged.

Interpretation of scores: Better quality = Higher Percentage

F. FREQUENTLY ASKED QUESTIONS

Questions Related to Screening Tools:

Q: Do all BHCs in a state have to use the same screening tool?
A: No, unless the state says otherwise, all BHCs do not have to use the same screening tool. They should, however, all use a tool that is "standardized," preferably one of those included in the Definition of Standardized Health-Related Social Needs (HRSN) Screening in section B of the Technical Specification for the measure. A standardized instrument is one that has been determined to be valid and reliable when administered and scored in a manner consistent with its validation in a given population.

Questions Related to Frequency of Screening:

Q: Can BHCs screen more frequently than once a year?
A: Yes, BHCs can screen more frequently. The measure, however, only requires one screening per Measurement Year.

Questions Related to Screening Provider:

Q: Which staff is required to screen?
A: The measure does not specify which staff should do the screening other than by inclusion of specific codes designating an eligible encounter. The BHC should follow any state or other requirements for licensure and training that would otherwise apply.

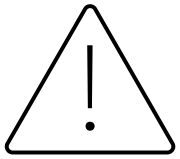
Questions Related to Client Age:

Q: Can the measure be reported for clients younger than age 18 years?
A: It is only required in the measure for those ages 18 year or older but BHCs may also report this submeasure for individuals younger than age 18 years of age if they wish but that information should be included in the additional notes in the bottom of the SDOH data reporting template.

Questions Related to Coding for the Numerator(s):

Q: Our system does not support the M codes needed to calculate the numerators. What should we do?
A: Although we recommend using the M codes for the numerators, a provider that does not use the M codes noted in the numerator specifications may rely on an **equally reliable** source of information (designated as "equivalent information source" in the numerator specifications).

Supplemental Materials for Screening for Depression and Follow-Up Plan (CDF-AD and CDF-CH)



Important Supplemental Materials for Clinic-Collected Required BHC Measures derived from CMS Medicaid Adult and/or Child Core Set Measures (CDF-AD and CDF-CH)

These supplemental materials are necessary for implementation of the Clinic-Collected Required BHC Measures that are derived from the CMS Medicaid Adult and/or Child Core Set Measures. This volume includes the exact specifications that are on the CMS website for the 2023 Medicaid Core Set, with simple modifications noted in the text. Limited additional needed modifications are included below, as well as supplemental useful materials.

1. **Measure CDF-AD: Screening for Depression and Follow-Up Plan: Age 18 and Older**
2. **Measure CDF-CH: Screening for Depression and Follow-Up Plan: Ages 12 to 17**

Changes within the specification: For both CDF measures, the changes within the CMS Medicaid Adult and Child Core Sets specifications reflect: (1) substitution of the word "client" for "beneficiary" or "patient", unless the latter is part of a copyrighted code description; (2) removal of age stratification in the adult measure (i.e., applicable here to adults ages 18 years and older); and (3) removal of references to the Core Set.

Additional information: For both CDF measures, the following material is provided to assist clinics in using the specifications and follows the numbering system used in the non-Medicaid Core Set-derived BHC specifications:

A. DESCRIPTION
Important Reporting Guidance:

- Both the CDF-AD and CDF-CH measures are to be used by BHCs to measure performance related to clients seen at the Provider during the Measurement Year.
- A Provider that does not use the G codes noted in the specifications may rely on an equally reliable source of information.
- Both CDF-AD and CDF-CH are to be stratified separately based on whether the client is:
    - Medicaid only or Other (including those dually eligible for Medicare and Medicaid)
      AND
    - A member of which of the following ethnic groups: Not Hispanic or Latino, Hispanic or Latino, or Unknown
      AND
    - A member of which of the following racial groups: White or Caucasian, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or Other Pacific Islander, More than one race, or Unknown

- Refer to the specific data-reporting template for the reporting requirements applicable to each measure.

Measurement Period: The Measurement Period is the period for which data are required for reporting purposes. The Measurement Period for the CDF **denominator** is the Measurement Year and, for the CDF **numerator**, is the Measurement Year. See Figure 1 for visual depiction of Measurement Year and Measurement Periods.

Figure 1. Visual of Measurement Year and Measurement Periods

Measurement Year
Measurement Year (MY): 12 month reporting period
Denominator Measurement Period (MP): 12 month MY
Numerator Measurement Period (MP): 12 month MY

Key: MY: Measurement Year; MP: Measurement Period.

B. DEFINITIONS

TERM	DEFINITION
Measurement Period	The specific time period for which data are needed for the numerator and denominator of a given measure. The Measurement Period may differ for the numerator and denominator and for each measure and is specified in section A above.
Measurement Year	The standard 12-month reporting period common to all measures being reported by the Provider.
Percentage	A Percentage is calculated as follows: numerator divided by denominator (n/d).
Provider	The Provider entity that is being measured (i.e., BHC)

E. ADDITIONAL NOTES

Interpretation of scores: Better quality = Higher Percentage

F. FREQUENTLY ASKED QUESTIONS

Questions related to eligible encounters:

Q: For the CDF measures, how do you define an encounter? Is it a visit with any provider (e.g., therapist, MD, nurse practitioner, physician assistant)?
A: The codes that indicate whether an encounter makes an individual eligible for inclusion in the denominator are provided in the measure specification. These codes include ones for services that may be utilized by a psychiatrist, a Master's-level clinician, a psychologist, PCPs, or other providers. You should review the precise codes and who, within the licensure and other applicable requirements in your state, can provide the "eligible encounter." Note that 42 CFR §440.50(a)(2)) allows those working under the supervision of a physician to perform services a physician would perform if it is within the licensure scope of services. For purposes of the CCBHC demonstration, if other codes are available, the state should consider developing a list of all such codes and the codes should be used uniformly across all CCBHCs.

Supplemental Materials for Screening for Depression and Follow-Up Plan (CDF-AD and CDF-CH)

Questions regarding screening tools:

Q: What screening tools should we use for the CDF measures?
A: The technical specifications for the CDF-AD and CDF-CH measures require that BHCs use standardized instruments and the specifications identify multiple examples of such instruments, including ones specifically for adults, children, prenatal, and perinatal screening. The lists are not exhaustive and you may use another, as long as it is a normalized and validated depression screening tool developed for the population in which it is being utilized.

Questions regarding exclusion criteria for existing diagnosis of depression or bipolar disorder:

Q: The CDF measure specifications exclude individuals with a diagnosis of depression or bipolar disorder. What if you do not know when the diagnosis was made or what depression screening tool was used?
A: The denominator exclusion in the CDF-AD and CDF-CH measures for those with an existing diagnosis of depression or bipolar disorder means that the person already has a diagnosis. In other words, that person presumably still satisfies the criteria for the diagnosis, and therefore you do not count them in either the numerator or the denominator because they are already diagnosed. It does not matter what tool was used to diagnose them in the past, and you do not need to screen them again for purposes of the measure. It is simply a way to only identify people who have not yet been diagnosed for depression or bipolar disorder.

Questions regarding need to screen all clients:

Q: Do the CDF measures require us to screen every client that is either new or currently open, who does not have a diagnosis of depression or bipolar disorder?
A: If clients are 12 years of age or older and have an encounter identified in the specification that qualifies them to be included in the denominator, such clients do need to be screened unless they: (1) meet an exclusion (i.e., have an existing diagnosis of depression or bipolar disorder) or satisfy one of the exceptions to being screened (i.e., exclusions include (a) refusal, (b) an urgent or emergent situation that precludes it, or (c) their cognitive or functional capacity, or motivation, may affect the accuracy of results).

Questions regarding need to screen on every visit:

Q: The CDF measures seem to indicate that screening should be done at all visits if there is not an existing diagnosis of depression or bipolar disorder. In some cases, individuals may be seen multiple times in a week (e.g., once for an injection, once to see a therapist, and once to see the doctor). Would we therefore have to screen for depression three times in one week? Is it the intent that these screenings be conducted at that frequency?
REVISED A: For CDF-AD and CDF-CH measures, the numerator specification requires screening for everyone who is eligible and does not meet one of the exclusions or exceptions. Even if a client of a BHC is not diagnosed with depression or bipolar disorder but is being seen frequently for one or more other mental health and/or substance use disorder diagnoses, it remains possible that the person has undiagnosed co-occurring depression. That is why the

measure previously was interpreted as requiring administration of a standardized instrument at each encounter if a diagnosis does not already exist. The electronic version of this measure, however, has been modified to indicate that "[t]his eCQM is a patient-based measure. Depression screening is required once per measurement period, not at all encounters." This reflects an upcoming change to the Core Set measure for 2024 which will parallel the electronic measure. For that reason, we will treat this as a once a Measurement Year requirement for those in the Eligible Population.

Standardized screening instruments for depression can be brief and can be administered at any point within 14 days prior to the encounter. However, this 14 day period prior to any given encounter means that administration of a standardized depression screening instrument within the past 14 days, that has been addressed by the provider, satisfies the screening requirement. If positive, it also triggers the requirement for a follow-up plan.

Questions regarding alternative measurement approaches:

Q: In calculating the CDF measures, BHCs will gather information on (a) whether a screening occurred, (b) whether the screen was positive, and (c) whether there was a follow-up plan if the screen was positive. By including only one numerator (was screened and, if positive, had follow-up plan), it will be difficult to tell if low rates on the quality measure are because patients are not being screened or because of provider failure to follow-up on positive screens. Could this measure be modified to include the following breakout?

1. Screening
    - Denominator: All eligible
    - Numerator: Encounters where screening occurred
2. Follow-up
    - Denominator: Positive screenings
    - Numerator: Follow-up plan was made

A: This information would be useful, and BHCs can elect to modify how they calculate this measure in that way **for their own use**. We, however, cannot modify it from the existing structure that parallels the source measure and request that BHCs report it on the data reporting template as it is written in the specification. BHCs also have the option of reporting the suggested alternative approach in the Additional Notes section at the bottom of the data reporting template.

Measure CDF-AD: Screening for Depression and Follow-Up Plan: Age 18 and Older[11]

Based on a CMS Medicaid Adult Core Set Measure (2023), stewarded by CMS

A. DESCRIPTION

Percentage of ~~beneficiaries~~ [clients] age 18 and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the eligible encounter.

Data Collection Method: Administrative or EHR

Guidance for Reporting:

The Screening for Depression and Follow-Up Plan measure includes ~~beneficiaries~~ [clients] ages 12 and older. The ~~Child Core Set~~ [CDF-CH] measure applies to ~~beneficiaries~~ [clients] ages 12 to 17 and ~~the Adult Core Set~~ [this] measure applies to ~~beneficiaries~~ [clients] age 18 and older. ~~For the purpose of Adult Core Set reporting, states should calculate and report this measure for two age groups (as applicable): ages 18 to 64 and age 65 and older.~~

The intent of the measure is to screen for depression in ~~beneficiaries~~ [clients] who have never had a diagnosis of depression or bipolar disorder prior to the eligible encounter used to evaluate the numerator. ~~Beneficiaries~~ [Clients] who have ever been diagnosed with depression or bipolar disorder will be excluded from the measure.

The denominator for this measure includes ~~beneficiaries~~ [clients] age 18 and older with an outpatient visit during the measurement year. The numerator for this measure includes the following two groups:

- Those ~~beneficiaries~~ [clients] with a positive screen for depression on the date of an outpatient visit or up to 14 days prior to the encounter using a standardized tool with a follow-up plan documented.
- Those ~~beneficiaries~~ [clients] with a negative screen for depression on the date of an outpatient visit or up to 14 days prior to the encounter using a standardized tool.

~~The QPP claims/CQM specifications for this measure include six G codes intended to capture whether individual providers reported on this measure. For the purpose of Adult Core Set reporting, t~~[T]here are two G codes included in the numerator to capture whether depression screening using an age-appropriate standardized tool was done on the date of the eligible encounter or up to 14 days prior to the date of the encounter and if the screen was positive, whether a follow-up plan was documented on the date of the eligible encounter.

[11]Aside from the minor modifications noted in this specification, this specification is taken directly from the 2023 CMS Medicaid Adult Core Set Measures. Use the most current version for the year being reported. See also Important Supplemental Materials for Clinic-Collected Required BHC Measures derived from CMS Medicaid Adult and/or Child Core Set Measures (in this manual immediately before the CDF measures).

Screening for Depression and Follow-Up Plan (CDF-AD)

An age-appropriate, standardized, and validated depression screening tool must be used and results documented as positive or negative for numerator compliance. The name of the age-appropriate standardized depression screening tool utilized must be documented in the medical record. This measure does not require documentation of a specific score, just whether results of the normalized and validated depression screening tool used are considered positive or negative. Each standardized screening tool provides guidance on whether a particular score is considered positive for depression. The screening should occur on the date of a qualifying encounter or up to 14 days prior to the date of the qualifying encounter. The depression screening must be reviewed and addressed by the provider on the date of the encounter. Positive pre-screening results indicating a ~~beneficiary~~ [client] is at high risk for self-harm should receive more urgent intervention as determined by the provider practice.

The measure assesses the most recent depression screening completed either during the eligible encounter or within the 14 days prior to that encounter. Therefore, a clinician would not be able to complete another screening at the time of the encounter to count toward a follow-up, because that would serve as the most recent screening. In order to satisfy the follow-up requirement for a ~~beneficiary~~ [client] screening positively, the eligible clinician would need to provide one of the specified follow-up actions, which includes one or more of the following:

Referral to a provider for additional evaluation.

Pharmacological interventions.

Other interventions for the treatment of depression.

A follow-up plan must be documented on the date of the qualifying encounter for a positive depression screen.

Should a ~~beneficiary~~ [client] screen positive for depression:

A clinician should only order pharmacological intervention when appropriate and after sufficient diagnostic evaluation. However, for the purposes of this measure, additional screening and assessment during the qualifying encounter will not qualify as a follow-up plan.

A clinician could opt to complete a suicide risk assessment when appropriate and based on individual ~~beneficiary~~ [client] characteristics. However, for the purposes of this measure, a suicide risk assessment will not qualify as a follow-up plan.

The screening tools listed in the measure specifications are examples of standardized tools. However, states may use any assessment tool that has been appropriately normalized and validated for the population in which it is being utilized. The name of the age-appropriate standardized depression screening tool utilized must be documented in the medical record.

This measure contains both exclusions and exceptions:

Denominator exclusion criteria are evaluated before checking if a ~~beneficiary~~ [client] meets the numerator criteria; a ~~beneficiary~~ [client] who qualifies for the denominator exclusion should be removed from the denominator.

Denominator exception criteria are only evaluated if the ~~beneficiary~~ [client] does not meet the numerator criteria; ~~beneficiaries~~ [clients] who do not meet numerator criteria and also meet denominator exception criteria (e.g., medical reason for not performing a screening) should be removed from the denominator.

This measure can be calculated using administrative data only. Medical record review may be used to validate the ~~state's~~ administrative data (for example, documentation of the name of the standardized depression screening tool utilized). However, validation is not required to calculate and report this measure.

Include all paid, suspended, pending, and denied claims.

The electronic specification for FFY 2023 is located on the eCQI resource center at https://ecqi.healthit.gov/sites/default/files/ecqm/measures/CMS2v11.html. [Use version current for year reporting.] ~~States~~ [Clinics] that use electronic specifications should indicate this by selecting "Electronic Health Records" in the Data Source section of the ~~online~~ reporting ~~system~~ [template].

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

B. DEFINITIONS

Screening	Completion of a clinical or diagnostic tool used to identify people at risk of developing or having a certain disease or condition, even in the absence of symptoms.
Standardized Depression Screening Tool	A normalized and validated depression screening tool developed for the population in which it is being utilized. Examples of depression screening tools include but are not limited to: Adult Screening Tools (age 18 and older) Patient Health Questionnaire (PHQ-9), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety- Depression Scale (DADS), Geriatric Depression Scale (GDS), Cornell Scale for Depression in Dementia (CSDD), PRIME MD-PHQ2, Hamilton Rating Scale for Depression (HAM-D), Quick Inventory of Depressive Symptomatology Self-Report (QID-SR), Computerized Adaptive Testing Depression Inventory (CAT-DI), and Computerized Adaptive Diagnostic Screener (CAD-MDD). Perinatal Screening Tools Edinburgh Postnatal Depression Scale, Postpartum Depression Screening Scale, Patient Health Questionnaire 9 (PHQ-9), Beck Depression Inventory, Beck Depression Inventory–II, Center for Epidemiologic Studies Depression Scale, and Zung Self-rating Depression Scale.

Follow-up plan	Documented follow-up for a positive depression screening must include one or more of the following: Referral to a provider for additional evaluation and assessment to formulate a follow-up plan for a positive depression screen. Pharmacological interventions. Other interventions or follow-up for the diagnosis or treatment of depression. Examples of a follow-up plan include but are not limited to: Referral to a provider or program for further evaluation for depression, for example, referral to a psychiatrist, psychologist, social worker, mental health counselor, or other mental health service such as family or group therapy, support group, depression management program, or other service for treatment of depression. Other interventions designed to treat depression such as behavioral health evaluation, psychotherapy, pharmacological interventions, or additional treatment options. The documented follow-up plan must be related to positive depression screening, for example: "Patient [Client] referred for psychiatric evaluation due to positive depression screening."

C. ELIGIBLE POPULATION

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

D. ADMINISTRATIVE SPECIFICATION

Denominator

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

Table CDF-A. Codes to Identify Outpatient Visits

CPT	HCPCS
59400, 59510, 59610, 59618, 90791, 90792, 90832, 90834, 90837, 92625, 96105, 96110, 96112, 96116, 96125, 96136, 96138, 96156, 96158, 97161, 97162, 97163, 97165, 97166, 97167, 99078, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99339, 99340, 99401, 99402, 99403, 99483, 99484, 99492, 99493, 99384, 99385, 99386, 99387, 99394, 99395, 99396, 99397	G0101, G0402, G0438, G0439, G0444

Screening for Depression and Follow-Up Plan (CDF-AD)

Numerator

~~Beneficiaries~~ [Clients] screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool AND, if positive, a follow-up plan is documented on the date of the eligible encounter using one of the codes in Table CDF-B.

Table CDF-B. Codes to Document Depression Screen

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

Exclusions

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

~~Beneficiaries~~ [Clients] who have been diagnosed with depression or bipolar disorder

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

Table CDF-C. HCPCS Code to Identify Exclusions

Code	Description
G9717	Documentation stating the patient has had a diagnosis of depression or has had a diagnosis of bipolar disorder

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

ICD-10 Code	Description
F01.51	Vascular dementia with behavioral disturbance
F32.A	Depression, unspecified
F32.0	Major depressive disorder, single episode, mild
F32.1	Major depressive disorder, single episode, moderate
F32.2	Major depressive disorder, single episode, severe without psychotic features
F32.3	Major depressive disorder, single episode, severe with psychotic features
F32.4	Major depressive disorder, single episode, in partial remission
F32.5	Major depressive disorder, single episode, in full remission
F32.89	Other specified depressive episodes
F32.9	Major depressive disorder, single episode, unspecified
F33.0	Major depressive disorder, recurrent, mild
F33.1	Major depressive disorder, recurrent, moderate
F33.2	Major depressive disorder, recurrent severe without psychotic features

ICD-10 Code	Description
F33.3	Major depressive disorder, recurrent, severe with psychotic symptoms
F33.40	Major depressive disorder, recurrent, in remission, unspecified
F33.41	Major depressive disorder, recurrent, in partial remission
F33.42	Major depressive disorder, recurrent, in full remission
F33.8	Other recurrent depressive disorders
F33.9	Major depressive disorder, recurrent, unspecified
F34.1	Dysthymic disorder
F34.81	Disruptive mood dysregulation disorder
F34.89	Other specified persistent mood disorders
F43.21	Adjustment disorder with depressed mood
F43.23	Adjustment disorder with mixed anxiety and depressed mood
F53.0	Postpartum depression
F53.1	Puerperal psychosis
O90.6	Postpartum mood disturbance
O99.340	Other mental disorders complicating pregnancy, unspecified trimester
O99.341	Other mental disorders complicating pregnancy, first trimester
O99.342	Other mental disorders complicating pregnancy, second trimester
O99.343	Other mental disorders complicating pregnancy, third trimester
O99.345	Other mental disorders complicating the puerperium

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

ICD-10 Code	Description
F31.10	Bipolar disorder, current episode manic without psychotic features, unspecified
F31.11	Bipolar disorder, current episode manic without psychotic features, mild
F31.12	Bipolar disorder, current episode manic without psychotic features, moderate
F31.13	Bipolar disorder, current episode manic without psychotic features, severe
F31.2	Bipolar disorder, current episode manic severe with psychotic features
F31.30	Bipolar disorder, current episode depressed, mild or moderate severity, unspecified
F31.31	Bipolar disorder, current episode depressed, mild
F31.32	Bipolar disorder, current episode depressed, moderate
F31.4	Bipolar disorder, current episode depressed, severe, without psychotic features
F31.5	Bipolar disorder, current episode depressed, severe, with psychotic features
F31.60	Bipolar disorder, current episode mixed, unspecified

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

Exceptions

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

~~Beneficiary~~ [Client] reason:

- ~~Beneficiary~~ [Client] refuses to participate.

Medical reason:

- ~~Beneficiary~~ [Client] is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the ~~beneficiary~~ [client]'s health status.
- Situations where the ~~beneficiary~~ [client]'s cognitive, functional, or motivational limitations may impact the accuracy of results.

Use the code in Table CDF-F to identify exceptions.

Table CDF-F. HCPCS Code to Identify Exceptions

Code	Description
G8433	Screening for depression not completed, documented patient or medical reason

Measure CDF-CH: Screening for Depression and Follow-Up Plan: Ages 12 to 17[12]

Based on a CMS Medicaid Child Core Set Measure (2023), stewarded by CMS

A. DESCRIPTION

Percentage of ~~beneficiaries~~ [clients] ages 12 to 17 screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the eligible encounter.

Data Collection Method: Administrative or EHR

Guidance for Reporting:

The Screening for Depression and Follow-Up Plan measure includes ~~beneficiaries~~ [clients] age 12 and older. ~~The Child Core Set measure~~ [This measure] applies to ~~beneficiaries~~ [clients] ages 12 to 17 and the ~~Adult Core Set measure~~ [CDF-AD measure] applies to ~~beneficiaries~~ [clients] age 18 and older.

The intent of the measure is to screen for depression in ~~beneficiaries~~ [clients] who have never had a diagnosis of depression or bipolar disorder prior to the eligible encounter used to evaluate the numerator. B~~eneficiaries~~ [Clients] who have ever been diagnosed with depression or bipolar disorder will be excluded from the measure.

The denominator for this measure includes ~~beneficiaries~~ [clients] ages 12 to 17 with an outpatient visit during the measurement year. The numerator for this measure includes the following two groups:

- Those ~~beneficiaries~~ [clients] with a positive screen for depression on the date of an outpatient visit or up to 14 days prior to the encounter using a standardized tool with a follow-up plan documented.
- Those ~~beneficiaries~~ [clients] with a negative screen for depression on the date of an outpatient visit or up to 14 days prior to the encounter using a standardized tool.

~~The QPP claims/CQM specifications for this measure included six G codes intended to capture whether individual providers reported on this measure. For the purpose of Child Core Set reporting, t~~[T]here are two G codes included in the numerator to capture whether depression screening using an age-appropriate standardized tool was done on the date of the eligible encounter or up to 14 days prior to the date of the encounter and if the screen was positive, whether a follow-up plan was documented on the date of the eligible encounter.

An age-appropriate, standardized, and validated depression screening tool must be used and results documented as positive or negative for numerator compliance. The name of the age-appropriate standardized depression screening tool utilized must be documented in the medical record. This measure does not require documentation of a specific score, just whether results of the normalized and validated depression screening tool used are considered positive or negative. The screening should occur on the date of a qualifying encounter or up to 14 days prior to the date of the qualifying encounter. The depression screening must be reviewed and addressed by the provider on the date of the encounter. Positive pre-screening results indicating a ~~beneficiary~~ [client] is at high risk for self-harm should receive more urgent intervention as determined by the provider practice.

[12]Aside from the minor modifications noted in this specification, this specification is taken directly from the 2023 CMS Medicaid Child Core Set Measures. Use the most current version for the year being reported. See also Important Supplemental Materials for Clinic-Collected Required BHC Measures derived from CMS Medicaid Adult and/or Child Core Set Measures (in this manual immediately before the CDF measures).

The measure assesses the most recent depression screening completed either during the eligible encounter or within the 14 days prior to that encounter. Therefore, a clinician would not be able to complete another screening at the time of the encounter to count toward a follow-up, because that would serve as the most recent screening. In order to satisfy the follow-up requirement for a ~~beneficiary~~ [client] screening positively, the eligible clinician would need to provide one of the specified follow-up actions, which includes one or more of the following:

Referral to a provider for additional evaluation.

Pharmacological interventions.

Other interventions for the treatment of depression.

A follow-up plan must be documented on the date of the qualifying encounter for a positive depression screen.

Should a ~~beneficiary~~ [client] screen positive for depression:

A clinician should only order pharmacological intervention when appropriate and after sufficient diagnostic evaluation. However, for the purposes of this measure, additional screening and assessment during the qualifying encounter will not qualify as a follow-up plan.

A clinician could opt to complete a suicide risk assessment when appropriate and based on individual ~~beneficiary~~ [client] characteristics. However, for the purposes of this measure, a suicide risk assessment will not qualify as a follow-up plan.

The screening tools listed in the measure specifications are examples of standardized tools. However, states may use any assessment tool that has been appropriately normalized and validated for the population in which it is being utilized. The name of the age-appropriate standardized depression screening tool utilized must be documented in the medical record.

This measure contains both exclusions and exceptions:

Denominator exclusion criteria are evaluated before checking if a ~~beneficiary~~ [client] meets the numerator criteria; a ~~beneficiary~~ [client] who qualifies for the denominator exclusion should be removed from the denominator.

Denominator exception criteria are only evaluated if the ~~beneficiary~~ [client] does not meet the numerator criteria; ~~beneficiaries~~ [clients] who do not meet numerator criteria and also meet denominator exception criteria (e.g., medical reason for not performing a screening) should be removed from the denominator.

This measure can be calculated using administrative data only. Medical record review may be used to validate the ~~state's~~ administrative data (for example, documentation of the name of the standardized depression screening tool utilized). However, validation is not required to calculate and report this measure.

Include all paid, suspended, pending, and denied claims.

The electronic specification for FFY 2023 is located on the eCQI resource center at https://ecqi.healthit.gov/sites/default/files/ecqm/measures/CMS2v11.html. [Use version current for year reporting.] ~~States~~ [Clinics] that use electronic specifications should indicate this by selecting "Electronic Health Records" in the Data Source section of the ~~online~~ reporting ~~system~~ [template].

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

Screening for Depression and Follow-Up Plan (CDF-CH)

B. DEFINITIONS

Screening	Completion of a clinical or diagnostic tool used to identify people at risk of developing or having a certain disease or condition, even in the absence of symptoms.
Standardized Depression Screening Tool	A normalized and validated depression screening tool developed for the population in which it is being utilized. Examples of depression screening tools include but are not limited to: Adolescent Screening Tools (12–17 years) Patient Health Questionnaire for Adolescents (PHQ-A), Beck Depression Inventory-Primary Care Version (BDI-PC), Mood Feeling Questionnaire (MFQ), Center for Epidemiologic Studies Depression Scale (CES-D), Patient Health Questionnaire (PHQ-9), Pediatric Symptom Checklist (PSC-17), and PRIME MD-PHQ2 Perinatal Screening Tools Edinburgh Postnatal Depression Scale, Postpartum Depression Screening Scale, Patient Health Questionnaire 9 (PHQ-9), Beck Depression Inventory, Beck Depression Inventory–II, Center for Epidemiologic Studies Depression Scale, and Zung Self-rating Depression Scale
Follow-up plan	Documented follow-up for a positive depression screening *must* include one or more of the following: Referral to a provider for additional evaluation and assessment to formulate a follow-up plan for a positive depression screen. Pharmacological interventions. Other interventions or follow-up for the diagnosis or treatment of depression. Examples of a follow-up plan include but are not limited to: Referral to a provider or program for further evaluation for depression, for example, referral to a psychiatrist, psychologist, social worker, mental health counselor, or other mental health service such as family or group therapy, support group, depression management program, or other service for treatment of depression. Other interventions designed to treat depression such as behavioral health evaluation, psychotherapy, pharmacological interventions, or additional treatment options. The documented follow-up plan must be related to positive depression screening, for example: "~~Patient~~ [Client] referred for psychiatric evaluation due to positive depression screening."

C. ELIGIBLE POPULATION

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

Screening for Depression and Follow-Up Plan (CDF-CH)

D. ADMINISTRATIVE SPECIFICATION

Denominator

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

Table CDF-A. Codes to Identify Outpatient Visits

CPT	HCPCS
59400, 59510, 59610, 59618, 90791, 90792, 90832, 90834, 90837, 92625, 96105, 96110, 96112, 96116, 96125, 96136, 96138, 96156, 96158, 97161, 97162, 97163, 97165, 97166, 97167, 99078, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99339, 99340, 99401, 99402, 99403, 99483, 99484, 99492, 99493, 99384, 99385, 99386, 99387, 99394, 99395, 99396, 99397	G0101, G0402, G0438, G0439, G0444

Numerator

~~Beneficiaries~~ [Clients] screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool AND, if positive, a follow-up plan is documented on the date of the eligible encounter using one of the codes in Table CDF-B.

Table CDF-B. Codes to Document Depression Screen

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

Exclusions

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

~~Beneficiaries~~ [Clients] who have been diagnosed with depression or bipolar disorder

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

Table CDF-C. HCPCS Code to Identify Exclusions

Code	Description
G9717	Documentation stating the patient has had a diagnosis of depression or has had a diagnosis of bipolar disorder

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

ICD-10 Code	Description
F01.51	Vascular dementia with behavioral disturbance
F32.A	Depression, unspecified
F32.0	Major depressive disorder, single episode, mild
F32.1	Major depressive disorder, single episode, moderate
F32.2	Major depressive disorder, single episode, severe without psychotic features
F32.3	Major depressive disorder, single episode, severe with psychotic features
F32.4	Major depressive disorder, single episode, in partial remission
F32.5	Major depressive disorder, single episode, in full remission
F32.89	Other specified depressive episodes
F32.9	Major depressive disorder, single episode, unspecified
F33.0	Major depressive disorder, recurrent, mild
F33.1	Major depressive disorder, recurrent, moderate
F33.2	Major depressive disorder, recurrent severe without psychotic features
F33.3	Major depressive disorder, recurrent, severe with psychotic symptoms
F33.40	Major depressive disorder, recurrent, in remission, unspecified
F33.41	Major depressive disorder, recurrent, in partial remission
F33.42	Major depressive disorder, recurrent, in full remission
F33.8	Other recurrent depressive disorders
F33.9	Major depressive disorder, recurrent, unspecified
F34.1	Dysthymic disorder
F34.81	Disruptive mood dysregulation disorder
F34.89	Other specified persistent mood disorders
F43.21	Adjustment disorder with depressed mood
F43.23	Adjustment disorder with mixed anxiety and depressed mood
F53.0	Postpartum depression
F53.1	Puerperal psychosis
O90.6	Postpartum mood disturbance
O99.340	Other mental disorders complicating pregnancy, unspecified trimester
O99.341	Other mental disorders complicating pregnancy, first trimester
O99.342	Other mental disorders complicating pregnancy, second trimester
O99.343	Other mental disorders complicating pregnancy, third trimester
O99.345	Other mental disorders complicating the puerperium

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

ICD-10 Code	Description
F31.10	Bipolar disorder, current episode manic without psychotic features, unspecified
F31.11	Bipolar disorder, current episode manic without psychotic features, mild
F31.12	Bipolar disorder, current episode manic without psychotic features, moderate
F31.13	Bipolar disorder, current episode manic without psychotic features, severe
F31.2	Bipolar disorder, current episode manic severe with psychotic features
F31.30	Bipolar disorder, current episode depressed, mild or moderate severity, unspecified
F31.31	Bipolar disorder, current episode depressed, mild
F31.32	Bipolar disorder, current episode depressed, moderate
F31.4	Bipolar disorder, current episode depressed, severe, without psychotic features
F31.5	Bipolar disorder, current episode depressed, severe, with psychotic features
F31.60	Bipolar disorder, current episode mixed, unspecified
F31.61	Bipolar disorder, current episode mixed, mild
F31.62	Bipolar disorder, current episode mixed, moderate
F31.63	Bipolar disorder, current episode mixed, severe, without psychotic features
F31.64	Bipolar disorder, current episode mixed, severe, with psychotic features
F31.70	Bipolar disorder, currently in remission, most recent episode unspecified
F31.71	Bipolar disorder, in partial remission, most recent episode hypomanic
F31.72	Bipolar disorder, in full remission, most recent episode hypomanic
F31.73	Bipolar disorder, in partial remission, most recent episode manic
F31.74	Bipolar disorder, in full remission, most recent episode manic
F31.75	Bipolar disorder, in partial remission, most recent episode depressed
F31.76	Bipolar disorder, in full remission, most recent episode depressed
F31.77	Bipolar disorder, in partial remission, most recent episode mixed
F31.78	Bipolar disorder, in full remission, most recent episode mixed
F31.81	Bipolar II disorder
F31.89	Other bipolar disorder
F31.9	Bipolar disorder, unspecified

Exceptions

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

~~Beneficiary~~ [Client] reason:

~~Beneficiary~~ [Client] refuses to participate.

Medical reason:

~~Beneficiary~~ [Client] is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the ~~beneficiary~~ [client]'s health status.

Situations where the ~~beneficiary~~ [client]'s cognitive, functional, or motivational limitations may impact the accuracy of results.

Use the code in Table CDF-F to identify exceptions.

Table CDF-F. HCPCS Code to Identify Exceptions

Code	Description
G8433	Screening for depression not completed, documented ~~patient~~ [client] or medical reason

Clinic-Reported Measures Optional for Submission as Part of CCBHC Demonstration

This section of Chapter IV includes the following Clinic-Collected optional measures:

1. Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC)
2. Major Depressive Disorder: Suicide Risk Assessment (SRA-A)
3. Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-C)
4. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-CH) — including supplemental materials
5. Controlling High Blood Pressure (CBP-AD) — including supplemental materials

Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC)[13]

Based on CMS MIPS CQMS #226 (2023), which is derived from a measure stewarded by the National Committee for Quality Assurance (NCQA)[8]

A. DESCRIPTION

The TSC measure calculates the Percentage of clients aged 18 years and older who were screened for Tobacco Use one or more times within the Measurement Year AND who received a Tobacco Cessation Intervention during the Measurement Year or in the six months prior to the Measurement Year if identified as a tobacco user.

Data Collection Method: Medical Records

Important Guidance for Reporting:

This section of the specification includes important guidance for reporting the measure. At the end of the specification, we include a section (F) on Frequently Asked Questions that also are important for the user to review.

- The MIPS CQMS measure 226 on which this measure is based contains three submeasures or submission criteria, with the third designed to allow comparison of performance to published versions of the measure prior to the MIPS 2018 performance year, when the measure had a single performance rate. ***We include all three but, for newer reporters who are not also reporting MIPS measures, submeasure 3 is optional.***
- This measure is to be reported once per Measurement Year for clients seen during the Measurement Year.
- Providers will rely on medical records to compile this information. There are several potential sources of information that may be used individually or together:
    - Electronic health records (including billing records)
    - Paper health records
    - A registry
- A Provider that does not use the G or M codes noted in the specifications below may rely on an equally reliable source of information (designated as "equivalent information source" in the specifications).

[8]The NCQA HEDIS® measure specification has been adjusted pursuant to NCQA's Rules for Allowable Adjustments of HEDIS.

[13]Note: The National Quality Forum (NQF) endorsed version or TSC (#0028) contains different requirements, including screening only every 24 months. The 2016 version of this Behavioral Health Clinic (BHC) measure relied on the NQF version of the measure. This 2023 version aligns, instead, with the MIPS version which requires screening every 12 months and Tobacco Cessation Intervention services during the Measurement Year or during the six months prior to the Measurement Year.

- For the purposes of the measure, the most recent denominator eligible encounter should be used to determine if the numerator action for the submeasure was performed within the 6-month look back period.
- TSC is stratified separately based on whether the client is:
    - Medicaid only or Other (including those dually eligible for Medicare and Medicaid)

    AND
    - A member of which of the following ethnic groups: Not Hispanic or Latino, Hispanic or Latino, or Unknown

    AND
    - A member of which of the following racial groups: White or Caucasian, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or Pacific Islander, More than one race, or Unknown
- Refer to the specific data-reporting template for the reporting requirements applicable to each measure.

Measurement Period: The Measurement Period is the period for which data are required for reporting purposes. The Measurement Period for the ***denominator*** for all TSC submeasures is the Measurement Year. The Measurement Period for the ***numerator***, for submeasure 1, is the Measurement Year and, for submeasures 2 and 3, is the Measurement Year and the prior six months. See Figure 1 for visual depiction of Measurement Year and Measurement Periods.

Figure 1. Visual of Measurement Year and Measurement Periods

Six Months before Measurement Year	Measurement Year
	Measurement Year (MY): 12 month reporting period
	Denominator Measurement Period (MP): 12 month MY
	Numerator Measurement Period Submeasure 1: 12 month MY
Numerator Measurement Period Submeasures 2 and 3: MY and previous six months	

Key: MY: Measurement Year; MP: Measurement Period.

B. DEFINITIONS

TERM	DEFINITION
Measurement Period	The specific period of time for which data are needed for the numerator and denominator of a given submeasure or quality measure. The Measurement Period may differ for the numerator and denominator and for each submeasure or measure and is described in section A above.
Measurement Year	The standard 12-month reporting period common to all measures being reported by the Provider.
Percentage	A Percentage is calculated as follows: numerator divided by denominator (n/d).
Provider	The Provider entity that is being measured (i.e., BHC)
Tobacco Cessation Intervention	Tobacco Cessation Intervention includes brief counseling (3 minutes or less), and/or pharmacotherapy.

Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC)

TERM	DEFINITION
	Note: Concepts aligned with brief counseling (e.g., minimal and intensive advice/counseling interventions conducted both in person and over the phone) are included in the numerator. Other concepts such as written self-help materials (e.g., brochures, pamphlets) and complementary/alternative therapies do not qualify for the numerator. Counseling also may be of longer duration or be performed more frequently, as evidence shows that higher-intensity interventions are associated with higher tobacco cessation rates (U.S. Preventive Services Task Force, 2021).
Tobacco Use	Tobacco Use includes use of any tobacco product. The 2021 USPSTF recommendation references the US Food and Drug Administration definition of tobacco which includes "any product made or derived from tobacco intended for human consumption (except products that meet the definition of drugs), including, but not limited to, cigarettes, cigars (including cigarillos and little cigars), dissolvables, hookah tobacco, nicotine gels, pipe tobacco, roll-your-own tobacco, smokeless tobacco products (including dip, snuff, snus, and chewing tobacco), vapes, electronic cigarettes (e-cigarettes), hookah pens, and other electronic nicotine delivery systems." • The 2021 USPSTF recommendation describes smoking as generally referring to "the inhaling and exhaling of smoke produced by combustible tobacco products such as cigarettes, cigars, and pipes." • The 2021 USPSTF recommendation describes vaping as "the inhaling and exhaling of aerosols produced by e-cigarettes." In addition, it states, "vaping products (i.e. , e-cigarettes) usually contain nicotine, which is the addictive ingredient in tobacco. Substances other than tobacco can also be used to smoke or vape. While the 2015 USPSTF recommendation statement used the term 'electronic nicotine delivery systems' or 'ENDS,' the USPSTF recognizes that the field has shifted to using the term 'e-cigarettes' (or 'e-cigs') and uses the term e-cigarettes in the current recommendation statement. e-Cigarettes can come in many shapes and sizes, but generally they heat a liquid that contains nicotine (the addictive drug in tobacco) to produce an aerosol (or 'vapor') that is inhaled ('vaped') by users."

Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC)

C. ELIGIBLE POPULATION

CRITERIA	REQUIREMENTS
Event/Age	Follow the steps below to identify the eligible population: ***Step 1*** Identify clients seen at the Provider during the Measurement Year. ***Step 2*** Identify clients from step 1 who were aged 18 years and older on the date of service during the Measurement Year. ***Step 3*** Identify clients from step 2 who met either of the following criteria during the Measurement Year: 3. Had at least two encounters at the Provider during the Measurement Year. Relevant codes (Current Procedural Terminology [CPT®] or Healthcare Common Procedure Coding System [HCPCS]) include: 90791, 90792, 90832, 90834, 90837, 90845, 92002, 92004, 92012, 92014, 92521, 92522, 92523, 92524, 92540, 92557, 92625, 96156, 96158, 97161, 97162, 97163, 97165, 97166, 97167, 97168, 97802, 97803, 97804, 99024, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, G0270, G0271 **OR** 4. Had one preventive care visit. Relevant codes (Current Procedural Terminology [CPT®] or Healthcare Common Procedure Coding System [HCPCS]) include: 99385*, 99386*, 99387*, 99395*, 99396*, 99397*, 99401*, 99402*, 99403*, 99404*, 99411*, 99412*, 99429*, G0438, G0439 ***NOTE #1:*** *Signifies that this CPT Category I code is a non-covered service under the Medicare Part B Physician Fee Schedule (PFS). These non-covered services should be counted in the eligible population. ***NOTE #2:*** Client encounters for this measure conducted via telehealth (e.g., encounters coded with GQ, GT, 95, or POS 02 modifiers) are allowable.

D. MEDICAL RECORD SPECIFICATION

There are three submeasures for the TSC measure:

1) Percentage of clients aged 18 years and older who were screened for Tobacco Use one or more times within the Measurement Year

AND

2) Percentage of clients aged 18 years and older who were identified as a tobacco user during the Measurement Year in submeasure 1 and who received a Tobacco Cessation Intervention during the Measurement Year or in the six months prior to the Measurement Year

AND

3) Percentage of clients aged 18 years and older who were screened for Tobacco Use one or more times within the Measurement Year and, if identified as a tobacco user, received a Tobacco Cessation Intervention during the Measurement Year or in the six months prior to the Measurement Year, or identified as a tobacco non-user ***(Providers should use only submeasures 1 and 2 unless they were reporting TSC as part of MIPS before 2018).***

SUBMEASURE 1: ALL CLIENTS WHO WERE SCREENED FOR TOBACCO USE

DENOMINATOR (SUBMEASURE 1):
All clients aged 18 years and older seen for at least two visits or at least one preventive visit during the Measurement Year (see MIPS source measure for 2023, or more current in later years, for visual example).

> **Denominator Criteria:**
> All clients in the Eligible Population (section C)
>
> **AND NOT**
> **Denominator Exclusion:**
> Clients who received hospice services at any time during the Measurement Year **(M1159 or equivalent information source)**

NUMERATOR (SUBMEASURE 1):
All clients in the denominator who were screened for Tobacco Use at least once within the Measurement Year

> ***NUMERATOR NOTE:*** *To satisfy the intent of this measure, a client must have at least one Tobacco Use screening during the Measurement Year. If a client has multiple Tobacco Use screenings during the Measurement Year, only the most recent screening, which has a documented status of tobacco user or tobacco non-user, will be used to satisfy the measure requirements.*

Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC)

Numerator Options:

Performance Met:

- Client screened for Tobacco Use AND identified as a tobacco user **(G9902 or equivalent information source),**
  OR
- Client screened for Tobacco Use AND identified as a tobacco non-user **(G9903 or equivalent information source)**

OR
Performance Not Met: Client not screened for Tobacco Use **(G9905 or equivalent information source)**

SUBMEASURE 2: ALL CLIENTS WHO WERE IDENTIFIED AS A TOBACCO USER AND WHO RECEIVED TOBACCO CESSATION INTERVENTION

DENOMINATOR (SUBMEASURE 2):
All clients aged 18 years and older seen for at least two visits or at least one preventive visit who were screened for Tobacco Use during the Measurement Year and identified as a tobacco user (see MIPS source measure for 2023, or more current in later years, for visual example).

Denominator Criteria:
All clients in the Eligible Population (section C)

AND
All eligible instances when **G9902 (or equivalent information source)** is submitted for Performance Met (client screened for Tobacco Use and identified as a tobacco user) in the numerator of submeasure 1

AND NOT
Denominator Exclusion:
Clients who received hospice services at any time during the Measurement Year **(M1159 or equivalent information source)**

NUMERATOR (SUBMEASURE 2):
All clients in the denominator of submeasure 2 who received Tobacco Cessation Intervention during the Measurement Year or in the six months prior to the Measurement Year

Numerator Options:

Performance Met: Client identified as a tobacco user received Tobacco Cessation Intervention during the Measurement Year or in the six months prior to the Measurement Year **(G9906 or equivalent information source)**

OR
Performance Not Met: Client identified as a tobacco user did not receive Tobacco Cessation Intervention during the Measurement Year or in the six months prior to the Measurement Year (**G9908 or equivalent information source)**

SUBMEASURE 3: ALL CLIENTS WHO WERE SCREENED FOR TOBACCO USE AND, IF IDENTIFIED AS A TOBACCO USER, RECEIVED TOBACCO CESSATION INTERVENTION, OR IDENTIFIED AS A TOBACCO NON-USER (*Providers should not use submeasure 3 unless they were reporting TSC as part of MIPS before 2018.*)

DENOMINATOR (SUBMEASURE 3):
All clients aged 18 years and older seen for at least two visits or at least one preventive visit during the Measurement Year (see MIPS source measure for 2023, or more current in later years, for visual example).

Denominator Criteria:
All clients in the Eligible Population (section C)

AND NOT
Denominator Exclusion:
Clients who received hospice services at any time during the Measurement Year **(M1159 or equivalent information source)**

NUMERATOR (SUBMEASURE 3):
All clients in the denominator who were screened for Tobacco Use at least once within the Measurement Year AND who received Tobacco Cessation Intervention during the Measurement Year or in the six months prior to the Measurement Year, if identified as a tobacco user, or identified as a tobacco non-user.

NUMERATOR NOTE: *To satisfy the intent of this measure, a client must have at least one Tobacco Use screening during the Measurement Year. If a client has multiple Tobacco Use screenings during the Measurement Year, only the most recent screening, which has a documented status of tobacco user or tobacco non-user, will be used to satisfy the measure requirements.*

Numerator Options:

Performance Met: Client screened for Tobacco Use **AND** identified as a tobacco user **AND** received Tobacco Cessation Intervention (counseling and/or pharmacotherapy)

during the Measurement Year or in the six months prior to the Measurement Year **(G0030 or equivalent information source)**
OR
Performance Met: Current tobacco non-user **(1036F or equivalent information source)**

OR
Performance Not Met: Tobacco screening not performed OR Tobacco Cessation Intervention not provided during the Measurement Period or in the six months prior to the Measurement Period **(G0029 or equivalent information source)**

E. ADDITIONAL NOTES

Both this and the source measure were specified at the provider level. Neither is risk adjusted. This measure is modified from the source measure to provide a specification consistent in format to other measures in this set of BHC measures. The substance of the measure is unchanged.

Interpretation of scores: Better quality = Higher Percentage

F. FREQUENTLY ASKED QUESTIONS

Questions Related to Definition of Tobacco:

Q: Should we include people who use smokeless tobacco in this measure?
A: Tobacco Use includes any type of tobacco, whether smokeless or smoked, including e-cigs.

Questions Related to Definition of Tobacco Cessation Intervention:

Q: Does a Tobacco Cessation Intervention include having a phone call with the state quit line?
A: No, the eligible encounters must be provided by the BHC. This does not preclude use of a quit line, but there should be an eligible brief intervention by the BHC as well.

Questions Related to Frequency of Screening:

Q: Can BHCs screen more frequently than once a year?
A: Yes, BHCs can screen more frequently. The measure, however, only looks at the last screen in the Measurement Year.

Questions Related to Duration or Frequency of Cessation Intervention:

Q: Can we include encounters where the intervention is longer than three minutes?
A: Yes, the intervention may be of longer duration or be performed more frequently, as evidence shows there is a dose-response relationship between the intensity of counseling provided (either length or frequency) and tobacco cessation rates (U.S. Preventive Services Task Force, 2015).

Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC)

Questions Related to Screening and/or Intervention Provider:

Q: For the measure of screening and cessation intervention for Tobacco Use, is use of the physician office codes required? Can nonphysicians report the CPT-II codes? Our state trains our Peer Recovery Support Specialists and our Wellness Coaches on the 5 A's, so they would more likely be working with the clients on this subject.
A: The measure does not specify which staff should do the screening or intervention other than by inclusion of specific codes designating an eligible encounter. BHCs may use staff who can provide these services within their state licensure. If operating under supervision of a physician, staff can use the physician codes. If you are a BHC participating in the CCBHC demonstration program, you also may compile a list of comparable codes; but the list should be clear and be provided to all CCBHCs in the state, and the deviation should be indicated on the reporting template.

Questions Related to Timing of Screening and Intervention:

Q: Do the screening and cessation intervention need to happen in the same session/encounter?
A: The screening and intervention should be performed during the same encounter although the measure is silent on this point.

Questions Related to Client Age:

Q: Can the measure be reported for clients younger than age 18 years?
A: It is only required for those ages 18 year or older but BHCs may also report this submeasure for individuals younger than age 18 years of age if they wish but that information should be included in the additional notes in the bottom of the TSC data reporting template.

Questions Related to Coding for the Numerator(s):

Q: Our system does not support the G or M codes needed to calculate the measure. What should we do?
A: Although we recommend using the specified G or M codes, a Provider that does not use the G or M codes noted in the specification, may rely on an **equally reliable** source of information (designated as "equivalent information source" in the numerator specifications).

Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-A)

Guidance for BHCs calculating MIPS eCQM ID CMS161v11 (2023), stewarded by Mathematica Policy Research

BHCs using this measure should access and use the electronic technical specifications that are current for the year being measured. At the time of publication of this manual, the 2023 eCQM ID CMS161v11 is the current version.

This document is intended as supplemental guidance for the use of those electronic specifications. This guidance uses the term "client" in lieu of "patient" and adds stratifications for purposes of CCBHC reporting.

A. DESCRIPTION

According to the 2023 electronic specification, this is the "Percentage of all ~~patient~~ [client] visits for those ~~patients~~ [clients] that turn 18 or older during the measurement period in which a new or recurrent diagnosis of major depressive disorder (MDD) was identified and a suicide risk assessment (SRA) was completed during the visit"

Data Source: Electronic Medical Records

Important Reporting Guidance:

This section of the specification includes important guidance for reporting the SRA-A measure. Also refer to section F for Frequently Asked Questions.

- According to the 2023 electronic specification, "This eCQM is an episode-based measure and should be reported for each instance of a new or recurrent episode of major depressive disorder (MDD) during the measurement period. This measure should be reported for each eligible encounter during which a new or recurrent episode of MDD is identified in adults that turn 18 or older during the measurement period."
- Providers will rely on electronic medical records to compile this information.
- Both the SRA-A and SRA-C measures are to be used by BHCs to measure performance related to clients seen at the Provider during the Measurement Year.
- In contrast to the electronic specification, CCBHCs reporting SRA-A are required to stratify separately based on whether the client is:
    - Medicaid only or Other (including those dually eligible for Medicare and Medicaid)

  AND
    - a member of which of the following ethnic groups: Not Hispanic or Latino, Hispanic or Latino, or Unknown

  AND

- a member of which of the following racial groups: White or Caucasian, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or Pacific Islander, More than one race, or Unknown

- Refer to the specific data-reporting template for the reporting requirements applicable to each measure.

Measurement Period: The Measurement Period is the period for which data are required for reporting purposes. The Measurement Period for the **denominator** is the Measurement Year and, for the **numerator**, is the Measurement Year and the 105 days before.

B. DEFINITIONS

TERM	DEFINITION
Measurement Period	The specific time period for which data are needed for the numerator and denominator of a given measure. The Measurement Period may differ for the numerator and denominator and for each measure and is specified in section A above.
Measurement Year	The standard 12-month reporting period common to all measures being reported by the Provider.
Percentage	A Percentage is calculated as follows: numerator divided by denominator (n/d).
Provider	The Provider entity that is being measured (i.e., BHC)
Suicide Risk Assessment	According to the 2023 electronic specification, "The specific type and magnitude of the suicide risk assessment is intended to be at the discretion of the individual clinician and should be specific to the needs of the ~~patient~~ [client]. At a minimum, suicide risk assessment should evaluate: 1) Suicidal ideation 2) ~~Patient's~~ [Client's] intent of initiating a suicide attempt AND, if either is present, 3) ~~Patient~~ [Client] plans for a suicide attempt 4) Whether the ~~patient~~ [client] has means for completing suicide Low burden tools to track suicidal ideation and behavior such as the Columbia-Suicide Severity Rating Scale (C-SSRS) and the Suicide Assessment Five-Step Evaluation and Triage (SAFE-T) can also be used. Because no validated assessment tool or instrument fully meets the aforementioned requirements for the suicide risk assessment, individual tools or instruments have not been explicitly included in coding."

C. ELIGIBLE POPULATION

CRITERIA	REQUIREMENTS
Event/Age	Follow the steps below to identify the eligible population:

CRITERIA	REQUIREMENTS
	Step 1 Identify clients seen at the Provider during the Measurement Year. ***Step 2*** After step 1, use the "Initial Population" described in the current electronic specification. For 2023, this is "~~Patient~~ [Client] visits for ~~patients~~ [clients] that turn 18 or older during the measurement period during which a new diagnosis of MDD, single or recurrent episode, was identified."

D. ELECTRONIC MEDICAL RECORD SPECIFICATION

DENOMINATOR:
The eligible population as listed in Section C is the denominator. Use the detailed electronic specifications in the current version of the measure.

NUMERATOR:
Use the detailed electronic specifications in the current version of the measure. For 2023, the numerator is described as "~~Patient~~ [Client] visits during which a new diagnosis of MDD, single or recurrent episode, was identified and a suicide risk assessment was completed during the visit."

> ***NUMERATOR NOTE #1:*** According to the 2023 electronic specification, "It is expected that a suicide risk assessment will be completed at the visit during which a new diagnosis is made or at the visit during which a recurrent episode is first identified (i.e., at the initial evaluation). For the purposes of this measure, an episode of major depressive disorder (MDD) would be considered to be recurrent if a patient has not had an MDD-related encounter in the past 105 days. If there is a gap of 105 or more days between visits for major depressive disorder (MDD), that would imply a recurrent episode. The 105-day look-back period is an operational provision and not a clinical recommendation, or definition of relapse, remission, or recurrence."
>
> ***NUMERATOR NOTE #2:*** According to the 2023 electronic specification, "In recognition of the growing use of integrated and team-based care, the diagnosis of depression and the assessment for suicide risk need not be performed by the same provider or clinician."
>
> ***NUMERATOR NOTE #3:*** According to the 2023 electronic specification, "Suicide risk assessments completed via telehealth services can also meet numerator performance."

E. ADDITIONAL NOTES

The source measure is specified at the provider level. It is not risk adjusted.

Interpretation of scores: Better quality = Higher Percentage

F. FREQUENTLY ASKED QUESTIONS

Questions Related to Age:

Q: How do we assess for suicide risk for younger clients who are not included in the eligible population for this measure?
A: According to the 2023 electronic specification, "The logic statement for the age requirement, as written, captures ~~patients~~ [clients] who turn 18 years old during the measurement period so that these ~~patients~~ [clients] are included in the measure, as long as the minimum criteria noted above is evaluated. To ensure all ~~patients~~ [clients] with major depressive disorder (MDD) are assessed for suicide risk, there are two clinical quality measures addressing suicide risk assessment; CMS177- Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment covers children and adolescents aged 6 through 17, and CMS161 covers the adult population aged 18 years and older, as no individual suicide risk assessment tool or instrument would satisfy the requirements alone."

Questions Regarding the Definition of "Recurrent Episode"

Q: In the "Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-A)" measure, how is "recurrent episode" defined?
A: According to the 2023 electronic specification, "It is expected that a suicide risk assessment will be completed at the visit during which a new diagnosis is made or at the visit during which a recurrent episode is first identified (i.e., at the initial evaluation). For the purposes of this measure, an episode of major depressive disorder (MDD) would be considered to be recurrent if a patient has not had an MDD-related encounter in the past 105 days. If there is a gap of 105 or more days between visits for major depressive disorder (MDD), that would imply a recurrent episode. The 105-day look-back period is an operational provision and not a clinical recommendation, or definition of relapse, remission, or recurrence."

Questions Regarding Suicide Risk Assessment Resources:

Q: Can you provide us with additional information on evidence-based practices to inform our suicide-risk assessment protocols?
A: Yes, please see https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials.

Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-C)

Guidance for BHCs calculating MIPS eCQM ID CMS177v11 (2023), stewarded by Mathematica Policy Research

BHCs using this measure should access and use the electronic technical specifications that are current for the year being measured. At the time of publication of this manual, the 2023 eCQM ID CMS177v11 is the current version.

This document is intended as supplemental guidance for the use of those electronic specifications. This guidance uses the term "client" in lieu of "patient" and adds stratifications for purposes of CCBHC reporting.

A. DESCRIPTION

According to the 2023 electronic specification, this is the "Percentage of ~~patient~~ [client] visits for those ~~patients~~ [clients] aged 6 through 17 years with a diagnosis of major depressive disorder (MDD) with an assessment for suicide risk"

Data Source: Electronic Medical Records

Important Reporting Guidance:

This section of the specification includes important guidance for reporting the SRA-C measure. Also refer to section F for Frequently Asked Questions.

- According to the 2023 electronic specification, "This eCQM is an episode-based measure. An episode is defined as each eligible encounter for major depressive disorder (MDD) during the measurement period."
- Providers will rely on electronic medical records to compile this information.
- Both the SRA-A and SRA-C measures are to be used by BHCs to measure performance related to clients seen at the Provider during the Measurement Year.
- In contrast to the electronic specification, CCBHCs reporting SRA-C are required to stratify separately based on whether the client is:
    - Medicaid only or Other (including those dually eligible for Medicare and Medicaid)

  AND
    - a member of which of the following ethnic groups: Not Hispanic or Latino, Hispanic or Latino, or Unknown

  AND

- a member of which of the following racial groups: White or Caucasian, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or Pacific Islander, More than one race, or Unknown

- Refer to the specific data-reporting template for the reporting requirements applicable to each measure.

Measurement Period: The Measurement Period is the period for which data are required for reporting purposes. The Measurement Period for both the **denominator and the numerator** is the Measurement Year.

B. DEFINITIONS

TERM	DEFINITION
Measurement Period	The specific time period for which data are needed for the numerator and denominator of a given measure. The Measurement Period may differ for the numerator and denominator and for each measure and is specified in section A above.
Measurement Year	The standard 12-month reporting period common to all measures being reported by the Provider.
Percentage	A Percentage is calculated as follows: numerator divided by denominator (n/d).
Provider	The Provider entity that is being measured (i.e., BHC)
Suicide Risk Assessment	According to the 2023 electronic specification, "The specific type and magnitude of the suicide risk assessment is intended to be at the discretion of the individual clinician and should be specific to the needs of the ~~patient~~ [client]. At a minimum, suicide risk assessment should evaluate: 1. Risk (e.g., age, sex, stressors, comorbid conditions, hopelessness, impulsivity) and protective factors (e.g., religious belief, concern not to hurt family) that may influence the desire to attempt suicide. 2. Current severity of suicidality. 3. Most severe point of suicidality in episode and lifetime. Low burden tools to track suicidal ideation and behavior such as the Columbia-Suicidal Severity Rating Scale can also be used. Because no validated assessment tool or instrument fully meets the aforementioned requirements for the suicide risk assessment, individual tools or instruments have not been explicitly included in coding." According to the 2023 electronic specification, "Use of a standardized tool(s) or instrument(s) to assess suicide risk will meet numerator performance, so long as the minimum criteria noted above is evaluated. Standardized tools can be mapped to the

TERM	DEFINITION
	concept "Intervention, Performed": "Suicide risk assessment (procedure)" included in the numerator logic ~~below~~ [in the current electronic specification], as no individual suicide risk assessment tool or instrument would satisfy the requirements alone."

C. ELIGIBLE POPULATION

CRITERIA	REQUIREMENTS
Event/Age	Follow the steps below to identify the eligible population: ***Step 1*** Identify clients seen at the Provider during the Measurement Year. ***Step 2*** After step 1, use the "Initial Population" described in the current electronic specification. For 2023, this is "All ~~patient~~ [client] visits for those ~~patients~~ [clients] aged 6 through 17 years with a diagnosis of major depressive disorder~~.~~"

D. ELECTRONIC MEDICAL RECORD SPECIFICATION

DENOMINATOR:
The eligible population as listed in Section C is the denominator. Use the detailed electronic specifications in the current version of the measure.

NUMERATOR:
Use the detailed electronic specifications in the current version of the measure. For 2023, the numerator is described as "~~Patient~~ [Client] visits with an assessment for suicide risk."

> ***NUMERATOR NOTE #1:*** According to the 2023 electronic specification, "A suicide risk assessment should be performed at every visit for MDD during the measurement period."
>
> ***NUMERATOR NOTE #2:*** According to the 2023 electronic specification, "In recognition of the growing use of integrated and team-based care, the diagnosis of depression and the assessment for suicide risk need not be performed by the same provider or clinician."
>
> ***NUMERATOR NOTE #3:*** According to the 2023 electronic specification, "Suicide risk assessments completed via telehealth services can also meet numerator performance."

E. ADDITIONAL NOTES

The source measure is specified at the provider level. It is not risk adjusted.

Interpretation of scores: Better quality = Higher Percentage

F. FREQUENTLY ASKED QUESTIONS

Questions requesting appropriate assessment instruments or tools:

Q: For the SRA-C measure, the technical specification says we need to use a standardized assessment tool, but it does not define which one to use. What do you recommend?
A: The SRA-C measure does not identify specific standardized assessment tools that it requires, but it does include types of information or inquiries that should be included in the assessment. BHCs should follow that definition.

Questions related to when clients should be assessed:

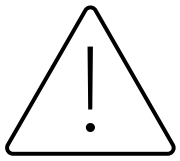
Q: Regarding the measure of child suicide risk assessment, a risk assessment is required to be completed at each visit where there is a MDD diagnosis. Some clinicians are concerned that this is too much to ask of the clients and that if they keep asking youth these questions, they may eventually decide that suicidality is expected of them. Is it necessary to assess youth with MDD for suicide risk each time they are seen?
A: For youth, the measure does expect that the SRA will be conducted at each visit within an episode of MDD to assess for suicide risk. The type and magnitude of the assessment is left to the discretion of the clinician, but it should be standardized and the Technical Specification notes that low burden tools can be used. There are no exclusions. Clinical judgment also should be exercised in determining what is best for the client.

Q: Regarding the children's measure, sessions are often performed with the parents without the child present. Can such clients be included in the eligible population and what is the reporting expectation in such cases?
A: We suggest that the BHC indicate in the Additional Notes on the data reporting template that it does not and cannot conduct an SRA for a child when only parents are in the session and that the BHC is excluding those visits from the denominator and numerator.

Questions Regarding Suicide Risk Assessment Resources:

Q: Can you provide us with additional information on evidence-based practices to inform our suicide-risk assessment protocols?
A: Yes, please see https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials.

Supplemental Materials for Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-CH)



Important Supplemental Materials for Clinic-Collected Optional BHC Measures derived from CMS Medicaid Adult and/or Child Core Set Measures (WCC-CH)

Measure WCC-CH: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

These supplemental materials are necessary for implementation of the BHC Clinic-Collected Optional BHC Measures that are derived from the CMS Medicaid Adult and/or Child Core Set Measures. This volume includes the exact specifications that are on the CMS website for the 2023 Medicaid Core Set, with simple modifications noted in the text. Limited additional needed modifications are included below, as well as supplemental useful materials.

Changes within the specification: For the WCC-CH measure, the changes in the specification from the CMS Medicaid Child Core Set reflects: (1) substitution of the word "client" for "beneficiary" or "patient", unless the latter is part of a copyrighted code description; (2) removal of age stratification within the child client population; and (3) removal of references to the Core Set.

Additional information: For the WCC-CH measure, the following material is provided to assist clinics using the specifications and follows the numbering system used in the non-Medicaid Core Set-derived BHC specifications:

A. DESCRIPTION
Important Reporting Guidance:

- The WCC-CH measure is to be used by BHCs to measure performance related to clients seen at the Provider during the Measurement Year.
- Value set references are underlined in the specifications (e.g., Physical Activity Counseling Value Set). Current value sets are available on the CMS Medicaid Child Core Set Reporting Resource website. Use the version current for the year being reported.
- The WCC-CH measure is to be stratified separately based on whether the client is:
  - Medicaid only or Other (including those dually eligible for Medicare and Medicaid)
    AND
  - A member of which of the following ethnic groups: Not Hispanic or Latino, Hispanic or Latino, or Unknown
    AND
  - A member of which of the following racial groups: White or Caucasian, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or Other Pacific Islander, More than one race, or Unknown

- Refer to the specific data-reporting template for the reporting requirements applicable to each measure.

Measurement Period: The Measurement Period is the period for which data are required for reporting purposes. The Measurement Period for the WCC **denominator** is the Measurement Year and, for the WCC **numerator**, is the Measurement Year. See Figure 1 for visual depiction of Measurement Year and Measurement Periods.

Figure 1. Visual of Measurement Year and Measurement Periods

Measurement Year
Measurement Year (MY): 12 month reporting period
Denominator Measurement Period (MP): 12 month MY
Numerator Measurement Period (MP): 12 month MY

Key: MY: Measurement Year; MP: Measurement Period.

B. DEFINITIONS

TERM	DEFINITION
Measurement Period	The specific time period for which data are needed for the numerator and denominator of a given measure. The Measurement Period may differ for the numerator and denominator and for each measure and is specified in section A above.
Measurement Year	The standard 12-month reporting period common to all measures being reported by the Provider.
Percentage	A Percentage is calculated as follows: numerator divided by denominator (n/d).
Provider	The Provider entity that is being measured (i.e., BHC)

E. ADDITIONAL NOTES

Interpretation of scores: Better quality = Higher Percentage

F. FREQUENTLY ASKED QUESTIONS

Question on relation of height and weight to BMI:

Q: For Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-CH)," if BMI percentile is present, why are height and weight required?
A: These are requirements from the source measure, most likely to ensure that whoever calculated the percentile captured the height and weight and did the calculation accurately based on those measurements.

Question on sampling for the WCC-CH measure:

Q: Are BHCs required to use sampling for the WCC-CH measure? If the BHCs have systems in

place to report on all consumers in the measure, can they report on all consumers or must they pick a subset?
A: Sampling is not required. Reporting on all consumers is completely acceptable. Sampling would likely be harder for you if you already have the required information in your EHR.

Questions regarding providers who may assess and provide services for clients under the WCC-CH measure:

Q: Should a primary care practitioner (PCP) or obstetrician/gynecologist (OB/GYN) complete the assessments and services included in the WCC-CH measure?
A: The Medicaid Core Set measure from which this measure derives requires that the services be provided "at an outpatient visit with a primary care practitioner (PCP) or obstetrician/gynecologist (OB/GYN)" and, further, that "[Client]-reported services and biometric values (height, weight, BMI percentile) are acceptable only if the information is collected by a primary care practitioner (refer to Appendix D of this manual for the definition of "PCP") or specialist, if the specialist is providing a primary care service related to the condition being assessed, while taking a patient's history." Although Appendix D defines PCP more broadly than one might literally, we realize that this still will make it difficult in many cases for BHCs to obtain data and assure that the BMI screening and other assessments or counseling occur. For this reason and in the context of the CCBHC demonstration, medical personnel beyond PCPs or OB/GYNs can conduct services contemplated within the specification, if they operate within the scope of their licensure. Because this is a deviation from the measure Technical Specification, the deviation should be indicated in the section of the data reporting template where adherence or non-adherence to the Technical Specification is reported.

Q: For the CCBHC demonstration project, the requirement for the OB/GYN and PCP to screen clients has been relaxed for the WCC-BH measure. Is the list of codes for the outpatient value set still going to be the same? If so, could this potentially be limiting to clinics that did not use a PCP or OB/GYN?
A: This is a BHC-reported measure. The BHCs will be able to have any "medical personnel" (within the licensure or certification requirements of the state) undertake the BMI screening to satisfy the measure. This might include nurses, medical assistants, and others. If a BHC or state does not believe that that the codes will allow this for all such staff at the BHCs, include the codes that are pertinent for eligible services with those other personnel and indicate this in the data reporting template as a deviation from the Technical Specifications. In circumstances such as this, the state should develop a list of such codes that is transparent and consistent across providers, especially across CCBHCs. Please note that federal regulations allow only properly licensed medical personnel, who are working under the supervision of a physician, to use billing codes designed for physicians.

Questions on reporting physical health services:

Q: Concerning the WCC-CH measure, if the CCBHC demonstration does not provide primary care services, why are CCBHCs required to report on the BMI for children served by a PCP?
A: One focus of the CCBHC initiative is to foster better coordination of physical and behavioral health care, and part of the scope of services to be provided by CCBHCs is physical health

screening and monitoring. The screenings such as BMI that are part of the quality measures are designed to promote this scope of services. If there is a PCP and you know that the screening already has been conducted and documented, then you can obtain and use that information.

Measure WCC-CH: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

Measure WCC-CH: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents[8,14]

Based on a CMS Medicaid Child Core Set Measure (2023), which is derived from a measure stewarded by the National Committee for Quality Assurance (NCQA)

A. DESCRIPTION

Percentage of children ages 3 to 17 who had an outpatient visit with a primary care practitioner (PCP) or obstetrician/gynecologist (OB/GYN) and who had evidence of the following during the measurement year:

Body mass index (BMI) percentile documentation*

Counseling for nutrition

Counseling for physical activity

* Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed, rather than an absolute BMI value.

Data Collection Method: Administrative, Hybrid, or EHR

Guidance for Reporting:

This measure applies to ~~beneficiaries~~ [clients] ages 3 to 17. For the purpose of [Medicaid] Child Core Set reporting, states ~~should~~ calculate and report this measure for two age groups and a total rate for each of the three indicators: ages 3 to 11, ages 12 to 17, and total (ages 1 to 17). [For purposes of Behavioral Health Clinic reporting, ~~states~~ [clinics] report only the total.]

The eligible population (denominator) for this measure includes children ages 3 to 17 who have an outpatient visit and meet the continuous enrollment criteria.

A BMI percentile is included in the numerator count if the specified documentation is present, regardless of the primary intent of the visit. A BMI without a percentile is not acceptable for inclusion in the numerator count.

The height, weight, and BMI must be from the same data source.

The height and weight measurement should be taken during the measurement year.

If using hybrid specifications, documentation in the medical record should indicate the weight and BMI value, dated during the measurement year.

Include all paid, suspended, pending, and denied claims.

This measure includes an optional exclusion for ~~beneficiaries~~ [clients] who die during the measurement year. For additional information, refer to the deceased ~~beneficiary~~ [client] exclusion guidance in ~~Section II. Data Collection and Reporting of the Child Core Set~~ [Section III. Technical Specification Components].

The electronic specification for FFY 2023 is located on the eCQI resource center at https://ecqi.healthit.gov/ecqm/ec/2022/cms155v10. [Use version current for year reporting.]

[8]The NCQA HEDIS® measure specification has been adjusted pursuant to NCQA's Rules for Allowable Adjustments of HEDIS.

[14]Aside from the minor modifications noted in this specification, this specification is taken directly from the 2023 CMS Medicaid Child Core Set Measures. Use the most current version for the year being reported.
See also Important Supplemental Materials for Clinic-Collected Optional BHC Measures derived from CMS Medicaid Adult and/or Child Core Set Measures (in this manual immediately before this specification).

States that use electronic specifications should indicate this by selecting "Electronic Health Records" in the Data Source section of the ~~online~~ reporting ~~system~~ [template].

Refer to [Appendix D of this manual] for definitions of a PCP and OB/GYN and other prenatal care practitioner.

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-10-CM, LOINC, SNOMED, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITION

BMI percentile	The percentile ranking based on the CDC's BMI-for-age growth charts, which indicates the relative position of the patient's BMI number among others of the same gender and age.

C. ELIGIBLE POPULATION

Ages	Ages 3 to 17 as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a ~~beneficiary~~ [client] for whom enrollment is verified monthly, the ~~beneficiary~~ [client] may not have more than a 1-month gap in coverage (e.g., a ~~beneficiary~~ [client] whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	An outpatient visit (Outpatient Value Set) with a PCP or an OB/GYN during the measurement year.
Required exclusion	~~Beneficiaries~~ [Clients] in hospice or using hospice services anytime during the measurement year. If a state reports this measure using the Hybrid method, and a ~~beneficiary~~ [client] is found to be in hospice or using hospice services during medical record review, the ~~beneficiary~~ [client] is removed from the sample and replaced by a ~~beneficiary~~ [client] from the oversample. For additional information, refer to the hospice exclusion guidance in ~~Section II. Data Collection and Reporting of the Child Core Set~~ [Section III. Technical Specification Components].

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerators

BMI Percentile

BMI percentile (BMI Percentile Value Set) during the measurement year.

Counseling for Nutrition

Counseling for nutrition (Nutrition Counseling Value Set) during the measurement year.

Counseling for Physical Activity

Counseling for physical activity (Physical Activity Counseling Value Set) during the measurement year.

Exclusions (optional)

Female ~~beneficiaries~~ [clients] who have a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year. The denominator for all rates must be the same. A state that excludes these ~~beneficiaries~~ [clients] must do so for all rates.

E. HYBRID SPECIFICATION

Denominator

A systematic sample drawn from the eligible population for the Total age band (ages 3 to 17). ~~The Total sample is stratified by age to report rates for the ages 3 to 11 and ages 12 to 17 age stratifications.~~ Refer to the sampling guidance under Section II. Data Collection and Reporting of the ~~Child Core Set~~ [Behavioral Health Clinic Quality Measures] for additional information.

Numerators

BMI Percentile

BMI percentile during the measurement year as identified by administrative data or medical record review.

Administrative Data

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

Medical Record Review

Documentation must include height, weight, and BMI percentile during the measurement year. The height, weight, and BMI percentile must be from the same data source.

Either of the following meets criteria for BMI percentile:

BMI percentile documented as a value (e.g., 85th percentile)
BMI percentile plotted on age-growth chart

Only evidence of the BMI percentile or BMI percentile plotted on an age-growth chart meets criteria.

~~Beneficiary~~ [Client]-reported services and biometric values (height, weight, BMI percentile) are acceptable only if the information is collected by a primary care practitioner (refer to [Appendix D of this manual] for the definition of "PCP") or specialist, if the specialist is providing a primary care service related to the condition being assessed, while taking a patient's history. The information must be recorded, dated, and maintained in the ~~beneficiary~~ [client]'s legal health record.

Ranges and thresholds do not meet criteria for this indicator. A distinct BMI percentile is required for numerator compliance. Documentation of >99 percent or <1 percent meet criteria because a distinct BMI percentile is evident (e.g., 100 percent or 0 percent).

Counseling for Nutrition

Documentation of counseling for nutrition or referral for nutrition education during the measurement year as identified by administrative data or medical record review.

Administrative Data

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

Medical Record Review

Documentation must include a note indicating the date and at least one of the following:

Discussion of current nutrition behaviors (e.g., eating habits, dieting behaviors)

Checklist indicating nutrition was addressed

Counseling or referral for nutrition education

~~Beneficiary~~ [Client] received education materials on nutrition during a face-to-face visit

Anticipatory guidance for nutrition

Weight or obesity counseling

Counseling for Physical Activity

Documentation of counseling for physical activity or referral for physical activity during the measurement year as identified by administrative data or medical record review.

Administrative Data

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

Medical Record Review

Documentation must include a note indicating the date and at least one of the following:

Discussion of current physical activity behaviors (e.g., exercise routine, participation in sports activities, exam for sports participation)

Checklist indicating physical activity was addressed

Counseling or referral for physical activity

~~Beneficiary~~ [Client] received educational materials on physical activity during a face-to-face visit

Anticipatory guidance specific to the child's physical activity

Weight or obesity counseling

Exclusions (optional)

Refer to Administrative Specification for exclusion criteria. Exclusionary evidence in the medical record must include a note indicating a diagnosis of pregnancy. The diagnosis must have occurred during the measurement year.

F. ADDITIONAL NOTES

The following notations or examples of documentation do not count as numerator compliant:

BMI Percentile

No BMI percentile documented in medical record or plotted on age-growth chart

Notation of BMI value only

- Notation of height and weight only
- Nutrition
  - No counseling/education on nutrition and diet
  - Counseling/education before or after the measurement year
  - Notation of "health education" or "anticipatory guidance" without specific mention of nutrition
  - A physical exam finding or observation alone (e.g., well-nourished) is not compliant because it does not indicate counseling for nutrition
  - Documentation related to a ~~beneficiary~~ [client]'s "appetite" does not meet criteria
- Physical Activity
  - No counseling/education on physical activity
  - Notation of "cleared for gym class" alone without documentation of a discussion
  - Counseling/education before or after the measurement year
  - Notation of "health education" or "anticipatory guidance" without specific mention of physical activity
  - Notation of anticipatory guidance related solely to safety (e.g., wears helmet or water safety) without specific mention of physical activity recommendations
  - Notation solely related to screen time (computer or television) without specific mention of physical activity

Services may be rendered during a visit other than a well-child visit. These services count if the specified documentation is present, regardless of the primary intent of the visit; however, services specific to the assessment or treatment of an acute or chronic condition do not count toward the Counseling for Nutrition and Counseling for Physical Activity indicators.

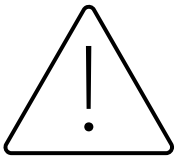
For example, the following documentation is specific to the assessment or treatment of an acute or chronic condition and does not meet criteria:

- Notation that a ~~beneficiary~~ [client] with chronic knee pain is able to run without limping
- Notation that a ~~beneficiary~~ [client] has exercise-induced asthma
- Notation that a ~~beneficiary~~ [client] with diarrhea is following the BRAT diet
- Notation that a ~~beneficiary~~ [client] has decreased appetite as a result of an acute or chronic condition

Services rendered for obesity or eating disorders may be used to meet criteria for the Counseling for Nutrition and Counseling for Physical Activity indicators if the specified documentation is present.

Referral to the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) may be used to meet criteria for the Counseling for Nutrition indicator.

The BMI Percentile, Counseling for Nutrition, and Counseling for Physical Activity indicators do not require a specific setting. Therefore, services rendered during a telephone visit, e-visit, or virtual check-in meet criteria.



Important Supplemental Materials for Clinic-Collected Optional BHC Measures derived from CMS Medicaid Adult and/or Child Core Set Measures (CBP-AD)

Measure CBP-AD: Controlling High Blood Pressure

These supplemental materials are necessary for implementation of the BHC Clinic-Collected Optional BHC Measures that are derived from the CMS Medicaid Adult and/or Child Core Set Measures. This volume includes the exact specifications that are on the CMS website for the 2023 Medicaid Core Set, with simple modifications noted in the text. Limited additional needed modifications are included below, as well as supplemental useful materials.

Changes within the specification: For the CBP-AD measure, the changes in the specification from the CMS Medicaid Adult Core Set reflects: (1) substitution of the word "client" for "beneficiary" or "patient", unless the latter is part of a copyrighted code description; (2) removal of age stratification in the adult measure (i.e., applicable here to adults ages 18 years and older); and (3) removal of references to the Core Set.

Additional information: For the CBP-AD measure, the following material is provided to assist clinics using the specifications and follows the numbering system used in the non-Medicaid Core Set-derived BHC specifications:

A. DESCRIPTION
Important Reporting Guidance:

- The CBP-AD measure is to be used by BHCs to measure performance related to clients seen at the Provider during the Measurement Year.
- Value set references are underlined in the specifications (e.g., Essential Hypertension Value Set). Current value sets are available on the CMS Medicaid Adult Core Set Reporting Resource website. Use the version current for the year being reported.
- The CBP-AD measure is to be stratified separately based on whether the client is:
  - Medicaid only or Other (including those dually eligible for Medicare and Medicaid)
    AND
  - A member of which of the following ethnic groups: Not Hispanic or Latino, Hispanic or Latino, or Unknown
    AND
  - A member of which of the following racial groups: White or Caucasian, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or Other Pacific Islander, More than one race, or Unknown
- Refer to the specific data-reporting template for the reporting requirements applicable to each measure.

Measurement Period: The Measurement Period is the period for which data are required for reporting purposes. The Measurement Period for the CBP-AD **denominator** is the

Measurement Year and the prior year and, for the WCC **numerator**, is the Measurement Year. See Figure 1 for visual depiction of Measurement Year and Measurement Periods.

Figure 1. Visual of Measurement Year and Measurement Periods

Measurement Year
Measurement Year (MY): 12 month reporting period
Denominator Measurement Period (MP): 12 month MY and prior year
Numerator Measurement Period (MP): 12 month MY

Key: MY: Measurement Year; MP: Measurement Period.

B. DEFINITIONS

TERM	DEFINITION
Measurement Period	The specific time period for which data are needed for the numerator and denominator of a given measure. The Measurement Period may differ for the numerator and denominator and for each measure and is specified in section A above.
Measurement Year	The standard 12-month reporting period common to all measures being reported by the Provider.
Percentage	A Percentage is calculated as follows: numerator divided by denominator (n/d).
Provider	The Provider entity that is being measured (i.e., BHC)

E. ADDITIONAL NOTES

Interpretation of scores: Better quality = Higher Percentage

F. FREQUENTLY ASKED QUESTIONS

None

Measure CBP-AD: Controlling High Blood Pressure1[8,15]

Based on a CMS Medicaid Adult Core Set Measure (2023), which is derived from a measure stewarded by the National Committee for Quality Assurance (NCQA)

A. DESCRIPTION

Percentage of ~~beneficiaries~~ [clients] ages 18 to 85 who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.

Data Collection Method: Administrative, Hybrid, or EHR

Guidance for Reporting:

For HEDIS, his measure applies to ~~beneficiaries~~ [clients] ages 18 to 85. For the purpose of [Medicaid] Adult Core Set reporting, states ~~should~~ calculate and report this measure for two age groups (as applicable): ages 18 to 64 and ages 65 to 85. [For purposes of Behavioral Health Clinic reporting, ~~states~~ [clinics] should only report the total.]

Include all paid, suspended, pending, and denied claims.

This measure includes an optional exclusion for ~~beneficiaries~~ [clients] who die during the measurement year. For additional information, refer to the deceased ~~beneficiary~~ [client] exclusion guidance in ~~Section II. Data Collection and Reporting of the Adult Core Set~~ [Section III. Technical Specification Components].

NCQA's Medication List Directory (MLD) for Dementia Medications *is available to order free of charge in the* NCQA Store (https://store.ncqa.org/hedis-my-2022-medication-list-directory.html). [Use version current for year reporting.] Once ordered, the Medication List Directory can be accessed through the NCQA Download Center (https://my.ncqa.org/Downloads).

The electronic specification for FFY 2023 is located on the eCQI resource center at https://ecqi.healthit.gov/ecqm/ec/2022/cms165v10. [Use version current for year reporting.] States that use electronic specifications should indicate this by selecting "Electronic Health Records" in the Data Source section of the ~~online~~ reporting [template] ~~system~~.

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-9-CM, ICD-9-PCS, ICD-10-CM, ICD-10-PCS, LOINC, POS, SNOMED, and UB. The Medication List Directory include the following coding systems for medications: NDC and RxNorm. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Adequate control	Both a representative systolic BP <140 mm Hg and a representative diastolic BP of <90 mm Hg.

[8]The NCQA HEDIS® measure specification has been adjusted pursuant to NCQA's Rules for Allowable Adjustments of HEDIS.

[15]Aside from the minor modifications noted in this specification, this specification is taken directly from the 2023 CMS Medicaid Adult Core Set Measures. Use the most current version for the year being reported. See also Important Supplemental Materials for Clinic-Collected Optional BHC Measures derived from CMS Medicaid Adult and/or Child Core Set Measures (in this manual immediately before this specification).

Representative BP	The most recent BP reading during the measurement year on or after the second diagnosis of hypertension. If multiple BP measurements occur on the same date, or are noted in the chart on the same date, use the lowest systolic and lowest diastolic BP reading. If no BP is recorded during the measurement year, assume that the ~~beneficiary~~ [client] is "not controlled."

C. ELIGIBLE POPULATION

Age	Ages 18 to 85 as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a ~~beneficiary~~ [client] for whom enrollment is verified monthly, the ~~beneficiary~~ [client] may not have more than a 1-month gap in coverage (e.g., a ~~beneficiary~~ [client] whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	~~Beneficiaries~~ [Clients] who had at least two visits on different dates of service with a diagnosis of hypertension on or between January 1 of the year prior to the measurement year and June 30 of the measurement year. Visit type need not be the same for the two visits. Any of the following code combinations meet criteria: Outpatient visit (Outpatient Without UBREV Value Set) with any diagnosis of hypertension (Essential Hypertension Value Set) A telephone visit (Telephone Visits Value Set) with any diagnosis of hypertension (Essential Hypertension Value Set) An e-visit or virtual check-in (Online Assessments Value Set) with any diagnosis of hypertension (Essential Hypertension Value Set)
Required exclusions	Exclude ~~beneficiaries~~ [clients] who meet either of the following criteria: • ~~Beneficiaries~~ [Clients] in hospice or using hospice services anytime during the measurement year. If a state reports this measure using the Hybrid method, and a ~~beneficiary~~ [client] is found to be in hospice or using hospice services during medical record review, the ~~beneficiary~~ [client] is removed from the sample and replaced by a ~~beneficiary~~ [client] from the oversample. For additional information, refer to the hospice exclusion guidance in ~~Section II. Data Collection and Reporting of the Adult Core Set~~ [Section III. Technical Specification Components]. • ~~Beneficiaries~~ [Clients] receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year.

Optional exclusions	Note: Supplemental and medical record data may not be used for these exclusions. Exclude ~~beneficiaries~~ [clients] who meet either of the following criteria: ~~Beneficiaries~~ [Clients] ages 66 to 80 as of December 31 of the measurement year with frailty and advanced illness. ~~Beneficiaries~~ [Clients] must meet both of the following frailty and advanced illness criteria to be excluded: At least one claim/encounter for frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) during the measurement year Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years): At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), telephone visits (Telephone Visits Value Set), e-visits or virtual check-ins (Online Assessments Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set), or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. To identify a nonacute inpatient discharge: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set) Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim Identify the discharge date for the stay At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set) At least one acute inpatient discharge with an advanced illness diagnosis (Advanced Illness Value Set) on the discharge claim. To identify an acute inpatient discharge: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set) Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set) Identify the discharge date for the stay A dispensed dementia medication (Dementia Medications List, see link to the Medication List Directory in Guidance for Reporting above) ~~Beneficiaries~~ [Clients] age 81 and older as of December 31 of the measurement year with frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) during the measurement year

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

Identify the most recent BP reading (Systolic Blood Pressure Value Set; Diastolic Blood Pressure Value Set) taken during the measurement year. Exclude BPs taken in an acute inpatient setting (Acute Inpatient Value Set; Acute Inpatient POS Value Set) or during an ED visit (ED Value Set; ED POS Value Set).

The BP reading must occur on or after the date of the second diagnosis of hypertension (identified using the event/diagnosis criteria).

The ~~beneficiary~~ [client] is numerator compliant if the BP is <140/90 mm Hg. The ~~beneficiary~~ [client] is not compliant if the BP is ≥ 140/90 mm Hg, if there is no BP reading during the measurement year, or if the reading is incomplete (e.g., the systolic or diastolic level is missing). If there are multiple BPs on the same date of service, use the lowest systolic and lowest diastolic BP on that date as the representative BP.

States that use CPT Category II codes to identify numerator compliance for this indicator must search for all codes in the following value sets and use the most recent codes during the measurement year to determine numerator compliance for both systolic and diastolic levels.

Value Set	Numerator Compliance
Systolic Less Than 140 Value Set	Systolic compliant
Systolic Greater Than or Equal To 140 Value Set	Systolic not compliant
Diastolic Less Than 80 Value Set	Diastolic compliant
Diastolic 80-89 Value Set	Diastolic compliant
Diastolic Greater Than or Equal To 90 Value Set	Diastolic not compliant

Exclusions (optional)

Exclude from the eligible population all ~~beneficiaries~~ [clients] with evidence of end-stage renal disease (ESRD) (ESRD Diagnosis Value Set), dialysis (Dialysis Procedure Value Set), nephrectomy (Total Nephrectomy Value Set; Partial Nephrectomy Value Set) or kidney transplant (Kidney Transplant Value Set; History of Kidney Transplant Value Set) on or prior to December 31 of the measurement year.

Exclude from the eligible population female ~~beneficiaries~~ [clients] with a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year.

Exclude from the eligible population all ~~beneficiaries~~ [clients] who had a nonacute inpatient admission during the measurement year. To identify nonacute inpatient admissions:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).

Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.

Identify the admission date for the stay.

E. HYBRID SPECIFICATION

Denominator

A systematic sample drawn from the eligible population. Refer to the sampling guidance under Section II. Data Collection and Reporting of the ~~Child Core Set~~ [Behavioral Health Clinic Quality Measures].

Identifying the Medical Record

All eligible BP measurements recorded in the record must be considered. If a ~~beneficiary~~ [client]'s medical record cannot be found, the ~~beneficiary~~ [client] remains in this measure denominator and is considered noncompliant for the numerator.

Use the following guidance to find the appropriate medical record to review.

Identify the ~~beneficiary~~ [client]'s PCP.

If the ~~beneficiary~~ [client] had more than one PCP for the time-period, identify the PCP who most recently provided care to the ~~beneficiary~~ [client].

If the ~~beneficiary~~ [client] did not visit a PCP for the time-period or does not have a PCP, identify the practitioner who most recently provided care to the ~~beneficiary~~ [client].

If a practitioner other than the ~~beneficiary~~ [client]'s PCP manages the hypertension, the medical record of that practitioner may be used.

Numerator

The number of ~~beneficiaries~~ [clients] in the denominator whose most recent BP (both systolic and diastolic) is adequately controlled during the measurement year. For a ~~beneficiary~~ [client]'s BP to be controlled the systolic and diastolic BP must be <140/90 mm Hg (adequate control). To determine if a ~~beneficiary~~ [client]'s BP is adequately controlled, the representative BP must be identified.

Administrative Data

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

Medical Record Review

Identify the most recent BP reading noted during the measurement year.

The BP reading must occur on or after the date when the second diagnosis of hypertension (identified using the event/diagnosis criteria) occurred.

Do not include BP readings:

Taken during an acute inpatient stay or ED visit

Taken on the same day as a diagnostic test or diagnostic or therapeutic procedure that requires a change in diet or change in medication on or one day before the day of the test or procedure, with the exception of fasting blood tests

Taken by the ~~beneficiary~~ [client] using a non-digital device such as with a manual blood pressure cuff and a stethoscope

Identify the lowest systolic and lowest diastolic BP reading from the most recent BP notation in the medical record. If multiple readings were recorded for a single date, use the lowest systolic and lowest diastolic BP on that date as the representative BP. The systolic and diastolic results do not need to be from the same reading.

BP readings taken by the ~~beneficiary~~ [client] and documented in the ~~beneficiary~~ [client]'s medical record are eligible for use in reporting (provided the BP does not meet any exclusion criteria). There is no requirement that there be evidence the BP was collected by a PCP or specialist.

The ~~beneficiary~~ [client] is not numerator compliant if the BP reading is ≥ 140/90 mm Hg or is missing, if there is no BP reading during the measurement year, or if the reading is incomplete (e.g., the systolic or diastolic level is missing).

Ranges and thresholds do not meet criteria for this measure. A distinct numeric result for both the systolic and diastolic BP reading is required for numerator compliance. A BP documented as an "average BP" (e.g., "average BP: 139/70") is eligible for use.

Exclusions (optional)

Refer to the Administrative Specification for exclusion criteria. Exclusionary evidence in the medical record must include a note indicating diagnosis of pregnancy or evidence of a nonacute inpatient admission during the measurement year, or evidence of ESRD, dialysis, nephrectomy, or kidney transplant any time during the ~~beneficiary~~ [client]'s history through December 31 of the measurement year.

F. ADDITIONAL NOTES

When identifying the most recent BP reading, all eligible BP readings in the appropriate medical record should be considered, regardless of practitioner type and setting (excluding acute inpatient and ED visit settings).

An electronic medical record (EMR) can be used to identify the most recent BP reading if it meets the criteria for appropriate medical record.

When excluding BP readings from the numerator, the intent is to identify diagnostic or therapeutic procedures that require a medication regimen, a change in diet, or a change in medication. Examples of such procedures include colonoscopies; dialysis, infusions, and chemotherapy; and nebulizer treatments with albuterol. A ~~beneficiary~~ [client] forgetting to take regular medications on the day of the procedure is not considered a required change in medication, and therefore the BP reading is eligible.

BP readings taken on the same day that the patient receives a common low-intensity or preventive procedure are eligible for use. These include procedures such as vaccinations; injections (e.g., allergy, vitamin B-12, insulin, steroid, toradol, Depo-Provera, testosterone, lidocaine); tuberculosis tests; intrauterine device (IUD) insertions; eye exams; or wart or mole removal.

V. STATE-COLLECTED MEASURE TECHNICAL SPECIFICATIONS

Section V contains the technical specifications and other guidance for the State-Collected BHC measures, including twelve measures that are required as part of the Section 223 CCBHC Demonstration, and two measures that are optional. These are:

Required Measures:

Patient Experience of Care Survey
Youth/Family Experience of Care Survey
Antidepressant Medication Management (AMM-AD)
Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)
Plan All-Cause Readmissions Rate (PCR-AD)
Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder (ADHD) Medication (ADD-CH)
Hemoglobin A1c Control for Patients with Diabetes (HBD-AD)
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD)
Follow-Up After Hospitalization for Mental Illness (FUH-CH and FUH-AD)
Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD and FUM-CH)
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA-AD and FUA-CH)

Optional Measures:

Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)

State-Collected Measures Required for Submission as Part of CCBHC Demonstration

This section of Chapter V includes the following State-Collected required measures:

1. Patient Experience of Care Survey
2. Youth/Family Experience of Care Survey
3. Antidepressant Medication Management (AMM-AD) — including supplemental materials
4. Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD) — including supplemental materials
5. Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD) — including supplemental materials
6. Plan All-Cause Readmissions Rate (PCR-AD) — including supplemental materials
7. Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder (ADHD) Medication (ADD-CH) — including supplemental materials
8. Hemoglobin A1c Control for Patients with Diabetes (HBD-AD) — including supplemental materials
9. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD) — including supplemental materials
10. Follow-Up After Hospitalization for Mental Illness (FUH-CH and FUH-AD) — including supplemental materials
11. Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD and FUM-CH) — including supplemental materials
12. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA-AD and FUA-CH) — including supplemental materials

Patient Experience of Care Survey (PEC)

SAMHSA-Developed Measure

A. DESCRIPTION

The PEC measure uses states' existing annual completion and submission of the Mental Health Statistics Improvement Program (MHSIP) Adult Consumer Experience of Care Survey, identifying results separately for BHCs and comparison clinics and oversampling those clinics.

Data Collection Method: MHSIP Survey

Important Guidance for Reporting:

This section of the specification includes important guidance for reporting the PEC measure. Also refer to section E for Frequently Asked Questions.

- Results of the MHSIP generally are not reported unless the survey is statewide and the sample size is sufficient to be statistically meaningful, and, as a general rule, states are directed not to report results from only a few providers or one region. **For purposes of the CCBHC Demonstration Program, however,** states will have specific responsibilities. States are to continue sampling as they presently do, using the same version of the MHSIP as they do at present. States, however, are asked to make the following modifications:
    - If not already doing so, modify procedures to allow reporting by CCBHC and comparison clinics specifically.
    - Oversample CCBHCs and comparison clinics to generate sufficient sample size, specifically reaching out to 300 clients per CCBHC and comparison clinic.
    - States will submit the results aggregated at the CCBHC and comparison clinic level as part of CCBHC data reporting using Tables 9, 11, and 11a of the URS reporting template that is current at the time of the survey and that may be found at SAMHSA|Uniform Reporting System (URS) Report Resources (Tables 16, 17A, and 17B for the Mental Health Block Grant), including required information on sampling methodology and response rates. This report will be provided separately from that already compiled by the state to allow analysis of only those data pertinent to the Demonstration Program.

- Refer to the specific data-reporting template for the reporting requirements applicable to each measure.

Measurement Period: The Measurement Period for both the **denominator** and **numerator** is the Measurement Year, with the survey to be performed as part of the state's existing survey.

B. DEFINITIONS

TERM	DEFINITION
Adult Consumer Experience of Care Survey	The Mental Health Statistics Improvement Program (MHSIP) Adult Consumer Experience of Care Survey is used to collect data on adult behavioral health client experience of care. The official version and instructions are found at SAMHSA|Uniform Reporting System (URS) Report Resources. Some states have customized this survey, and instructions on the site address that circumstance.
Measurement Period	The specific period of time for which data are needed for the numerator and denominator of a given measure. The Measurement Period is specified in section A above.
Measurement Year	The standard 12-month reporting period common to all measures being reported by the Provider.
Mental Health Statistics Improvement Program (MHSIP)	The MHSIP Consumer Surveys measure concerns that are important to clients of publicly funded mental health services in the areas of Access, Quality/Appropriateness, Outcomes, Overall Satisfaction, Participation in Treatment Planning, Social Connectedness and Functioning.
Provider	The Provider entity that is being measured (i.e., BHC)
Uniform Reporting System (URS)	The URS is used by SAMHSA to collect uniform reporting of state-level data to describe the public mental health system and the outcomes of that system's programs .

C. ELIGIBLE POPULATION

CRITERIA	REQUIREMENTS
Age	Clients aged 18 years or older at the time of survey

D. SPECIFICATION

For purposes of the CCBHC Demonstration Program, results for CCBHCs and comparison clinics should be submitted in a way that permits distinction between each CCBHC and each comparison clinic, with oversampling of those provider entities.

E. FREQUENTLY ASKED QUESTIONS

Questions Regarding Survey Sample:

Q: Does the survey need to cover all populations served?
A: The goal of the survey is to be representative of the population served but the measure is written to allow the states to continue to collect as they do now, with the exception of oversampling (300) and requiring that the results be reported separately for the BHCs.

Q: Is the sample size of 300 the TOTAL of youth and adult, or 300 EACH: youth and adult?
A: The sample size of 300 is for youth and adult separately, unless there are fewer than those numbers of individuals in the population of the BHC.

Q: Do the sample sizes need to be representative of the relative size of the populations?
A: There is no requirement that the states change what they are doing now, other than oversampling (300) and reporting the results separately by BHCs. The goal is that it be as representative as possible, given that caveat.

Q: Our state currently selects a blind sample across the entire system with no provider- specific identifiers. The departmental IRB exercises oversight of the process. Surveying within the particular agency will be a significant departure from the current practice. How do we handle this?
A: Yes. It may be a departure for some states and should be raised with state departmental internal review boards.

Questions Regarding Stratification:

Q: Are there any stratification requirements?
A: There are no explicit stratification requirements in the two existing surveys referenced in the BHC measures. Some states do incorporate more stratification than do others, in part to get a more representative sample. These BHC measures incorporating the two (2) patient experience of care measures were very deliberately created to allow states to continue to conduct the surveys just as they are doing presently. For that reason, there is nothing specific here related to stratification. The only change for these surveys is that you must report at the BHC level and reach out to 300 clients per BHC per survey for reporting within the BHC quality measures.

Questions Regarding Application to Clients Receiving Substance Use Services:

Q: We do not use mixed surveys for substance use clients. Is there an appropriate survey to use on substance use clients?
A: The quality measures are intended to apply to everybody served by the BHC. The CCBHC demonstration program is designed to integrate care and to break down distinctions within behavioral health. The same surveys should, for the CCBHC demonstration program, be used for all CCBHC clients. For non-CCBHC states or BHCs that are not either CCBHCs or comparison sites, the state has the option of using another survey if they wish.

Youth and Family Experience of Care Survey (Y/FEC)

SAMHSA-Developed Measure

A. DESCRIPTION

The Y/FEC measure uses states' existing annual completion and submission of the Youth/Family Services Survey for Families (YSS-F) Experience of Care Survey, identifying results separately for BHCs and comparison clinics and oversampling those clinics.

Data Collection Method: YSS-F Survey

Important Guidance for Reporting:

This section of the specification includes important guidance for reporting the Y/FEC measure. Also refer to section E for Frequently Asked Questions.

- Results of the YSS-F generally are not reported unless the survey is statewide and the sample size is sufficient to be statistically meaningful, and, as a general rule, states are directed not to report results from only a few providers or one region. **For purposes of the CCBHC Demonstration Program, however,** states will have specific responsibilities. States are to continue sampling as they presently do, using the same version of the YSS-F as they do at present. States, however, are asked to make the following modifications:
    - If not already doing so, modify procedures to allow reporting by CCBHC and comparison clinics specifically.
    - Oversample CCBHCs and comparison clinics to generate sufficient sample size, specifically reaching out to 300 clients per CCBHC and comparison clinic.
    - States will submit the results aggregated at the CCBHC and comparison clinic level as part of CCBHC data reporting using Tables 9, 11, and 11a of the URS reporting template that is current at the time of the survey and that may be found at SAMHSA|Uniform Reporting System (URS) Report Resources (Tables 16, 17A, and 17B for the Mental Health Block Grant), including required information on sampling methodology and response rates. This report will be provided separately from that already compiled by the state to allow analysis of only those data pertinent to the Demonstration Program.

- Refer to the specific data-reporting template for the reporting requirements applicable to each measure.

Measurement Period: The Measurement Period for both the **denominator** and **numerator** is the Measurement Year, with the survey to be performed as part of the state's existing survey.

B. DEFINITIONS

TERM	DEFINITION
Measurement Period	The specific period of time for which data are needed for the numerator and denominator of a given measure. The Measurement Period is specified in section A above.
Measurement Year	The standard 12-month reporting period common to all measures being reported by the Provider.
Provider	The Provider entity that is being measured (i.e., BHC)
Uniform Reporting System (URS)	The URS is used by SAMHSA to collect uniform reporting of state-level data to describe the public mental health system and the outcomes of that system's programs .
YSS-F Experience of Care Survey	The YSS-F Experience of Care Survey is used to collect data on youth and family behavioral health client experience of care. The official version and instructions are found at SAMHSA|Uniform Reporting System (URS) Report Resources. Some states have customized this survey, and instructions on the site address that circumstance.

C. ELIGIBLE POPULATION

CRITERIA	REQUIREMENTS
Age	Clients aged 17 years or younger at the time of survey

D. SPECIFICATION

For purposes of the CCBHC Demonstration Program, results for CCBHCs and comparison clinics should be submitted in a way that permits distinction between each CCBHC and each comparison clinic, with oversampling of those provider entities.

E. FREQUENTLY ASKED QUESTIONS

Questions Regarding Survey Sample:

Q: Does the survey need to cover all populations served?
A: The goal of the survey is to be representative of the population served but the measure is written to allow the states to continue to collect as they do now, with the exception of oversampling (300) and requiring that the results be reported separately for the BHCs.

Q: Is the sample size of 300 the TOTAL of youth and adult, or 300 EACH: youth and adult?
A: The sample size of 300 is for youth and adult separately, unless there are fewer than those numbers of individuals in the population of the BHC.

Q: Do the sample sizes need to be representative of the relative size of the populations?
A: There is no requirement that the states change what they are doing now, other than oversampling (300) and reporting the results separately by BHCs. The goal is that it be as representative as possible, given that caveat.

Q: Our state currently selects a blind sample across the entire system with no provider- specific identifiers. The departmental IRB exercises oversight of the process. Surveying within the particular agency will be a significant departure from the current practice. How do we handle this?
A: Yes. It may be a departure for some states and should be raised with state departmental internal review boards.

Questions Regarding Stratification:

Q: Are there any stratification requirements?
A: There are no explicit stratification requirements in the two existing surveys referenced in the BHC measures. Some states do incorporate more stratification than do others, in part to get a more representative sample. These BHC measures incorporating the two (2) patient experience of care measures were very deliberately created to allow states to continue to conduct the surveys just as they are doing presently. For that reason, there is nothing specific here related to stratification. The only change for these surveys is that you must report at the BHC level and reach out to 300 clients per BHC per survey for reporting within the BHC quality measures.

Questions Regarding Application to Clients Receiving Substance Use Services:

Q: We do not use mixed surveys for substance use clients. Is there an appropriate survey to use on substance use clients?
A: The quality measures are intended to apply to everybody served by the BHC. The CCBHC demonstration program is designed to integrate care and to break down distinctions within behavioral health. The same surveys should, for the CCBHC demonstration program, be used for all CCBHC clients. For non-CCBHC states or BHCs that are not either CCBHCs or comparison sites, the state has the option of using another survey if they wish.

Important Supplemental Materials for State-Collected Required BHC Measures derived from CMS Medicaid Adult and/or Child Core Set Measures (AMM-AD)

These supplemental materials are necessary for implementation of the State-Collected Required BHC Measures that are derived from the CMS Medicaid Adult and/or Child Core Set Measures. This volume includes the exact specifications that are on the CMS website for the 2023 Medicaid Core Set, with simple modifications noted in the text. Limited additional needed modifications are included below, as well as supplemental useful materials.

Changes directly in the specifications: For all Core Set-derived measures, the changes in the specification from the CMS Medicaid Adult or Child Core Set reflect: (1) substitution of the word "client" for "beneficiary" or "patient", unless the latter is part of a copyrighted code description; (2) removal of age stratification for adults (i.e., applicable to adults ages 18 years and older); and (3) removal of most references to the Core Set.

Additional needed modifications specific to each measure are included below, as well as supplemental useful materials.

Measure AMM-AD: Antidepressant Medication Management

Additional information: The following material is provided to assist clinics using the specifications and follows the numbering system used in the non-Core derived BHC specifications:

A. DESCRIPTION
Important Reporting Guidance:

- The AMM-AD measure is to be used to measure performance related to clients seen at the BHC Provider during the Measurement Year.
- Current value sets are available on the CMS Medicaid Adult Core Set Reporting Resource website. Use the version current for the year being reported.
- AMM-AD is stratified separately based on whether the client is:
    - Medicaid only or Other (including those dually eligible for Medicare and Medicaid)

      AND
    - A member of which of the following ethnic groups: Not Hispanic or Latino, Hispanic or Latino, or Unknown

      AND
    - A member of which of the following racial groups: White or Caucasian, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or Other Pacific Islander, More than one race, or Unknown

- Refer to the specific data-reporting template for the reporting requirements applicable to each measure.

Measurement Period: The Measurement Period is the period for which data are required for reporting purposes. The AMM measure **denominator** includes two Measurement Periods, both of which are defined in the specification: (a) ***Index prescription start date (IPSD) and (b) Negative medication history review***. The Measurement Periods for the AMM measure **numerator** include a different period for each of the two submeasures of ***Effective Acute Phase Treatment*** (IPSD through 114 days following IPSD) and ***Effective Continuation Phase Treatment*** (IPSD through 231 days following IPSD).

B. DEFINITIONS

TERM	DEFINITION
Measurement Period	The specific time period for which data are needed for the numerator and denominator of a given measure. The Measurement Period may differ for the numerator and denominator and for each measure and is specified in section A above.
Measurement Year	The standard 12-month reporting period common to all measures being reported by the Provider.
Percentage	A Percentage is calculated as follows: numerator divided by denominator (n/d).
Provider	The Provider entity that is being measured (i.e., BHC)

E. ADDITIONAL NOTES

Interpretation of scores: Better quality = Higher Percentage

F. FREQUENTLY ASKED QUESTIONS

None

Measure AMM-AD: Antidepressant Medication Management[8,16]

Based on a CMS Medicaid Adult Core Set Measure (2023), which is derived from a measure stewarded by the National Committee for Quality Assurance (NCQA)

A. DESCRIPTION

Percentage of ~~beneficiaries~~ [clients] age 18 and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment. Two rates are reported:

Effective Acute Phase Treatment. Percentage of ~~beneficiaries~~ [clients] who remained on an antidepressant medication for at least 84 days (12 weeks)

Effective Continuation Phase Treatment. Percentage of ~~beneficiaries~~ [clients] who remained on an antidepressant medication for at least 180 days (6 months)

Data Collection Method: Administrative or EHR

Guidance for Reporting:

For HEDIS, this measure applies to ~~beneficiaries~~ [clients] age 18 and older. ~~For the purpose of Adult Core Set reporting, states should calculate and report the two rates listed above for each of the two age groups (as applicable): ages 18 to 64 and age 65 and older.~~ Include all paid, suspended, pending, and denied claims.

This measure includes an optional exclusion for ~~beneficiaries~~ [clients] who die during the measurement year. For additional information, refer to the deceased ~~beneficiary~~ [client] exclusion guidance in ~~Section II. Data Collection and Reporting of the Adult Core Set~~ [Section III. Technical Specification Components].

NCQA's Medication List Directory (MLD) for Antidepressant Medications is available to order free of charge in the NCQA Store (https://store.ncqa.org/hedis-my-2022-medication-list-directory.html). [Use version current for year reporting.] Once ordered, the Medication List Directory can be accessed through the NCQA Download Center (https://my.ncqa.org/Downloads).

The electronic specification for FFY 2023 is located on the eCQI resource center at https://ecqi.healthit.gov/ecqm/ec/2022/cms128v10. [Use version current for year reporting.] States that use electronic specifications should indicate this by selecting "Electronic Health Records" in the Data Source section of the ~~online~~ reporting ~~system~~ [template].

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-10-CM, ICD-10-PCS, POS, SNOMED, and UB. The Medication List Directory includes the following coding systems for medications: NDC and RxNorm. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Intake period	The 12-month window starting on May 1 of the year prior to the measurement year and ending on April 30 of the measurement year.

[8]The NCQA HEDIS® measure specification has been adjusted pursuant to NCQA's Rules for Allowable Adjustments of HEDIS.

[16]Aside from the minor modifications noted in this specification, this specification is taken directly from the 2023 CMS Medicaid Adult Core Set Measures. Use the most current version for the year being reported. See also Important Supplemental Materials for State-Collected Required BHC Measures derived from CMS Medicaid Adult and/or Child Core Set Measures (in this manual immediately before this specification).

IPSD	Index Prescription Start Date (IPSD). The earliest prescription dispensing date for an antidepressant medication where the date is in the Intake Period and there is a Negative Medication History.
Negative medication history	A period of 105 days prior to the IPSD when the ~~beneficiary~~ [client] had no pharmacy claims for either new or refill prescriptions for an antidepressant medication.
Treatment days	The actual number of calendar days covered with prescriptions within the specified measurement interval. For Effective Continuation Phase Treatment, a prescription of 90 days (3 months) supply dispensed on the 151st day will have 82 days counted in the 232-day interval.

C. ELIGIBLE POPULATION

Age	Age 18 and older as of April 30 of the measurement year.
Continuous enrollment	105 days prior to the IPSD through 231 days after the IPSD.
Allowable gap	One gap in enrollment of up to 45 days. To determine continuous enrollment for a ~~beneficiary~~ [client] for whom enrollment is verified monthly, the ~~beneficiary~~ [client] may not have more than a 1-month gap in coverage (e.g., a ~~beneficiary~~ [client] whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	IPSD.
Benefits	Medical and pharmacy.
Event/ diagnosis	Follow the steps below to identify the eligible population, which is used for both rates. Step 1: Determine the IPSD Identify the date of the earliest dispensing event for an antidepressant medication (Antidepressant Medications List, see link to the Medication List Directory in Guidance for Reporting above) during the Intake Period. Step 2: Required exclusions Exclude ~~beneficiaries~~ [clients] who did not have an encounter with a diagnosis of major depression during the 121-day period from 60 days prior to the IPSD, through the IPSD and the 60 days after the IPSD. ~~Beneficiaries~~ [Clients] who meet any of the following criteria remain in the eligible population: An acute or nonacute inpatient stay with any diagnosis of major depression (Major Depression Value Set) on the discharge claim. To identify acute and nonacute inpatient stays: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the admission and discharge dates for the stay. Either an admission or discharge during the required time frame meets criteria. An acute inpatient encounter with any diagnosis of major depression: Acute Inpatient Value Set with Major Depression Value Set A nonacute inpatient encounter with any diagnosis of major depression: Nonacute Inpatient Value Set with Major Depression Value Set

Event/ diagnosis (continued)	An outpatient visit with any diagnosis of major depression: Visit Setting Unspecified Value Set with Outpatient POS Value Set with Major Depression Value Set An outpatient visit with any diagnosis of major depression: BH Outpatient Value Set with Major Depression Value Set An intensive outpatient encounter or partial hospitalization with any diagnosis of major depression: Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set with Major Depression Value Set An intensive outpatient encounter or partial hospitalization with any diagnosis of major depression: Partial Hospitalization or Intensive Outpatient Value Set with Major Depression Value Set A community mental health center visit with any diagnosis of major depression: Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set with Major Depression Value Set Electroconvulsive therapy with any diagnosis of major depression: Electroconvulsive Therapy Value Set with Major Depression Value Set Transcranial magnetic stimulation visit with any diagnosis of major depression: Transcranial Magnetic Stimulation Value Set with Major Depression Value Set A telehealth visit with any diagnosis of major depression: Visit Setting Unspecified Value Set with Telehealth POS Value Set with Major Depression Value Set An observation visit (Observation Value Set) with any diagnosis of major depression (Major Depression Value Set) An ED visit (ED Value Set) with any diagnosis of major depression (Major Depression Value Set) An ED visit with any diagnosis of major depression: Visit Setting Unspecified Value Set with ED POS Value Set with Major Depression Value Set A telephone visit (Telephone Visits Value Set) with any diagnosis of major depression (Major Depression Value Set) An e-visit or virtual check-in (Online Assessments Value Set) with any diagnosis of major depression (Major Depression Value Set) ~~Beneficiaries~~ [Clients] in hospice or using hospice services anytime during the measurement year. For additional information, refer to the hospice exclusion guidance in ~~Section II. Data Collection and Reporting of the Adult Core Set~~ [Section III. Technical Specification Components]. Step 3: Test for Negative Medication History Exclude ~~beneficiaries~~ [clients] who filled a prescription for an antidepressant medication 105 days prior to the IPSD. Step 4: Calculate continuous enrollment ~~Beneficiaries~~ [Clients] must be continuously enrolled for 105 days prior to the IPSD to 231 days after the IPSD.

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerators

Effective Acute Phase Treatment

At least 84 days (12 weeks) of treatment with antidepressant medication (Antidepressant Medications List, see link to the Medication List Directory in Guidance for Reporting above) beginning on the IPSD through 114 days after the IPSD (115 total days). This allows gaps in medication treatment up to a total of 31 days during the 115-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.

Effective Continuation Phase Treatment

At least 180 days (6 months) of treatment with antidepressant medication (Antidepressant Medications List, see link to the Medication List Directory in Guidance for Reporting above), beginning on the IPSD through 231 days after the IPSD (232 total days). This allows gaps in medication treatment up to a total of 52 days during the 232-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.

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 period specified.

Supplemental Materials for Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)

Important Supplemental Materials for State-Collected Required BHC Measures derived from CMS Medicaid Adult and/or Child Core Set Measures (OUD-AD)

These supplemental materials are necessary for implementation of the State-Collected Required BHC Measures that are derived from the CMS Medicaid Adult and/or Child Core Set Measures. This volume includes the exact specifications that are on the CMS website for the 2023 Medicaid Core Set, with simple modifications noted in the text. Limited additional needed modifications are included below, as well as supplemental useful materials.

Changes directly in the specifications: For all Core Set-derived measures, the changes in the specification from the CMS Medicaid Adult or Child Core Set reflect: (1) substitution of the word "client" for "beneficiary" or "patient", unless the latter is part of a copyrighted code description; and (2) removal of most references to the Core Set.

Additional needed modifications specific to each measure are included below, as well as supplemental useful materials.

Measure OUD-AD: Use of Pharmacotherapy for Opioid Use Disorder

Additional information: The following material is provided to assist clinics using the specifications and follows the numbering system used in the non-Core derived BHC specifications:

A. DESCRIPTION
Important Reporting Guidance:

- The OUD-AD measure is to be used to measure performance related to clients seen at the BHC Provider during the Measurement Year.
- Current value sets are available on the CMS Medicaid Adult Core Set Reporting Resource website. Use the version current for the year being reported.
- OUD-AD is stratified separately based on whether the client is:
    - Medicaid only or Other (including those dually eligible for Medicare and Medicaid)

      AND
    - A member of which of the following ethnic groups: Not Hispanic or Latino, Hispanic or Latino, or Unknown

      AND
    - A member of which of the following racial groups: White or Caucasian, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or Other Pacific Islander, More than one race, or Unknown

- Refer to the specific data-reporting template for the reporting requirements applicable to each measure.

Measurement Period: The Measurement Period is the period for which data are required for reporting purposes. For both the **denominator** and the **numerator** of OUD-AD, the Measurement Period is the Measurement Year.

B. DEFINITIONS

TERM	DEFINITION
Measurement Period	The specific time period for which data are needed for the numerator and denominator of a given measure. The Measurement Period may differ for the numerator and denominator and for each measure and is specified in section A above.
Measurement Year	The standard 12-month reporting period common to all measures being reported by the Provider.
Percentage	A Percentage is calculated as follows: numerator divided by denominator (n/d).
Provider	The Provider entity that is being measured (i.e., BHC)

E. ADDITIONAL NOTES

Interpretation of scores: Better quality = Higher Percentage

F. FREQUENTLY ASKED QUESTIONS

None

Measure OUD-AD: Use of Pharmacotherapy for Opioid Use Disorder[16]

Based on a CMS Medicaid Adult Core Set Measure (2023)

A. DESCRIPTION

Percentage of ~~Medicaid beneficiaries~~ [clients] ages 18 to 64 with an opioid use disorder (OUD) who filled a prescription for or were administered or dispensed an FDA-approved medication for the disorder during the measurement year. Five rates are reported:

A total (overall) rate capturing any medications used in medication assisted treatment of opioid dependence and addiction (Rate 1)

Four separate rates representing the following types of FDA-approved drug products:

Buprenorphine (Rate 2)

Oral naltrexone (Rate 3)

Long-acting, injectable naltrexone (Rate 4)

Methadone (Rate 5)

Data Collection Method: Administrative

Guidance for Reporting:

The measure includes a total rate (Rate 1) and four separate rates for the following four types of FDA-approved drug products:

Buprenorphine (Rate 2)

Oral naltrexone (Rate 3)

Long-acting, injectable naltrexone (Rate 4)

Methadone (Rate 5)

Tables OUD-A and OUD-B are available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-adult-non-hedis-value-set-directory.zip. [Use version current for year reporting.] Table OUD-B designates which medications are assigned to the separate rates. Filter on the 'Numerator' column to identify which NDC codes are assigned to each rate.

The measure uses inpatient, outpatient, residential, long-term care, and pharmacy claims and encounters.

The numerator for the total rate is not a sum of the numerators for the four medication cohorts. Count ~~beneficiaries~~ [clients] in the numerator for the total rate if they had at least one of the four FDA-approved drug products for OUD during the measurement year. Report ~~beneficiaries~~ [clients] with multiple drug products only once for the numerator for the total rate.

Only formulations with an OUD indication (not pain management) are included in value sets for measure calculation.

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

[16]Aside from the minor modifications noted in this specification, this specification is taken directly from the 2023 CMS Medicaid Adult Core Set Measures. Use the most current version for the year being reported. See also Important Supplemental Materials for State-Collected Required BHC Measures derived from CMS Medicaid Adult and/or Child Core Set Measures (in this manual immediately before this specification).

B. DEFINITIONS

Measurement year	January 1 to December 31 of the measurement year.

C. ELIGIBLE POPULATION

Age	Ages 18 to 64 years. Age is calculated as of January 1 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No allowable gap during the continuous enrollment period.
Anchor date	None.
Benefit	Medical and chemical dependency (inpatient, residential, and outpatient).
Event/ Diagnosis	~~Beneficiaries~~ [Clients] who had at least one encounter with a diagnosis of opioid abuse, dependence, or remission (primary or other) at any time during the measurement year. ICD-10 codes for OUD are provided in Table OUD-A available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-adult-non-hedis-value-set-directory.zip. [Use version current for year reporting.]
Care settings	Inpatient/hospital, outpatient, emergency department.

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerators

For each ~~beneficiary~~ [client] in the denominator population, follow the steps below to identify ~~beneficiaries~~ [clients] for the total numerator and the numerator for each rate.

Numerator 1: Total

Identify ~~beneficiaries~~ [clients] with evidence of at least one prescription filled, or who were administered or dispensed an FDA-approved medication for OUD during the measurement year through use of pharmacy claims (relevant NDC code) or through relevant HCPCS coding of medical service. See Table OUD-B, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-adult-non-hedis-value-set-directory.zip. [Use version current for year reporting.]

Note: The numerator for the total rate is not a sum of the numerators for the four medication cohorts. Count ~~beneficiaries~~ [clients] in the numerator for the total rate if they had at least one of the four FDA-approved drug products for OUD during the measurement year. Report ~~beneficiaries~~ [clients] with multiple drug products only once for the numerator for the total rate.

Numerator 2: Buprenorphine

Identify ~~beneficiaries~~ [clients] with evidence of at least one prescription for buprenorphine at any point during the measurement year. See Table OUD-B, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-adult-non-hedis-value-set-

directory.zip. [Use version current for year reporting.] Include NDC codes assigned to Numerator 2 in the Numerator column in Table OUD-B.

Numerator 3: Oral Naltrexone

Identify ~~beneficiaries~~ [clients] with evidence of at least one prescription for oral naltrexone at any point during the measurement year. See Table OUD-B, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-adult-non-hedis-value-set-directory.zip. [Use version current for year reporting.] Include NDC codes assigned to Numerator 3 in the Numerator column in Table OUD-B.

Numerator 4: Long-Acting, Injectable Naltrexone

Identify ~~beneficiaries~~ [clients] with evidence of at least one prescription for long-acting, injectable naltrexone at any point during the measurement year. See Table OUD-B, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-adult-non-hedis-value-set-directory.zip. [Use version current for year reporting.] Include NDC codes assigned to Numerator 4 in the Numerator column in Table OUD-B.

Numerator 5: Methadone

Identify ~~beneficiaries~~ [clients] with evidence of at least one dose of methadone at any point during the measurement year. See Table OUD-B, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-adult-non-hedis-value-set-directory.zip. [Use version current for year reporting.] This rate includes HCPCS codes only. There are no NDC codes assigned to this rate.

Rates

The total rate is calculated by dividing the number of ~~beneficiaries~~ [clients] with evidence of at least one prescription (Numerator 1) by the number of ~~beneficiaries~~ [clients] with at least one encounter associated with a diagnosis of opioid abuse, dependence, or remission (i.e., the Denominator).

To calculate the separate rates for each of the four FDA-approved medications for OUD, divide the Numerator for the medication by the Denominator. For example, to calculate the buprenorphine rate, divide the number of ~~beneficiaries~~ [clients] with evidence of at least one prescription for buprenorphine during the measurement year (Numerator 2) by the number of ~~beneficiaries~~ [clients] with at least one encounter associated with a diagnosis of opioid abuse, dependence, or remission (i.e., the Denominator).

E. ADDITIONAL NOTES

None.

Supplemental Materials for Measure SAA-AD: Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)

Important Supplemental Materials for State-Collected Required BHC Measures derived from CMS Medicaid Adult and/or Child Core Set Measures (SAA-AD)

These supplemental materials are necessary for implementation of the State-Collected Required BHC Measures that are derived from the CMS Medicaid Adult and/or Child Core Set Measures. This volume includes the exact specifications that are on the CMS website for the 2023 Medicaid Core Set, with simple modifications noted in the text. Limited additional needed modifications are included below, as well as supplemental useful materials.

Changes directly in the specifications: For all Core Set-derived measures, the changes in the specification from the CMS Medicaid Adult or Child Core Set reflect: (1) substitution of the word "client" for "beneficiary" or "patient", unless the latter is part of a copyrighted code description; and (2) removal of most references to the Core Set.

Additional needed modifications specific to each measure are included below, as well as supplemental useful materials.

Measure SAA-AD: Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Additional information: The following material is provided to assist clinics using the specifications and follows the numbering system used in the non-Core derived BHC specifications:

A. DESCRIPTION
Important Reporting Guidance:

- The SAA-AD measure is to be used to measure performance related to clients seen at the BHC Provider during the Measurement Year.
- Current value sets are available on the CMS Medicaid Adult Core Set Reporting Resource website. Use the version current for the year being reported.
- SAA-AD is stratified separately based on whether the client is:
    - Medicaid only or Other (including those dually eligible for Medicare and Medicaid)

      AND
    - A member of which of the following ethnic groups: Not Hispanic or Latino, Hispanic or Latino, or Unknown

      AND

  - A member of which of the following racial groups: White or Caucasian, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or Other Pacific Islander, More than one race, or Unknown
- Refer to the specific data-reporting template for the reporting requirements applicable to each measure.

Measurement Period: The Measurement Period is the period for which data are required for reporting purposes. For both the **denominator** and the **numerator** of SAA-AD, the Measurement Period is the Measurement Year.

B. DEFINITIONS

TERM	DEFINITION
Measurement Period	The specific time period for which data are needed for the numerator and denominator of a given measure. The Measurement Period may differ for the numerator and denominator and for each measure and is specified in section A above.
Measurement Year	The standard 12-month reporting period common to all measures being reported by the Provider.
Percentage	A Percentage is calculated as follows: numerator divided by denominator (n/d).
Provider	The Provider entity that is being measured (i.e., BHC)

E. ADDITIONAL NOTES

Interpretation of scores: Better quality = Higher Percentage

F. FREQUENTLY ASKED QUESTIONS

None

Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)

Measure SAA-AD: Adherence to Antipsychotic Medications for Individuals With Schizophrenia[8,16]

Based on a CMS Medicaid Adult Core Set Measure (2023), which is derived from a measure stewarded by the National Committee for Quality Assurance (NCQA)[17]

A. DESCRIPTION

Percentage of ~~beneficiaries~~ [clients] ages 18 and older during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period.

Data Collection Method: Administrative

Guidance for Reporting:

If an oral medication and a long-acting injection are dispensed on the same day, calculate number of days covered by an antipsychotic medication (for the numerator) using the prescription with the longest days supply.

If an oral medication and long-acting injection are dispensed on different days, with some overlapping days of supply, count each day within the treatment period only once toward the numerator.

Include all paid, suspended, pending, and denied claims.

This measure includes an optional exclusion for ~~beneficiaries~~ [clients] who die during the measurement year. For additional information, refer to the deceased ~~beneficiary~~ [client] exclusion guidance in ~~Section II. Data Collection and Reporting of the Adult Core Set~~ [Section III. Technical Specification Components].

NCQA's Medication List Directory (MLD) for Dementia Medications, Oral Antipsychotic Medications, and Long-Acting Injections *is available to order free of charge in the* NCQA Store (https://store.ncqa.org/hedis-my-2022-medication-list-directory.html). [Use version current for year reporting.] Once ordered, the Medication List Directory can be accessed through the NCQA Download Center **(**https://my.ncqa.org/Downloads**).**

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-9-CM, ICD-10-CM, ICD-10-PCS, POS, SNOMED, and UB. The Medication List Directory includes the following coding systems for medications: NDC and RxNorm. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

[8]The NCQA HEDIS® measure specification has been adjusted pursuant to NCQA's Rules for Allowable Adjustments of HEDIS.

[16]Aside from the minor modifications noted in this specification, this specification is taken directly from the 2023 CMS Medicaid Adult Core Set Measures. Use the most current version for the year being reported. See also Important Supplemental Materials for State-Collected Required BHC Measures derived from CMS Medicaid Adult and/or Child Core Set Measures (in this manual immediately before this specification).

[17]Adapted by NCQA with permission of the measure developer, CMS.

Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)

B. DEFINITIONS

IPSD	Index Prescription Start Date (IPSD). The earliest prescription dispensing date for any antipsychotic medication during the measurement year.
Treatment period	The period of time beginning on the IPSD through the last day of the measurement year.
PDC	Proportion of Days Covered. The number of days a ~~beneficiary~~ [client] is covered by at least one antipsychotic medication prescription, divided by the number of days in the treatment period.
Oral medication dispensing event	One prescription of an amount lasting 30 days or less. To calculate dispensing events for prescriptions longer than 30 days, divide the days supply by 30 and round down to convert. For example, a 100-day prescription is equal to three dispensing events. Multiple prescriptions for different medications dispensed on the same day are counted as separate dispensing events. If multiple prescriptions for the same medication are dispensed on the same day, use the prescription with the longest days supply. Use the medication lists (see Medication List table below and link to the Medication List Directory in Guidance for Reporting above) to determine if the drugs are the same or different. Drugs in different lists are considered different drugs.
Long-acting injections dispensing event	Injections count as one dispensing event. Multiple codes (from the value sets and medication lists) for the same or different medication on the same day are counted as a single dispensing event.
Calculating number of days covered for oral medications	If multiple prescriptions for the same or different oral medications are dispensed on the same day, calculate number of days covered by an antipsychotic medication (for the numerator) using the prescription with the longest days supply. If multiple prescriptions for different oral medications are dispensed on different days, count each day within the treatment period only once toward the numerator. If multiple prescriptions for the same oral medication are dispensed on different days, sum the days supply and use the total to calculate the number of days covered by an antipsychotic medication (for the numerator). For example, if three antipsychotic prescriptions for the same oral medication are dispensed on different days, each with a 30-day supply; sum the days supply for a total of 90 days covered by an oral antipsychotic (even if there is overlap). Use the medication lists (see Medication List table below and link to the Medication List Directory in Guidance for Reporting above) to determine if the drugs are the same or different. Drugs in different lists are considered different drugs.
Calculating number of days covered for long-acting injections	Calculate number of days covered (for the numerator) for long-acting injections using the days supply specified for the medication in the medication list or in the value set name. For multiple codes (from the value sets and medication lists) for the same or different medications on the same day, use the medication with the longest days supply. For multiple codes (from the value sets and medication lists) for the same or different medications on different days with overlapping days supply, count each day within the treatment period only once toward the numerator.

Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)

Note: If an oral medication and a long-acting injection are dispensed on the same day, calculate number of days covered by an antipsychotic medication (for the numerator) using the prescription with the longest days supply.

If an oral medication and long-acting injection are dispensed on different days, with some overlapping days of supply, count each day within the treatment period only once toward the numerator.

C. ELIGIBLE POPULATION

Age	Ages 18 and older as of January 1 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a ~~beneficiary~~ [client] for whom enrollment is verified monthly, the ~~beneficiary~~ [client] may not have more than a 1-month gap in coverage (e.g., a ~~beneficiary~~ [client] whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefits	Medical and pharmacy.
Event/ diagnosis	Follow the steps below to identify the eligible population. Step 1 Identify ~~beneficiaries~~ [clients] with schizophrenia or schizoaffective disorder as those who met at least one of the following criteria during the measurement year: At least one acute inpatient encounter with any diagnosis of schizophrenia or schizoaffective disorder. Either of the following code combinations meets criteria: BH Stand Alone Acute Inpatient Value Set with Schizophrenia Value Set – Visit Setting Unspecified Value Set with Acute Inpatient POS Value Set with Schizophrenia Value Set At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED, or nonacute inpatient setting, on different dates of service, with any diagnosis of schizophrenia or schizoaffective disorder. Two of any of the following meets criteria: – An outpatient visit with any diagnosis of schizophrenia or schizoaffective disorder (Visit Setting Unspecified Value Set with Outpatient POS Value Set with Schizophrenia Value Set) – An outpatient visit with any diagnosis of schizophrenia or schizoaffective disorder (BH Outpatient Value Set with Schizophrenia Value Set) – An intensive outpatient encounter or partial hospitalization with any diagnosis of schizophrenia or schizoaffective disorder (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set with Schizophrenia Value Set)

Event/ diagnosis (continued)	– An intensive outpatient encounter or partial hospitalization with any diagnosis of schizophrenia or schizoaffective disorder (Partial Hospitalization or Intensive Outpatient Value Set with Schizophrenia Value Set) – A community mental health center visit with any diagnosis of schizophrenia or schizoaffective disorder (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set with Schizophrenia Value Set) – Electroconvulsive therapy (Electroconvulsive Therapy Value Set) with any diagnosis of schizophrenia or schizoaffective disorder (Schizophrenia Value Set) – An observation visit (Observation Value Set) with any diagnosis of schizophrenia or schizoaffective disorder (Schizophrenia Value Set) – An ED visit (ED Value Set) with any diagnosis of schizophrenia or schizoaffective disorder (Schizophrenia Value Set) – An ED visit with any diagnosis of schizophrenia or schizoaffective disorder (Visit Setting Unspecified Value Set with ED POS Value Set with Schizophrenia Value Set) – A nonacute inpatient encounter (BH Stand Alone Nonacute Inpatient Value Set) with any diagnosis of schizophrenia or schizoaffective disorder (Schizophrenia Value Set) – A nonacute inpatient encounter with any diagnosis of schizophrenia or schizoaffective disorder (Visit Setting Unspecified Value Set with Nonacute Inpatient POS Value Set with Schizophrenia Value Set) – A telehealth visit with any diagnosis of schizophrenia or schizoaffective disorder (Visit Setting Unspecified Value Set with Telehealth POS Value Set with Schizophrenia Value Set) – A telephone visit (Telephone Visits Value Set) with any diagnosis of schizophrenia or schizoaffective disorder (Schizophrenia Value Set) – An e-visit or virtual check-in (Online Assessments Value Set) with any diagnosis of schizophrenia or schizoaffective disorder (Schizophrenia Value Set) Step 2: Required Exclusions Exclude ~~beneficiaries~~ [clients] who met any of the following during the measurement year: A diagnosis of dementia (Dementia Value Set) Did not have at least two antipsychotic medication dispensing events. There are two ways to identify dispensing events: by claim/encounter data and by pharmacy data. The state must use both methods to identify dispensing events, but an event need only be identified by one method to be counted.
Event/ diagnosis (continued)	– Claims/encounter data. An antipsychotic medication (Long-Acting Injections 14 Days Supply Value Set; Long-Acting Injections 28 Days Supply Value Set; Long Acting Injections 30 Days Supply Value Set) Pharmacy data. Dispensed an antipsychotic medication. Use all the medication lists in the Oral Antipsychotic Medications and Long-Acting Injections (see Medication List table below and link to the Medication List Directory in Guidance for Reporting above) to identify antipsychotic medication dispensing events ~~Beneficiaries~~ [Clients] in hospice or using hospice services anytime during the measurement year. For additional information, refer to the hospice exclusion guidance in ~~Section II. Data Collection and Reporting of the Adult Core Set~~ [Section III. Technical Specification Components].

Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)

Optional exclusions	Note: Supplemental and medical record data may not be used for the following exclusions. Exclude ~~beneficiaries~~ [clients] who meet any of the following criteria: ~~Beneficiaries~~ [Clients] ages 66 to 80 as of December 31 of the measurement year with frailty and advanced illness. ~~Beneficiaries~~ [Clients] must meet both of the following frailty and advanced illness criteria to be excluded: 1. At least one claim/encounter for frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) during the measurement year 2. Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years): At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), telephone visits (Telephone Visits Value Set), e-visits or virtual check-ins (Online Assessments Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set), or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. To identify a nonacute inpatient discharge: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim. Identify the discharge date for the stay. At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set)
Optional exclusions (continued)	At least one acute inpatient discharge with an advanced illness diagnosis (Advanced Illness Value Set) on the discharge claim. To identify an acute inpatient discharge: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). 3. Identify the discharge date for the stay. A dispensed dementia medication (Dementia Medications List, see link to the Medication List Directory in Guidance for Reporting above) ~~Beneficiaries~~ [Clients] age 81 and older as of December 31 of the measurement year with frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) during the measurement year.

Oral Antipsychotic Medications

Description	Prescription	Medication Lists
Miscellaneous antipsychotic agents (oral)	Aripiprazole	Aripiprazole Oral Medications List
	Asenapine	Asenapine Oral Medications List
	Brexpiprazole	Brexpiprazole Oral Medications List
	Cariprazine	Cariprazine Oral Medications List
	Clozapine	Clozapine Oral Medications List

Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)

Description	Prescription	Medication Lists
	Haloperidol	Haloperidol Oral Medications List
	Iloperidone	Iloperidone Oral Medications List
	Loxapine	Loxapine Oral Medications List
	Lumateperone	Lumateperone Oral Medications List
	Lurasidone	Lurasidone Oral Medications List
	Molindone	Molindone Oral Medications List
	Olanzapine	Olanzapine Oral Medications List
	Paliperidone	Paliperidone Oral Medications List
	Quetiapine	Quetiapine Oral Medications List
	Risperidone	Risperidone Oral Medications List
	Ziprasidone	Ziprasidone Oral Medications List
Phenothiazine antipsychotics (oral)	Chlorpromazine	Chlorpromazine Oral Medications List
	Fluphenazine	Fluphenazine Oral Medications List
	Perphenazine	Perphenazine Oral Medications List
	Prochlorperazine	Prochlorperazine Oral Medications List
	Thioridazine	Thioridazine Oral Medications List
	Trifluoperazine	Trifluoperazine Oral Medications List
Psychotherapeutic combinations (oral)	Amitriptyline-perphenazine	Amitriptyline Perphenazine Oral Medications List
Thioxanthenes (oral)	Thiothixene	Thiothixene Oral Medications List

Long-Acting Injections

Description	Prescription	Medication Lists
Long-acting injections 14 days supply	Risperidone (excluding Perseris®)	Long Acting Injections 14 Days Supply Medications List
Long-acting injections 28 days supply	Aripiprazole Aripiprazole lauroxil Fluphenazine decanoate Haloperidol decanoate Olanzapine Paliperidone palmitate	Long Acting Injections 28 Days Supply Medications List
Long-acting injections 30 days supply	Risperidone (Perseris®)	Long Acting Injections 30 Days Supply Medications List

Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

The number of ~~beneficiaries~~ [clients] who achieved a PDC of at least 80 percent for their antipsychotic medications during the measurement year.

Follow the steps below to identify numerator compliance. Use the Long Acting Injections 14 Days Supply Value Set; Long Acting Injections 28 Days Supply Value Set; Long Acting Injections 30 Days Supply Value Set and all the medication lists in the Oral Antipsychotic Medications and Long-Acting Injections (see Medication List table above and link to the Medication List Directory in Guidance for Reporting above) to identify antipsychotic medication dispensing events.

Step 1

Identify the IPSD. The IPSD is the earliest dispensing event for any antipsychotic medication during the measurement year.

Step 2

To determine the treatment period, calculate the number of days beginning on the IPSD through the end of the measurement year.

Step 3

Count the days covered by at least one antipsychotic medication during the treatment period. To ensure that days supply that extend beyond the measurement year are not counted, subtract any days supply that extends beyond December 31 of the measurement year.

Step 4

Calculate the ~~beneficiary~~ [client]'s PDC using the following equation. Multiply the equation by 100 and round (using the .5 rule) to the nearest whole number. For example, if a ~~beneficiary~~ [client] has 291 total days covered by a medication during a 365-day treatment period, this calculates to 0.7972. Multiply this number by 100, convert it to 79.72% and round it to 80%, the nearest whole number.

$$\frac{\textit{Total days covered by antipsychotic medication in the treatment period (Step 3)}}{\textit{Total days in treatment period (Step2)}}$$

Step 5

Sum the number of ~~beneficiaries~~ [clients] whose PDC is ≥ 80 percent for their treatment period.

Important Supplemental Materials for State-Collected Required BHC Measures derived from CMS Medicaid Adult and/or Child Core Set Measures (PCR-AD)

These supplemental materials are necessary for implementation of the State-Collected Required BHC Measures that are derived from the CMS Medicaid Adult and/or Child Core Set Measures. This volume includes the exact specifications that are on the CMS website for the 2023 Medicaid Core Set, with simple modifications noted in the text. Limited additional needed modifications are included below, as well as supplemental useful materials.

Changes directly in the specifications: For all Core Set-derived measures, the changes in the specification from the CMS Medicaid Adult or Child Core Set reflect: (1) substitution of the word "client" for "beneficiary" or "patient", unless the latter is part of a copyrighted code description; and (2) removal of most references to the Core Set.

Additional needed modifications specific to each measure are included below, as well as supplemental useful materials.

Measure PCR-AD: Plan All-Cause Readmissions

Additional information: The following material is provided to assist clinics using the specifications and follows the numbering system used in the non-Core derived BHC specifications:

A. DESCRIPTION
Important Reporting Guidance:

- The PCR-AD measure is to be used to measure performance related to clients seen at the BHC Provider during the Measurement Year.
- Current value sets are available on the CMS Medicaid Adult Core Set Reporting Resource website. Use the version current for the year being reported.
- PCR-AD is stratified separately based on whether the client is:
    - Medicaid only or Other (including those dually eligible for Medicare and Medicaid)
- Refer to the specific data-reporting template for the reporting requirements applicable to each measure.

Measurement Period: The Measurement Period is the period for which data are required for reporting purposes. The Measurement Period for the PCR-AD **denominator** covers the allowable period for Index Hospital Stays to be included and is January 1 – December 1 when the Measurement Year is the Calendar Year. The Measurement Period for the PCR-AD **numerator** (or the allowable period for readmissions to be included) is the Measurement Year, excluding the first two days of that Measurement Year (January 3 – December 31).

B. DEFINITIONS

TERM	DEFINITION
Measurement Period	The specific time period for which data are needed for the numerator and denominator of a given measure. The Measurement Period may differ for the numerator and denominator and for each measure and is specified in section A above.
Measurement Year	The standard 12-month reporting period common to all measures being reported by the Provider.
Percentage	A Percentage is calculated as follows: numerator divided by denominator (n/d).
Provider	The Provider entity that is being measured (i.e., BHC)

E. ADDITIONAL NOTES

Interpretation of scores: Better quality = Lower Percentage

F. FREQUENTLY ASKED QUESTIONS

None

Measure PCR-AD: Plan All-Cause Readmissions[8,16]

Based on a CMS Medicaid Adult Core Set Measure (2023), which is derived from a measure stewarded by the National Committee for Quality Assurance (NCQA)

A. DESCRIPTION

For ~~beneficiaries~~ [clients] ages 18 to 64, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories:

Count of Index Hospital Stays (IHS)

Count of Observed 30-Day Readmissions

Count of Expected 30-Day Readmissions

Data Collection Method: Administrative

Guidance for Reporting:

For HEDIS, this measure applies to ~~beneficiaries~~ [clients] ages 18 to 64. Although the HEDIS measure includes stratified reporting by age, [as] for the Adult Core Set, states should calculate and report only the Total rate [rather than stratifying by age].

This measure requires risk adjustment. Risk adjustment guidelines are provided in the administrative specification. Please note that in the risk adjustment tables, clinical conditions (CCs) and hierarchical clinical conditions (HCCs) not listed receive a weight of ZERO (e.g., 0.0000).

Report the Count of Expected 30-Day Readmissions for this measure to four decimal places.

As shown in Table PCR-A, the data elements in columns 1, 2, 4, 7, and 8 are reported by the state. The data elements in columns 3, 5, 6, and 9 will be derived from the reported data.

Supplemental data may not be used for this measure [with the exception of supplemental data needed to determine the hospice exclusion].

When applying risk adjustment, include all services, whether or not the state paid for them or expects to pay for them (e.g., include denied claims). When identifying all other events, do not include denied services (e.g., only include paid services and services expected to be paid).

If this measure has a Count of Index Hospital Stays less than 150 and the state chooses not to report this measure due to small numbers, please note this in the "~~Reason for Not Reporting~~[Adherence to Measure Specifications]" fields and specify the denominator size.

For observation stays (Observation Stay Value Set) that do not have a recorded admission or discharge date, set the admission date to the earliest date of service on the claim and set the discharge date to the last date of service on the claim.

[8]The NCQA HEDIS® measure specification has been adjusted pursuant to NCQA's Rules for Allowable Adjustments of HEDIS.

[16]Aside from the minor modifications noted in this specification, this specification is taken directly from the 2023 CMS Medicaid Adult Core Set Measures. Use the most current version for the year being reported. See also Important Supplemental Materials for State-Collected Required BHC Measures derived from CMS Medicaid Adult and/or Child Core Set Measures (in this manual immediately before this specification).

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-9-PCS, ICD-10-CM, ICD-10-PCS, SNOMED, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Index hospital stay (IHS)	An acute inpatient or observation stay with a discharge on or between January 1 and December 1 of the measurement year as identified in the denominator.
Index admission date	The IHS admission date.
Index discharge date	The IHS discharge date. The index discharge date must occur on or between January 1 and December 1 of the measurement year.
Index readmission stay	An acute inpatient or observation stay for any diagnosis with an admission date within 30 days of a previous Index Discharge Date.
Index readmission date	The admission date associated with the Index Readmission Stay.
Planned hospital stay	A hospital stay is considered planned if it meets criteria as described under step 3, Count of Observed 30-Day Readmissions.
Direct transfer	A direct transfer is when the discharge date from the initial stay precedes the admission date to a subsequent stay by one calendar day or less. For example: A discharge on June 1, followed by a subsequent admission on June 1, is a direct transfer. A discharge on June 1, followed by a subsequent admission on June 2, is a direct transfer. A discharge on June 1, followed by a subsequent admission on June 3, is not a direct transfer; these are two distinct inpatient stays. A discharge on June 1, followed by a subsequent admission on June 2 (with discharge on June 3), followed by a subsequent admission on June 4, is a direct transfer. Direct transfers may occur from and between different facilities and/or different services levels.
Medicaid population	~~Beneficiaries~~ [Clients] in the eligible population prior to exclusion of outliers (denominator steps 1-5). The Medicaid population is only used as a denominator for the Outlier rate. ~~Beneficiaries~~ [Clients] must be ages 18 to 64 as of the earliest Index Discharge Date. The Medicaid population is based on ~~beneficiaries~~ [clients], not discharges. Count ~~beneficiaries~~ [clients] only once in the Medicaid population.
Outliers	~~Beneficiaries~~ [Clients] in the eligible population with four or more index hospital stays between January 1 and December 1 of the measurement year.
Nonoutliers	~~Beneficiaries~~ [Clients] in the eligible population who are not considered outliers.
Classification period	365 days prior to and including an Index Discharge Date.

Risk Adjustment Tables

The PCR measure leverages the Risk Adjustment Tables, which define condition-based risk-adjustment variables. The table helps users determine a ~~beneficiary~~ [client]'s condition-based risk-adjustment variables and select the proper risk weights.

Table	Table Description
Table CC-Mapping	Discharge Clinical Condition category codes for Risk Adjustment Determination. Comorbid Clinical Condition category codes for Risk Adjustment Determination step 2.
Table HCC–Rank	HCC rankings for Risk Adjustment Determination step 3.
Table HCC-Comb	Combination HCCs for Risk Adjustment Determination step 5.
PCR Risk Adjustment Table, Medicaid	Medicaid primary discharge weights for Risk Adjustment Weighting step 3. Medicaid comorbidity weights for Risk Adjustment Weighting step 4. Medicaid observation stay, surgery, age and gender weights for Risk Adjustment Weighting steps 1, 2, 5.

Source: Please refer to the HEDIS® MY2022 Volume 2 Risk Adjustment Utilization Tables User Manual for technical detail on table format and content. [Use version current for the year reported.]

Note: The risk adjustment tables and Risk Adjustment Utilization Tables User Manual are available to order free of charge in the NCQA store at https://store.ncqa.org/hedis-my-2022-risk-adjustment-tables.html. [Use version current for the year reported.] Once ordered, the risk adjustment tables can be accessed through the NCQA Download Center (https://my.ncqa.org/Downloads). The tables needed to calculate this measure are found in both the PCR Risk Adjustment Tables and the RAU Table - PCR Medicaid MY2022 (which includes the CC-Mapping, HCC-Rank, and HCC-Comb tables). [Use version current for the year reported.]

C. ELIGIBLE POPULATION

Age	Ages 18 to 64 as of the Index Discharge Date.
Continuous enrollment	365 days prior to the Index Discharge Date through 30 days after the Index Discharge Date.
Allowable gap	No more than one gap in enrollment of up to 45 days during the 365 days prior to the Index Discharge Date and no gap during the 30 days following the Index Discharge Date.
Anchor date	Index Discharge Date.
Benefit	Medical.

Event/ diagnosis	An acute inpatient or observation stay discharge on or between January 1 and December 1 of the measurement year. The denominator for this measure is based on discharges, not ~~beneficiaries~~ [clients]. Include all acute inpatient or observation stay discharges for nonoutlier ~~beneficiaries~~ [clients] who had one or more discharges on or between January 1 and December 1 of the measurement year. Follow the steps below to identify acute inpatient and observation stays.
Required exclusion	~~Beneficiaries~~ [Clients] in hospice or using hospice services anytime during the measurement year. For additional information, refer to the hospice exclusion guidance in ~~Section II. Data Collection and Reporting of the Adult Core Set~~ [Section III. Technical Specification Components].

D. ADMINISTRATIVE SPECIFICATION

Count of Index Hospital Stays (IHS)

The eligible population as defined above.

Step 1

Identify all acute inpatient and observation stay discharges on or between January 1 and December 1 of the measurement year.

To identify acute inpatient and observation stay discharges:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set) and observation stays (Observation Stay Value Set).
2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
3. Identify the discharge date for the stay.

Inpatient and observation 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 stays.

This measure includes acute discharges from any type of facility (including behavioral healthcare facilities).

Step 2

Direct transfers: For discharges with one or more direct transfers, use the last discharge.

Using the discharges identified in step 1, identify direct transfers between acute inpatient and observation or between observation and acute inpatient using the definition of "direct transfer" above.

Exclude the hospital stay if the direct transfer's discharge date occurs after December 1 of the measurement year.

Step 3

Exclude hospital stays where the Index Admission Date is the same as the Index Discharge Date.

Step 4

Exclude hospital stays for the following reasons:

The ~~beneficiary~~ [client] died during the stay.

Female ~~beneficiaries~~ [clients] 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 a direct transfer (identified in step 2), use the original stay and any direct transfer stays to identify exclusions in this step.

Step 5

Calculate continuous enrollment.

Step 6

Remove hospital stays for outlier ~~beneficiaries~~ [clients] and report these ~~beneficiaries~~ [clients] as outliers.

Note: Count discharges with one or more direct transfers (identified in step 2) as one discharge when identifying outlier ~~beneficiaries~~ [clients].

Risk Adjustment Determination

For each IHS among nonoutlier ~~beneficiaries~~ [clients], use the following steps to identify risk adjustment categories based on presence of observation stay status at discharge, surgeries, discharge condition, comorbidity, age, and gender.

Observation Stay	Determine if the IHS at discharge was an observation stay (Observation Stay Value Set). For direct transfers, determine the hospitalization status using the last discharge.
Surgeries	Determine if the ~~beneficiary~~ [client] underwent surgery during the stay (Surgery Procedure Value Set). Consider an IHS to include a surgery if at least one procedure code is present from any provider between the admission and discharge dates.
Discharge Condition	Assign a discharge Clinical Condition (CC) category code or codes to the IHS based on its principal discharge diagnosis, using Table CC-Mapping. For direct transfers, use the principal discharge diagnosis from the last discharge. Exclude diagnoses that cannot be mapped to Table CC-Mapping.
Comorbidities	Assign Risk Adjustment Comorbidity Category Determination based on all the encounters during the classification period, as described in the Steps for Risk Adjustment Comorbidity Category Determination.

Steps for Risk Adjustment Comorbidity Category Determination

Follow the steps below for Risk Adjustment Comorbidity Category Determination.

Step 1

Identify all diagnoses for encounters during the classification period. Include the following when identifying encounters:

Outpatient visits (Outpatient Value Set)

Telephone Visits (Telephone Visits Value Set)

Observation visits (Observation Value Set)

ED visits (ED Value Set)

Inpatient events:

- Nonacute inpatient encounters (Nonacute Inpatient Value Set)

- Acute inpatient encounters (Acute Inpatient Value Set)
- Acute and nonacute inpatient discharges (Inpatient Stay Value Set)

Use the date of service for outpatient, observation, and ED visits. Use the discharge date for inpatient events.

Exclude the principal discharge diagnosis on the index hospital stay (IHS).

Step 2

Assign each diagnosis to a comorbid Clinical Condition (CC) category using Table CC—Mapping, available at https://store.ncqa.org/hedis-my-2022-risk-adjustment-tables.html. [Use version current for the year reported.] If the code appears more than once in Table CC—Mapping, it is assigned to multiple CCs.

Exclude all diagnoses that cannot be assigned to a comorbid CC category. For ~~beneficiaries~~ [clients] with no qualifying diagnoses from face-to-face encounters, skip to the Risk Adjustment Weighting section.

All digits must match exactly when mapping diagnosis codes to the comorbid CCs.

Step 3

Determine Hierarchical Condition Categories (HCCs) for each comorbid CC identified. Refer to Table HCC—Rank, available at https://store.ncqa.org/hedis-my-2022-risk-adjustment-tables.html. [Use version current for the year reported.]

For each denominator unit's comorbid CC list, match the comorbid CC code to the comorbid CC code in the table, and assign:

The ranking group

The rank

The HCC

For comorbid CCs that do not match to Table HCC—Rank, use the comorbid CC as the HCC and assign a rank of 1.

Note: One comorbid CC can map to multiple HCCs; each HCC can have one or more comorbid CCs.

Step 4

Assess each ranking group separately and select only the highest ranked HCC in each ranking group using the “Rank” column (1 is the highest rank possible).

Drop all other HCCs in each ranking group, and de-duplicate the HCC list if necessary.

Example

Assume a denominator unit with the following comorbid CCs: CC-85, CC-17, and CC-19 (assume no other CCs).

CC-85 does not have a map to the ranking table and becomes HCC-85.

HCC-17 and HCC-19 are part of Diabetes Ranking Group 1. Because CC-17 is ranked higher than CC-19 in Ranking Group Diabetes 1, the comorbidity is assigned as HCC-17 for Ranking Group 1.

The final comorbidities for this denominator unit are HCC-17 and HCC-85.

Example: Table HCC—Rank

Ranking Group	CC	Description	Rank	HCC
Not Applicable (NA)	CC-85	Congestive Heart Failure	NA	HCC-85
Diabetes 1	CC-17	Diabetes With Acute Complications	1	HCC-17
	CC-18	Diabetes With Chronic Complications	2	HCC-18
	CC-19	Diabetes without Complication	3	HCC-19

Step 5

Identify combination HCCs listed in Table HCC—Comb, available at https://store.ncqa.org/hedis-my-2022-risk-adjustment-tables.html.[Use version current for the year reported.]

Some combinations suggest a greater amount of risk when observed together. For example, when diabetes and congestive heart failure are present, an increased amount of risk is evident. Additional HCCs are selected to account for these relationships.

Compare each denominator unit's list of unique HCCs to those in the Comorbid HCC columns in Table HCC—Comb and assign any additional HCC conditions.

If there are fully nested combinations, use only the more comprehensive pattern. For example, if the diabetes/CHF combination is nested in the diabetes/CHF/renal combination, count only the diabetes/CHF/renal combination.

If there are overlapping combinations, use both sets of combinations. Based on the combinations, a denominator unit can have none, one, or more than one of these added HCCs.

Example:

For a denominator unit with comorbidities HCC-17 and HCC-85 (assume no other HCCs), assign HCC-901 in addition to HCC-17 and HCC-85. This does not replace HCC-17 and HCC-85.

Example: Table HCC—Comb

Comorbid HCC 1	Comorbid HCC 2	Comorbid HCC 3	Combination HCC 4	HCC-Comb Description
HCC-17	HCC-85	NA	HCC-901	Combination: Diabetes and CHF
HCC-18	HCC-85	NA	HCC-901	Combination: Diabetes and CHF
HCC-19	HCC-85	NA	HCC-901	Combination: Diabetes and CHF

Risk Adjustment Weighting

For each IHS among nonoutlier ~~beneficiaries~~ [clients], use the following steps to identify risk adjustment weights based on observation stay status at discharge, surgeries, discharge condition, comorbidity, age, and gender. Refer to the reporting indicator column in the risk adjustment tables to ensure that weights are linked appropriately.

Step 1	For each IHS discharge that is an observation stay, link the observation stay IHS weight.
Step 2	For each IHS with a surgery, link the surgery weight.
Step 3	For each IHS with a discharge CC Category, link the primary discharge weights.
Step 4	For each IHS with a comorbidity HCC Category, link the comorbidity weights.
Step 5	Link the age and gender weights for each IHS.
Step 6	Sum all weights associated with the IHS (e.g., observation stay status at discharge, presence of surgery, principal discharge diagnosis, comorbidities, age, and gender) and use the formula below to calculate the Estimated Readmission Risk for each IHS. $\text{Estimated Readmission Risk} = \frac{e^{(\Sigma Weights for IHS)}}{1 + e^{(\Sigma Weights for IHS)}}$ OR Estimated Readmission Risk = [exp (sum of weights for IHS)] / [1 + exp (sum of weights for IHS)] Note: "Exp" refers to the exponential or antilog function.
Step 7	Calculate the Count of Expected Readmissions. The Count of Expected Readmissions is the sum of the Estimated Readmissions Risk calculated in step 6 for each IHS. *Count of Expected Readmissions = ∑ (Estimated Readmission Risk)*

Count of Observed 30-Day Readmissions

At least one acute readmission for any diagnosis within 30 days of the Index Discharge Date.

Step 1

Identify all acute inpatient and observation stays with an admission date on or between January 3 and December 31 of the measurement year. To identify acute inpatient and observation admissions:

Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set) and observation stays (Observation Stay Value Set).

Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).

Identify the admission date for the stay.

Step 2

Direct transfers: For discharges with one or more direct transfers, use the last discharge

Using the discharges identified in step 1, identify direct transfers between acute inpatient and observation or between observation and acute inpatient using the definition of "direct transfer" above.

Step 3

Exclude acute hospitalizations meeting any of the following criteria on the discharge claim:

Female ~~beneficiaries~~ [clients] with a principal diagnosis of pregnancy (Pregnancy Value Set)

A principal diagnosis for a condition originating in the perinatal period (Perinatal Conditions Value Set)

A planned hospital stay using any of the following:

- A principal diagnosis of maintenance chemotherapy (Chemotherapy Encounter Value Set)
- A principal diagnosis of rehabilitation (Rehabilitation Value Set)
- An organ transplant (Kidney Transplant Value Set, Bone Marrow Transplant Value Set, Organ Transplant Other Than Kidney Value Set, Introduction of Autologous Pancreatic Cells Value Set)
- A potentially planned procedure (Potentially Planned Procedures Value Set) without a principal acute diagnosis (Acute Conditions Value Set)

Note: For hospital stays where there was a direct transfer (identified in step 2), use the original stay and any direct transfer stays to identify exclusions in this step.

Step 4

For each IHS identified in the denominator, determine if any of the acute inpatient and observation stays identified in the numerator have an admission date within 30 days after the Index Discharge Date.

Note: Count each acute hospitalization only once toward the numerator for the last denominator event.

If a single numerator event meets criteria for multiple denominator events, only count the last denominator event. For example, consider the following events:

Acute Inpatient Stay 1: May 1-10

Acute Inpatient Stay 2: May 15-25 (principal diagnosis of maintenance chemotherapy)

Acute Inpatient Stay 3: May 30–June 5.

All three acute inpatient stays are included as denominator events. Stay 2 is excluded from the numerator because it is a planned hospitalization. Stay 3 is within 30 days of Stay 1 and Stay 2. Count Stay 3 as a numerator event only toward the last denominator event (Stay 2, May 15-25).

Reporting: Count of Index Hospital Stays (IHS)

Count the number of IHS among nonoutlier ~~beneficiaries~~ [clients] and enter this value into the reporting table under Count of Index Stays (Table PCR-A, column 1).

Reporting: Count of 30-Day Readmissions

Count the number of observed IHS among nonoutlier ~~beneficiaries~~ [clients] with a readmission within 30 days of discharge and enter this value into the reporting table under Count of Observed 30-Day Readmissions (Table PCR-A, column 2).

Reporting: Count of Expected 30-Day Readmissions

Sum the Expected Readmission Risk for each IHS among nonoutlier ~~beneficiaries~~ [clients] to calculate the Count of Expected Readmissions. Round to four decimal places using the .5 rule and enter the Count of Expected Readmissions into the reporting table (Table PCR-A, column 4).

Reporting: Count of ~~Beneficiaries~~ [Clients] in Medicaid Population

Step 1

Determine the ~~beneficiary~~ [client]'s age as of the earliest Index Discharge Date.

Step 2

Report the count of ~~beneficiaries~~ [clients] in the Medicaid population and enter this value into the reporting table under Count of ~~Beneficiaries~~ [Clients] in Medicaid Population (Table PCR-A, column 7).

Reporting: Number of Outliers

Step 1

Determine the ~~beneficiary~~ [client]'s age as of the earliest Index Discharge Date.

Step 2

Report the count of outlier ~~beneficiaries~~ [clients] and enter this value into the reporting table under Number of Outliers (Table PCR-A, column 8).

E. ADDITIONAL NOTES

The following data elements will be calculated based on the five reported data elements:

Observed Readmission Rate: Count of Observed 30-Day Readmissions divided by the Count of Index Hospital Stays (Table PCR-A, column 3).

Expected Readmission Rate: Count of Expected 30-Day Readmissions divided by the Count of Index Hospital Stays (Table PCR-A, column 5).

Observed-to-Expected Ratio (O/E): Count of Observed 30-Day Readmissions divided by Count of Expected 30-Day Readmissions (Table PCR-A, column 6).

Outlier Rate: Number of Outliers divided by Count of ~~beneficiaries~~ [clients] in Medicaid Population (Table PCR-A, column 9), displayed as a permillage (multiplied by 1,000).

Note: The O/E ratio is interpreted as "lower-is-better":

- O/E ratio <1.0 means the state had fewer readmissions than expected given the case mix
- O/E ratio = 1.0 means that the number of readmissions was the same as expected given the case mix
- O/E ratio >1.0 means that the state had more readmissions than expected given the case mix

Plan All-Cause Readmissions (PCR-AD)

Table PCR-A. Plan All-Cause Readmissions Rates

	Count of Index Hospital Stays (1)	Count of Observed 30-Day Readmissions (2)	Observed Readmission Rate (3)	Count of Expected 30-Day Readmissions (4)	Expected Readmission Rate (5)	O/E Ratio (Count of Observed 30-Day Readmissions/ Count of Expected 30-Day Readmissions) (6)	Count of Beneficiaries in Medicaid Population (7)	Number of Outliers (8)	Outlier Rate (9)
Total			Calculated		Calculated	Calculated			Calculated

Supplemental Materials for Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)

Important Supplemental Materials for State-Collected Required BHC Measures derived from CMS Medicaid Adult and/or Child Core Set Measures (ADD-CH)

These supplemental materials are necessary for implementation of the State-Collected Required BHC Measures that are derived from the CMS Medicaid Adult and/or Child Core Set Measures. This volume includes the exact specifications that are on the CMS website for the 2023 Medicaid Core Set, with simple modifications noted in the text. Limited additional needed modifications are included below, as well as supplemental useful materials.

Changes directly in the specifications: For all Core Set-derived measures, the changes in the specification from the CMS Medicaid Adult or Child Core Set reflect: (1) substitution of the word "client" for "beneficiary" or "patient", unless the latter is part of a copyrighted code description; and (2) removal of most references to the Core Set.

Additional needed modifications specific to each measure are included below, as well as supplemental useful materials.

Measure ADD-CH: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication

Additional information: The following material is provided to assist clinics using the specifications and follows the numbering system used in the non-Core derived BHC specifications:

A. DESCRIPTION
Important Reporting Guidance:

- The ADD-CH measure is to be used to measure performance related to clients seen at the BHC Provider during the Measurement Year.
- Current value sets are available on the CMS Medicaid Child Core Set Reporting Resource website. Use the version current for the year being reported.
- ADD-CH is stratified separately based on whether the client is:
    - Medicaid only or Other (including those dually eligible for Medicare and Medicaid)

      AND
    - A member of which of the following ethnic groups: Not Hispanic or Latino, Hispanic or Latino, or Unknown

      AND
    - A member of which of the following racial groups: White or Caucasian, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or Other Pacific Islander, More than one race, or Unknown

- Refer to the specific data-reporting template for the reporting requirements applicable to each measure.

Measurement Period: The Measurement Period is the period for which data are required for reporting purposes. For the ADD-CH **denominator**, two measurement periods are used:

- Index prescription start date (IPSD): The earliest prescription dispensing date for an ADHD medication where the date is in the Intake Period and there is a Negative Medication History.
- Negative medication history review: 120 days prior to the IPSD

For the ADD-CH **numerator**, two measurement periods are used:

- Initiation Phase: 30 days following the IPSD
- Continuation and Maintenance Phase: The time period between 300 days following the IPSD

B. DEFINITIONS

TERM	DEFINITION
Measurement Period	The specific time period for which data are needed for the numerator and denominator of a given measure. The Measurement Period may differ for the numerator and denominator and for each measure and is specified in section A above.
Measurement Year	The standard 12-month reporting period common to all measures being reported by the Provider.
Percentage	A Percentage is calculated as follows: numerator divided by denominator (n/d).
Provider	The Provider entity that is being measured (i.e., BHC)

E. ADDITIONAL NOTES

Interpretation of scores: Better quality = Higher Percentage

F. FREQUENTLY ASKED QUESTIONS

None

Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)

Measure ADD-CH: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication[8,18]

Based on a CMS Medicaid Child Core Set Measure (2023), which is derived from a measure stewarded by the National Committee for Quality Assurance (NCQA)

A. DESCRIPTION

Percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported.

Initiation Phase: Percentage of children ages 6 to 12 with a prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase.

Continuation and Maintenance (C&M) Phase: Percentage of children ages 6 to 12 with a prescription dispensed for ADHD medication who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.

Data Collection Method: Administrative or EHR[19]

Guidance for Reporting:

Children who switch between Medicaid and CHIP and whom the state cannot identify as continuously enrolled between the Rate 1 and Rate 2 continuous enrollment periods should only be included in Rate 1 (initiation phase).

Many of the ADHD medications are also used in the treatment of narcolepsy. In order to have a precise ADHD measure, children with narcolepsy are removed from the denominator of both indicators.

Include all paid, suspended, pending, and denied claims.

This measure includes an optional exclusion for ~~beneficiaries~~ [clients] who die during the measurement year. For additional information, refer to the deceased ~~beneficiary~~ [client] exclusion guidance in ~~Section II. Data Collection and Reporting of the Child Core Set~~ [Section III. Technical Specification Components].

NCQA's Medication List Directory (MLD) for ADHD Medications is *available to order free of charge in the NCQA Store (*https://store.ncqa.org/hedis-my-2022-medication-list-directory.html*).* [Use version current for year reporting.] **Once ordered, the Medication List Directory can be accessed through the NCQA Download Center (**https://my.ncqa.org/Downloads**).**

[8]The NCQA HEDIS® measure specification has been adjusted pursuant to NCQA's Rules for Allowable Adjustments of HEDIS.

[18]Aside from the minor modifications noted in this specification, this specification is taken directly from the 2023 CMS Medicaid Child Core Set Measures. Use the most current version for the year being reported. See also Important Supplemental Materials for State-Collected Required BHC Measures derived from CMS Medicaid Adult and/or Child Core Set Measures (in this manual immediately before this specification).

[19]The Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication measure is also specified for Electronic Clinical Data System (ECDS) reporting for HEDIS reporting. ECDS specifications are not currently available for Child Core Set [or BHC] reporting.

Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)

The electronic specification for FFY 2023 is located on the eCQI resource center at https://ecqi.healthit.gov/ecqm/ec/2022/cms136v11. [Use version current for year reporting.] States that use electronic specifications should indicate this by selecting "Electronic Health Records" in the Data Source section of the ~~online~~ reporting ~~system~~ [template]. Refer to [Appendix D of this manual] for the definition of a prescribing practitioner.

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-9-CM, ICD-10-CM, POS, SNOMED, and UB. The Medication List Directory includes the following coding systems for medications: NDC and RxNorm. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Intake period	The 12-month window starting March 1 of the year prior to the measurement year and ending the last calendar day of February of the measurement year.
Negative medication history	A period of 120 days (4 months) prior to the IPSD when the ~~beneficiary~~ [client] had no ADHD medications dispensed for either new or refill prescriptions.
IPSD	Index Prescription Start Date (IPSD). The earliest prescription dispensing date for an ADHD medication where the date is in the Intake Period and there is a Negative Medication History.
Initiation phase	The 30 days following the IPSD.
C&M phase	The 300 days following the IPSD (10 months).
Continuous medication treatment	The number of medication treatment days during the 301-day period must be ≥ 210 days (e.g., 301 treatment days – 91 gap days).
Treatment days (Covered days)	The actual number of calendar days covered with prescriptions within the specified 301-day period (e.g., a prescription of a 90-day supply dispensed on the 220th day will have 82 days counted in the 301-day interval).

C. ELIGIBLE POPULATION

Eligible Population: Rate 1 – Initiation Phase

Age	Age 6 as of March 1 of the year prior to the measurement year to age 12 as of the last calendar day of February of the measurement year.
Continuous enrollment	120 days (4 months) prior to the IPSD through 30 days after the IPSD.
Allowable gap	No allowable gaps in the continuous enrollment period.
Anchor date	None.
Benefits	Medical and pharmacy.
Event/diagnosis	Follow the steps under Administrative Specifications: Rate 1 – Initiation Phase (Section D) to identify the eligible population for the Initiation Phase.

Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)

Eligible Population: Rate 2 – Continuation and Maintenance Phase

Age	Age 6 as of March 1 of the year prior to the measurement year to age 12 as of the last calendar day of February of the measurement year.
Continuous enrollment	120 days (4 months) prior to the index prescription start date (IPSD) and 300 days (10 months) after the IPSD.
Allowable gap	One 45-day gap in enrollment between 31 days and 300 days (10 months) after the IPSD. To determine continuous enrollment for a ~~beneficiary~~ [client] for whom enrollment is verified monthly, the child may not have more than a 1-month gap in coverage (e.g., a child whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	None.
Benefits	Medical and pharmacy.
Event/diagnosis	Follow the steps under Administrative Specifications: Rate 2 – Continuation and Maintenance (Section D) to identify the eligible population for the Continuation and Maintenance Phase.

D. ADMINISTRATIVE SPECIFICATION

Rate 1 – Initiation Phase

Denominator

The Rate 1 eligible population.

Step 1

Identify all children in the specified age range who were dispensed an ADHD medication (ADHD Medications List, see link to the Medication List Directory in Guidance for Reporting above) during the 12-month Intake Period.

Step 2

Test for Negative Medication History. For each child identified in step 1, test each ADHD prescription for a Negative Medication History. The IPSD is the dispensing date of the earliest ADHD prescription in the Intake Period with a Negative Medication History.

Step 3

Calculate continuous enrollment. Children must be continuously enrolled for 120 days (4 months) prior to the IPSD through 30 days after the IPSD.

Step 4

Remove children who had an acute inpatient encounter for a mental, behavioral, or neurodevelopmental disorder during the 30 days after the IPSD. Either of the following meet criteria:

An acute inpatient encounter (Acute Inpatient Value Set) with a principal diagnosis of mental, behavioral, or neurodevelopmental disorder (Mental, Behavioral and Neurodevelopmental Disorders Value Set)

An acute inpatient discharge with a principal diagnosis of mental, behavioral or neurodevelopmental disorder (Mental, Behavioral and Neurodevelopmental Disorders Value Set) on the discharge claim. To identify an acute inpatient discharge:

Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).

Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).

Identify the discharge date for the stay.

Required Exclusions

Exclude ~~beneficiaries~~ [clients] who meet either of the following criteria:

~~Beneficiaries~~ [Clients] with a diagnosis of narcolepsy (Narcolepsy Value Set) any time during their history through December 31 of the measurement year

~~Beneficiaries~~ [Clients] in hospice or using hospice services anytime during the measurement year. Refer to the hospice exclusion guidance in ~~Section II. Data Collection and Reporting of the Child Core Set~~ [Section III. Technical Specification Components].

Numerator

A follow-up visit with a practitioner with prescribing authority, within 30 days after the IPSD. Any of the following code combinations billed by a practitioner with prescribing authority meet criteria:

An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set)

An outpatient visit (BH Outpatient Value Set)

An observation visit (Observation Value Set)

A health and behavior assessment or intervention (Health and Behavior Assessment or Intervention Value Set)

An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set)

An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set)

A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set)

A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set)

A telephone visit (Telephone Visits Value Set)

Note: Do not count a visit on the IPSD as the Initiation Phase visit.

Rate 2 – Continuation and Maintenance Phase

Denominator

The Rate 2 eligible population.

Step 1

Identify all children who meet the eligible population criteria for Rate 1 – Initiation Phase.

Step 2

Calculate continuous enrollment. Children must be continuously enrolled for 120 days (4 months) prior to the IPSD and 300 days (10 months) after the IPSD.

Step 3

Calculate the continuous medication treatment. Using the children in Step 2, determine if the child was dispensed a sufficient number of prescriptions to provide continuous treatment for at least 210 days out of the 301-day period beginning on the IPSD through 300 days after the IPSD. The

definition of "continuous medication treatment" allows gaps in medication treatment, up to a total of 91 days during the 301-day (10-month) period.

Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.

Regardless of the number of gaps, the total gap days may be no more than 91. Count any combination of gaps (e.g., one washout gap of 14 days and numerous weekend drug holidays).

Step 4

Remove children who had an acute inpatient encounter for a mental, behavioral, or neurodevelopmental disorder during the 300 days (10 months) after the IPSD. Either of the following meets criteria:

An acute inpatient encounter (Acute Inpatient Value Set) with a principal diagnosis of mental, behavioral, or neurodevelopmental disorder (Mental, Behavioral, and Neurodevelopmental Disorders Value Set)

An acute inpatient discharge with a principal diagnosis of mental, behavioral, or neurodevelopmental disorder (Mental, Behavioral, and Neurodevelopmental Disorders Value Set) on the discharge claim. To identify an acute inpatient discharge:

Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).

Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).

Identify the discharge date for the stay.

Numerator

Identify all children who meet the following criteria:

Numerator compliant for Rate 1 Initiation Phase, and

At least two follow-up visits on different dates of service with any practitioner, from 31–300 days (9 months) after the IPSD

Any of the following code combinations identify follow-up visits:

An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set)

An outpatient visit (BH Outpatient Value Set)

An observation visit (Observation Value Set)

A health and behavior assessment or intervention (Health and Behavior Assessment or Intervention Value Set)

An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set)

An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set)

A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set)

A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set)

A telephone visit (Telephone Visits Value Set)

An e-visit or virtual check-in (Online Assessments Value Set)

Only one of the two visits (during days 31–300 after the IPSD) may be an e-visit or virtual check-in (Online Assessments Value Set).

Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)

E. ADDITIONAL NOTES

For children who have multiple overlapping prescriptions, count the overlap days once toward the days supply (whether the overlap is for the same drug or for a different drug).

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 period required for the rate (e.g., within 30 days after or from 31–300 days after the IPSD).

Supplemental Materials for Hemoglobin A1C Control for Patients with Diabetes (HBD-AD)

Important Supplemental Materials for State-Collected Required BHC Measures derived from CMS Medicaid Adult and/or Child Core Set Measures (HBD-AD)

These supplemental materials are necessary for implementation of the State-Collected Required BHC Measures that are derived from the CMS Medicaid Adult and/or Child Core Set Measures. This volume includes the exact specifications that are on the CMS website for the 2023 Medicaid Core Set, with simple modifications noted in the text. Limited additional needed modifications are included below, as well as supplemental useful materials.

Changes directly in the specifications: For all Core Set-derived measures, the changes in the specification from the CMS Medicaid Adult or Child Core Set reflect: (1) substitution of the word "client" for "beneficiary" or "patient", unless the latter is part of a copyrighted code description; (2) removal of age stratification for adults (i.e., applicable to adults ages 18 years and older); and (3) removal of most references to the Core Set.

Additional needed modifications specific to each measure are included below, as well as supplemental useful materials.

Measure HBD-AD: Hemoglobin A1C Control for Patients with Diabetes

Additional information: The following material is provided to assist clinics using the specifications and follows the numbering system used in the non-Core derived BHC specifications:

A. DESCRIPTION
Important Reporting Guidance:

- The HBD-AD measure is to be used to measure performance related to clients seen at the BHC Provider during the Measurement Year.
- Current value sets are available on the CMS Medicaid Adult Core Set Reporting Resource website. Use the version current for the year being reported.
- HBD-AD is stratified separately based on whether the client is:
    - Medicaid only or Other (including those dually eligible for Medicare and Medicaid)

      AND
    - A member of which of the following ethnic groups: Not Hispanic or Latino, Hispanic or Latino, or Unknown

      AND
    - A member of which of the following racial groups: White or Caucasian, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or Other Pacific Islander, More than one race, or Unknown

- Refer to the specific data-reporting template for the reporting requirements applicable to each measure.

Measurement Period: The Measurement Period is the period for which data are required for reporting purposes. For the HBD-AD measure, the **denominator** Measurement Period is the Measurement Year but, data from the entire year previous to the Measurement Year also is used in order to identify the diabetes diagnosis. For the HBD-AD **numerator**, the Measurement Period is the Measurement Year.

B. DEFINITIONS

TERM	DEFINITION
Measurement Period	The specific time period for which data are needed for the numerator and denominator of a given measure. The Measurement Period may differ for the numerator and denominator and for each measure and is specified in section A above.
Measurement Year	The standard 12-month reporting period common to all measures being reported by the Provider.
Percentage	A Percentage is calculated as follows: numerator divided by denominator (n/d).
Provider	The Provider entity that is being measured (i.e., BHC)

E. ADDITIONAL NOTES

Interpretation of scores: Better quality = Higher Percentage

F. FREQUENTLY ASKED QUESTIONS

None

Measure HBD-AD: Hemoglobin A1c Control for Patients with Diabetes[8,16]

Based on a CMS Medicaid Adult Core Set Measure (2023), which is derived from a measure stewarded by the National Committee for Quality Assurance (NCQA)

A. DESCRIPTION

Percentage of ~~beneficiaries~~ [clients] ages 18 to 75 with diabetes (type 1 and type 2) whose hemoglobin A1c (HbA1c) was at the following levels during the measurement year:

- HbA1c control (<8.0%)
- HbA1c poor control (>9.0%)

Note: States must use the same data collection method (Administrative or Hybrid) to report these indicators.

Data Collection Method: Administrative, Hybrid, or EHR

Guidance for Reporting:

For HEDIS, this measure applies to ~~beneficiaries~~ [clients] ages 18 to 75. ~~For the purpose of Adult Core Set reporting, states should calculate and report this measure for two age groups (as applicable): ages 18 to 64 and ages 65 to 75.~~

Include all paid, suspended, pending, and denied claims.

This measure includes an optional exclusion for ~~beneficiaries~~ [clients] who die during the measurement year. For additional information, refer to the deceased ~~beneficiary~~ [client] exclusion guidance in ~~Section II. Data Collection and Reporting of the Adult Core Set~~ [Section III. Technical Specification Components].

NCQA's Medication List Directory (MLD) for Dementia Medications and Diabetes Medications is available to order free of charge in the NCQA Store (https://store.ncqa.org/hedis-my-2022-medication-list-directory.html). [Use version current for year reporting.] Once ordered, the Medication List Directory can be accessed through the NCQA Download Center **(**https://my.ncqa.org/Downloads**).**

The electronic specification for FFY 2023 is located on the eCQI resource center at https://ecqi.healthit.gov/ecqm/ec/2022/cms122v10. [Use version current for year reporting.] States that use electronic specifications should indicate this by selecting "Electronic Health Records" in the Data Source section of the ~~online~~ reporting ~~system~~ [template].

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-10-CM, LOINC, Modifier, POS, SNOMED, and UB. The Medication List Directory includes the following coding systems for medications: NDC and RxNorm. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

[16]Aside from the minor modifications noted in this specification, this specification is taken directly from the 2023 CMS Medicaid Adult Core Set Measures. Use the most current version for the year being reported.

See also Important Supplemental Materials for State-Collected Required BHC Measures derived from CMS Medicaid Adult and/or Child Core Set Measures (in this manual immediately before this specification).

[8] The NCQA HEDIS® measure specification has been adjusted pursuant to NCQA's Rules for Allowable Adjustments of HEDIS.

B. ELIGIBLE POPULATION

Age	Ages 18 to 75 as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a ~~beneficiary~~ [client] for whom enrollment is verified monthly, the ~~beneficiary~~ [client] may not have more than a 1-month gap in coverage (e.g., a ~~beneficiary~~ [client] whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	There are two ways to identify ~~beneficiaries~~ [clients] with diabetes: by claim/encounter data and by pharmacy data. The state must use both methods to identify the eligible population, but a ~~beneficiary~~ [client] only needs to be identified by one method to be included in this measure. ~~Beneficiaries~~ [Clients] may be identified as having diabetes during the measurement year or the year prior to the measurement year. Claim/encounter data. ~~Beneficiaries~~ [Clients] who met any of the following criteria during the measurement year or year prior to the measurement year (count services that occur over both years): At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of diabetes (Diabetes Value Set) without telehealth (Telehealth Modifier Value Set; Telehealth POS Value Set) At least one acute inpatient discharge with a diagnosis of diabetes (Diabetes Value Set) on the discharge claim. To identify an acute inpatient discharge: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). 3. Identify the discharge date for the stay. At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), telephone visits (Telephone Visits Value Set), e-visits or virtual check-ins (Online Assessments Value Set), ED visits (ED Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set), or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim), on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two encounters. To identify a nonacute inpatient discharge: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim. 3. Identify the discharge date for the stay. Only include nonacute inpatient encounters (Nonacute Inpatient Value Set) without telehealth (Telehealth Modifier Value Set; Telehealth POS Value Set).

Event/diagnosis (continued)	Pharmacy data. ~~Beneficiaries~~ [Clients] who were dispensed insulin or hypoglycemics/antihyperglycemics on an ambulatory basis during the measurement year or year prior to the measurement year (Diabetes Medications List, see link to the Medication List Guidance for Reporting above).
Required exclusions	Exclude ~~beneficiaries~~ [clients] who meet any of the following criteria: • ~~Beneficiaries~~ [Clients] who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year. • ~~Beneficiaries~~ [Clients] in hospice or using hospice services anytime during the measurement year. If a state reports this measure using the Hybrid method, and a ~~beneficiary~~ [client] is found to be in hospice or using hospice services during medical record review, the ~~beneficiary~~ [client] is removed from the sample and replaced by a ~~beneficiary~~ [client] from the oversample. For additional information, refer to the hospice exclusion guidance in ~~Section II. Data Collection and Reporting of the Adult Core Set~~ [Section III. Technical Specification Components]. • ~~Beneficiaries~~ [Clients] receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year.
Optional exclusion	Note: Supplemental and medical record data may not be used for this exclusion. Exclude ~~beneficiaries~~ [clients] who meet of the following criteria: ~~Beneficiaries~~ [Clients] age 66 and older as of December 31 of the measurement year with frailty and advanced illness. ~~Beneficiaries~~ [Clients] must meet both of the following frailty and advanced illness criteria to be excluded: 3. At least one claim/encounter for frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) during the measurement year 4. Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years): At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), telephone visits (Telephone Visits Value Set), e-visits or virtual check-ins (Online Assessments Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set), or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. To identify a nonacute inpatient discharge:

Optional exclusion (continued)	Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim. Identify the discharge date for the stay. At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set) At least one acute inpatient discharge with an advanced illness diagnosis (Advanced Illness Value Set) on the discharge claim. To identify an acute inpatient discharge: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). 3. Identify the discharge date for the stay. A dispensed dementia medication (Dementia Medications List, see link to the Medication List Directory in Guidance for Reporting above)

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerators

Numerator 1: HbA1c Control <8%

Use codes (HbA1c Lab Test Value Set; HbA1c Test Result or Finding Value Set) to identify the most recent HbA1c test during the measurement year. The ~~beneficiary~~ [client] is ~~not~~ numerator compliant if the most recent HbA1c level is <8.0%. The ~~beneficiary~~ [client] is not numerator compliant if the result for the most recent HbA1c test is ≥ 8.0% or is missing a result, or if an HbA1c test was not done during the measurement year.

States that use CPT Category II codes to identify numerator compliance for this indicator must search for all codes in the following value sets and use the most recent code during the measurement year to evaluate whether the ~~beneficiary~~ [client] is numerator compliant.

Value Set	Numerator 1 Compliance
HbA1c Level Less Than 7.0 Value Set	Compliant
HbA1c Level Greater Than or Equal To 7.0 and Less Than 8.0 Value Set	Compliant
HbA1c Level Greater Than or Equal To 8.0 and Less Than or Equal To 9.0 Value Set	Not compliant
HbA1c Level Greater Than 9.0 Value Set	Not compliant

Numerator 2: HbA1c Poor Control >9%

Use codes (HbA1c Lab Test Value Set; HbA1c Test Result or Finding Value Set) to identify the most recent HbA1c test during the measurement year. The ~~beneficiary~~ [client] is numerator compliant if the most recent HbA1c level is >9.0% or is missing a result, or if an HbA1c test was not

done during the measurement year. The ~~beneficiary~~ [client] is not numerator compliant if the result for the most recent HbA1c test during the measurement year is ≤ 9.0%.

States that use CPT Category II codes to identify numerator compliance for this indicator must search for all codes in the following value sets and use the most recent code during the measurement year to evaluate whether the ~~beneficiary~~ [client] is numerator compliant.

Value Set	Numerator 2 Compliance
HbA1c Level Less Than 7.0 Value Set	Not compliant
HbA1c Level Greater Than or Equal To 7.0 and Less Than 8.0 Value Set	Not compliant
HbA1c Level Greater Than or Equal To 8.0 and Less Than or Equal To 9.0 Value Set	Not compliant
HbA1c Level Greater Than 9.0 Value Set	Compliant

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

D. HYBRID SPECIFICATION

Denominator

A systematic sample drawn from the eligible population. Refer to the sampling guidance under Section II. Data Collection and Reporting of the Behavioral Health Clinic Quality Measures for additional information.

Numerators

Numerator 1: HbA1c Control <8%

The most recent HbA1c level (performed during the measurement year) is <8.0% as identified by laboratory data or medical record review.

Administrative Data

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

Medical Record Review

At a minimum, documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result. The ~~beneficiary~~ [client] is numerator compliant if the result for the most recent HbA1c level during the measurement year is <8.0%. The ~~beneficiary~~ [client] is not numerator compliant if the most recent HbA1c level during the measurement year is ≥ 8.0% or is missing, or if an HbA1c test was not performed during the measurement year.

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

Numerator 2: HbA1c Poor Control >9%

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

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

Administrative Data

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

Medical Record Review

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

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

E. ADDITIONAL NOTES

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

Supplemental Materials for Initiation and Engagement of Substance Use Disorder Treatment (IET-AD)

Important Supplemental Materials for State-Collected Required BHC Measures derived from CMS Medicaid Adult and/or Child Core Set Measures (IET-AD)

These supplemental materials are necessary for implementation of the State-Collected Required BHC Measures that are derived from the CMS Medicaid Adult and/or Child Core Set Measures. This volume includes the exact specifications that are on the CMS website for the 2023 Medicaid Core Set, with simple modifications noted in the text. Limited additional needed modifications are included below, as well as supplemental useful materials.

Changes directly in the specifications: For all Core Set-derived measures, the changes in the specification from the CMS Medicaid Adult or Child Core Set reflect: (1) substitution of the word "client" for "beneficiary" or "patient", unless the latter is part of a copyrighted code description; (2) removal of age stratification for adults (i.e., applicable to adults ages 18 years and older); and (3) removal of most references to the Core Set.

Additional needed modifications specific to each measure are included below, as well as supplemental useful materials.

Measure IET-AD: Initiation and Engagement of Substance Use Disorder Treatment

Additional information: The following material is provided to assist clinics using the specifications and follows the numbering system used in the non-Core derived BHC specifications:

A. DESCRIPTION
Important Reporting Guidance:

- The IET-AD measure is to be used to measure performance related to clients seen at the BHC Provider during the Measurement Year.
- Current value sets are available on the CMS Medicaid Adult Core Set Reporting Resource website. Use the version current for the year being reported.
- IET-AD is stratified separately based on whether the client is:
    - Medicaid only or Other (including those dually eligible for Medicare and Medicaid)

      AND
    - A member of which of the following ethnic groups: Not Hispanic or Latino, Hispanic or Latino, or Unknown

      AND

  - A member of which of the following racial groups: White or Caucasian, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or Other Pacific Islander, More than one race, or Unknown
- Refer to the specific data-reporting template for the reporting requirements applicable to each measure.

Measurement Period: The Measurement Period is the period for which data are required for reporting purposes. For the IET-AD measure **denominator**, two measurement periods are used:

- The SUD Episode Date Measurement Period is November 15 of the prior year through November 14 of the Measurement Year (using a calendar year as the Measurement Year).
- The Negative SUD Diagnosis and Medication History Review Measurement Period begins 194 days prior to the SUD Episode date.

For the **numerator**, two measurement periods are used:

- The Measurement Period for Initiation is the period within 14 days of the SUD Episode date
- The Measurement Period for Engagement is the period beginning the day after the Initiation encounter through 34 days after the Initiation event (inclusive).

B. DEFINITIONS

TERM	DEFINITION
Measurement Period	The specific time period for which data are needed for the numerator and denominator of a given measure. The Measurement Period may differ for the numerator and denominator and for each measure and is specified in section A above.
Measurement Year	The standard 12-month reporting period common to all measures being reported by the Provider.
Percentage	A Percentage is calculated as follows: numerator divided by denominator (n/d).
Provider	The Provider entity that is being measured (i.e., BHC)

E. ADDITIONAL NOTES

Interpretation of scores: Better quality = Higher Percentage

F. FREQUENTLY ASKED QUESTIONS

Question related to client age:

Q: What if the client is 17 when he or she is admitted but turns 18 within a week. How is that client counted in the Initiation and Engagement measure?

A: For each measure, the Technical Specification Manual provides instructions on how to ascertain age (e.g., the first day of the Measurement Year, the last day of the Measurement

Year, the day that a specific service is provided). For the IET-AD measure, age is determined as of the "SUD Episode Date." The measure defines the SUD Episode Date variously as the date of service or the date of discharge, depending on the setting. So, if, on July 17, a 17-year old is admitted to an inpatient stay, turns 18 on July 19, and is discharged on July 20, the person is 18 for purposes of the IET-AD denominator. In contrast, if the 17-year old seen in an outpatient setting on July 17, he or she is treated as 17 and not included in the denominator.

Question related to using alternatives to SNOMED codes:

Q: CCBHCs in our state provide services identified in the Value Sets using SNOMED codes but our CCBHCs do not use SNOMED codes. Are they allowed to interpret the SNOMED codes into codes that they actually use?

A: For purposes of the CCBHC demonstration, because this is a measure that is calculated and reported by the state, if the CCBHCs use other codes, the state will want to make sure it has a mechanism to capture them. In situations such as this, the state should identify these codes and make them available to all CCBHCs so that reporting is consistent. We ask for consistency and transparency and that the state provide this information to SAMHSA in the section of the reporting template for "Additional Notes," so that the national evaluator has accurate information.

Measure IET-AD: Initiation and Engagement of Substance Use Disorder Treatment[8,16]

Based on a CMS Medicaid Adult Core Set Measure (2023), which is derived from a measure stewarded by the National Committee for Quality Assurance (NCQA)

A. DESCRIPTION

Percentage of new substance use disorder (SUD) episodes that result in treatment initiation and engagement. Two rates are reported:

- **Initiation of SUD Treatment.** The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit, or medication treatment within 14 days.
- **Engagement of SUD Treatment**. The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.

Data Collection Method: Administrative or EHR

[16]Aside from the minor modifications noted in this specification, this specification is taken directly from the 2023 CMS Medicaid Adult Core Set Measures. Use the most current version for the year being reported.

See also Important Supplemental Materials for State-Collected Required BHC Measures derived from CMS Medicaid Adult and/or Child Core Set Measures (in this manual immediately before this specification).

[8]The NCQA HEDIS® measure specification has been adjusted pursuant to NCQA's Rules for Allowable Adjustments of HEDIS.

Guidance for Reporting:

For HEDIS, this measure has three reportable age groups and a total rate: ages 13 to 17, ages 18 to 64, age 65 and older, and total (age 13 and older). For the purpose of ~~Adult Core Set~~ [BHC] reporting, this measure should be calculated for ~~beneficiaries~~ [clients] age 18 and older. ~~States should calculate and report each of the rates for two age groups (as applicable): ages 18 to 64 and age 65 and older.~~

Two rates are reported: initiation of SUD treatment and engagement of SUD treatment. For each rate, report the following SUD diagnosis cohorts for each age group:

- Alcohol use disorder
- Opioid use disorder
- Other substance use disorder
- Total (The total is the sum of the SUD diagnosis cohort stratifications)

Exclude ~~beneficiaries~~ [clients] from the denominator for both rates (initiation of SUD treatment and engagement of SUD 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.

This measure includes an optional exclusion for ~~beneficiaries~~ [clients] who die during the measurement year. For additional information, refer to the deceased ~~beneficiary~~ [client] exclusion guidance in ~~Section II. Data Collection and Reporting of the Adult Core Set~~ [Section III. Technical Specification Components].

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/hedis-my-2022-medication-list-directory.html). [Use version current for year reporting.] **Once ordered, the Medication List Directory can be accessed through the** NCQA Download Center **(**https://my.ncqa.org/Downloads**).**

The electronic specification for FFY 2023 is located on the eCQI resource center at https://ecqi.healthit.gov/ecqm/ec/2022/cms137v10. [Use version current for year reporting.] States that use electronic specifications should indicate this by selecting "Electronic Health Records" in the Data Source section of the ~~online~~ reporting [template]~~system~~.

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-10-CM, ICD-10-PCS, POS, SNOMED, and UB. The Medication List Directory includes the following coding systems for medications: NDC and RxNorm. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Intake period	November 15 of the year prior to the measurement year to November 14 of the measurement year. The Intake Period is used to capture new SUD episodes
SUD Episode	An encounter during the Intake Period with a diagnosis of SUD. For visits that result in an inpatient stay, the inpatient discharge is the SUD Episode (an SUD diagnosis is not required for the inpatient stay; use the diagnosis from the visit that resulted in the inpatient stay to determine the diagnosis cohort).
SUD Episode Date	The date of service for an encounter during the Intake period with a diagnosis of SUD. For an outpatient, intensive outpatient, partial hospitalization, observation, telehealth, or ED visit (not resulting in an inpatient stay), the SUD Episode Date is the date of service. For an inpatient stay or for medically managed withdrawal events (i.e., detoxification) that occurred during an inpatient stay, the SUD Episode Date is the date of discharge. For medically managed withdrawal (i.e., detoxification), other than those that occurred during an inpatient stay, the SUD Episode Date is the date of service. For direct transfers, the SUD Episode Date is the discharge date from the last admission (an SUD diagnosis is not required for the transfer; use the diagnosis from the initial admission to determine the diagnosis cohort).
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 SUD Episode Date, negative diagnosis history and numerator events).
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 the SUD Episode Date.
SUD diagnosis cohort stratification	Report the following SUD diagnosis cohort stratifications and a total: • Alcohol use disorder • Opioid use disorder • Other substance use disorder • Total (The total is the sum of the SUD diagnosis cohort stratifications)
Continuous enrollment	194 days prior to the SUD Episode Date through 47 days after the SUD Episode Date (242 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~~ [Clients] with detoxification-only chemical dependency benefits do not meet these criteria.

Event/ diagnosis	New episode of SUD during the Intake Period. Follow the steps below to identify the denominator for both rates. Step 1 Identify all SUD episodes. Any of the following meet criteria: An outpatient visit (Visit Setting Unspecified Value Set) with (Outpatient POS 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 An outpatient visit (BH Outpatient 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 intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) with (Partial Hospitalization POS 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 An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient 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 A non-residential substance abuse treatment facility visit (Visit Setting Unspecified Value Set) with (Non-residential Substance Abuse Treatment Facility POS 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 A community mental health center visit (Visit Setting Unspecified Value Set) with (Community Mental Health Center POS 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 A telehealth visit (Visit Setting Unspecified Value Set) with (Telehealth POS 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 A substance use disorder service (Substance Use Disorder Services 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 A medically managed withdrawal (i.e., detoxification) event (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

Event/ diagnosis (continued)	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). Identify the discharge date for the stay. 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). Step 2 Test for Negative SUD Diagnosis History. Exclude SUD episodes if there was an encounter in any setting other than an ED visit (ED Value Set) or a medically managed withdrawal (i.e., detoxification) event (Detoxification Value Set) with a diagnosis of SUD (Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set) during the 194 days prior to the SUD Episode Date. If the SUD Episode was an inpatient stay, use the admission date to determine Negative SUD History. For visits with an SUD diagnosis that resulted in an inpatient stay (where the inpatient stay becomes the SUD Episode), use the earliest date of service to determine the Negative SUD Diagnosis History (so that the visit that resulted in the inpatient stay is not considered a positive diagnosis history). For direct transfers, use the first admission date to determine the Negative SUD Diagnosis History. Step 3 Test for Negative SUD Medication History. Exclude SUD episodes if either of the following occurred during the 194 days prior to the SUD Episode Date:

Event/ diagnosis (continued)	An SUD medication treatment dispensing event (Alcohol Use Disorder Treatment Medications List; Naltrexone Injection Medications List; Buprenorphine Oral Medications List; Buprenorphine Injection Medications List; Buprenorphine Implant Medications List; Buprenorphine Naloxone Medications List, see link to the Medication List Directory in Guidance for Reporting above) An SUD medication administration event (Naltrexone Injection Value Set, Buprenorphine Oral Value Set; Buprenorphine Oral Weekly Value Set; Buprenorphine Injection Value Set; Buprenorphine Naloxone Value Set; Buprenorphine Implant Value Set; Methadone Oral Value Set; Methadone Oral Weekly Value Set) Step 4 Exclude SUD Episodes that do not meet continuous enrollment criteria. ~~Beneficiaries~~ [Clients] must be continuously enrolled from 194 days before the SUD Episode Date through 47 days after the SUD Episode Date (242 total days), with no gaps. Note: The denominator for this measure is based on episodes, not on ~~beneficiaries~~ [clients]. All eligible episodes that were not excluded remain in the denominator. Step 5 Identify the SUD diagnosis cohort for each SUD Episode. If the SUD Episode has a diagnosis of alcohol use disorder (Alcohol Abuse and Dependence Value Set), include the episode in the alcohol use disorder cohort. If the SUD Episode has a diagnosis of opioid use disorder (Opioid Abuse and Dependence Value Set), include the episode in the opioid use disorder cohort. If the SUD Episode has a diagnosis of SUD that is neither for opioid or alcohol (Other Drug Abuse and Dependence Value Set), place the ~~beneficiary~~ [client] in the other substance use disorder cohort. Include SUD Episodes in all SUD diagnosis cohorts for which they meet criteria. For example, if the SUD Episode has a diagnosis of alcohol use disorder and opioid use disorder, include the episode in the alcohol use disorder and opioid use disorder cohorts.
Required exclusion	~~Beneficiaries~~ [Clients] in hospice or using hospice services anytime during the measurement year. For additional information, refer to the hospice exclusion guidance in ~~Section II. Data Collection and Reporting of the Adult Core Set~~ [Section III. Technical Specification Components].

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerators

Numerator 1: Initiation of SUD Treatment

Initiation of SUD treatment within 14 days of the SUD Episode Date.

Follow the steps below to identify numerator compliance.

Step 1

If the SUD Episode was an inpatient discharge, the inpatient stay is considered initiation of treatment and the SUD Episode is compliant.

Step 2

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

Step 3

For remaining SUD Episodes (those not compliant after steps 1–2), identify episodes with at least one of the following on the SUD Episode Date or during the 13 days after the SUD Episode Date (14 total days).

An acute or nonacute inpatient admission with a diagnosis (on the discharge claim) of 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:

Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).

Identify the admission date for the stay.

An outpatient visit (Visit Setting Unspecified Value Set) with (Outpatient POS 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 outpatient visit (BH Outpatient 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 intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) with (Partial Hospitalization POS 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 intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient 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
- A non-residential substance abuse treatment Facility visit (Visit Setting Unspecified Value Set) with (Non-residential Substance Abuse Treatment Facility POS 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
- A community mental health center visit (Visit Setting Unspecified Value Set) with (Community Mental Health Center POS 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
- A telehealth visit: (Visit Setting Unspecified Value Set) with (Telehealth POS 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
- A substance use disorder service (Substance Use Disorder Services 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
- 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

- 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
- A weekly or monthly opioid treatment service (OUD Weekly Non Drug Service Value Set; OUD Monthly Office Based Treatment Value Set; OUD Weekly Drug Treatment Service Value Set)
- For SUD Episodes in the alcohol use disorder cohort, an alcohol use disorder medication treatment dispensing event (Alcohol Use Disorder Treatment Medications List, see link to the Medication List Directory in Guidance for Reporting above) or a medication administration event (Naltrexone Injection Value Set)
- For SUD Episodes in the opioid use disorder cohort, an opioid use disorder medication treatment dispensing event (Naltrexone Oral Medications List; Naltrexone Injection Medications List; Buprenorphine Oral Medications List; Buprenorphine Injection Medications List; Buprenorphine Implant Medications List; Buprenorphine Naloxone Medications List, see link to the Medication List Directory in Guidance for Reporting above) or a medication administration event (Naltrexone Injection Value Set, Buprenorphine Oral Value Set, Buprenorphine Oral Weekly Value Set, Buprenorphine Injection Value Set, Buprenorphine Implant Value Set, Buprenorphine Naloxone Value Set, Methadone Oral Value Set, Methadone Oral Weekly Value Set)

For all initiation events except medication treatment dispensing events and medication administration events, initiation on the same day as the SUD Episode Date must be with different providers in order to count.

Exclude the ~~beneficiary~~ [client] from the denominator for both indicators (Initiation of SUD Treatment and Engagement of SUD 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 SUD Treatment

Follow the steps below to identify numerator compliance.

If Initiation of SUD Treatment was an inpatient admission, the 34-day period for engagement begins the day after discharge.

Step 1

Identify all SUD Episodes compliant for the Initiation of SUD Treatment numerator. SUD Episodes that are not compliant for Initiation of SUD Treatment are not compliant for Engagement of SUD Treatment.

Step 2

Identify SUD Episodes that had at least one weekly or monthly opioid treatment service with medication administration (OUD Monthly Office Based Treatment Value Set; OUD Weekly Drug Treatment Service Value Set) on the day after the initiation encounter through 34 days after the initiation event. The opioid treatment service is considered engagement of treatment and the SUD Episode is compliant.

Step 3

Identify SUD Episodes with long-acting SUD medication administration events on the day after the initiation encounter through 34 days after the initiation event. The long-acting SUD medication administration event is considered engagement of treatment and the SUD Episode is compliant. Any of the following meet criteria:

For SUD Episodes in the alcohol use disorder cohort, an alcohol use disorder medication treatment dispensing event (Naltrexone Injection Medications List, see link to the Medication List Directory in Guidance for Reporting above) or a medication administration event (Naltrexone Injection Value Set)

For SUD Episodes in the opioid use disorder cohort, an opioid use disorder medication treatment dispensing event (Naltrexone Injection Medications List; Buprenorphine Injection Medications List; Buprenorphine Implant Medications List, see link to the Medication List Directory in Guidance for Reporting above) or a medication administration event (Naltrexone Injection Value Set; Buprenorphine Injection Value Set; Buprenorphine Implant Value Set)

Step 4

For remaining SUD Episodes identify episodes with at least two of the following (any combination) on the day after the initiation encounter through 34 days after the initiation event:

- Engagement visit
- Engagement medication treatment event

Two engagement visits may 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 meet criteria for an engagement visit:

An acute or nonacute inpatient admission with a diagnosis (on the discharge claim) of 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 or nonacute inpatient admissions:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Identify the admission date for the stay.

An outpatient visit (Visit Setting Unspecified Value Set) with (Outpatient POS 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 outpatient visit (BH Outpatient 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 intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) with (Partial Hospitalization POS 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 intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient 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

A non-residential substance abuse treatment Facility visit (Visit Setting Unspecified Value Set) with (Non-residential Substance Abuse Treatment Facility POS 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

A community mental health center visit (Visit Setting Unspecified Value Set) with (Community Mental Health Center POS 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

A telehealth visit: (Visit Setting Unspecified Value Set) with (Telehealth POS 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

A substance use disorder service (Substance Use Disorder Services 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

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

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)

Engagement Medication Treatment Events

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

For SUD Episodes in the alcohol use disorder cohort, an alcohol use disorder medication treatment dispensing event (Alcohol Use Disorder Treatment Medications List, see link to the Medication List Directory in Guidance for Reporting above)

For SUD Episodes in the opioid use disorder cohort, an opioid use disorder medication treatment dispensing event (Naltrexone Oral Medications List; Buprenorphine Oral Medications List; Buprenorphine Naloxone Medications List, see link to the Medication List Directory in Guidance for Reporting above) or a medication administration event (Buprenorphine Oral Value Set; Buprenorphine Oral Weekly Value Set; Buprenorphine Naloxone Value Set; Methadone Oral Value Set; Methadone Oral Weekly Value Set)

Opioid Use Disorder Treatment Medications

Description	Prescription	Medication Lists
Antagonist	Naltrexone (oral)	Naltrexone Oral Medications List
Antagonist	Naltrexone (injectable)	Naltrexone Injection Medications List
Partial agonist	Buprenorphine (sublingual tablet)	Buprenorphine Oral Medications List

Description	Prescription	Medication Lists
Partial agonist	Buprenorphine (injection)	Buprenorphine Injection Medications List
Partial agonist	Buprenorphine (implant)	Buprenorphine Implant Medications List
Partial agonist	Buprenorphine/naloxone (sublingual tablet, buccal film, sublingual film)	Buprenorphine Naloxone Medications List

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.

Methadone is not included on the medication lists for this measure. Methadone for opioid use disorder (OUD) administered or dispensed by federally certified opioid treatment programs (OTP) is billed on a medical claim. A pharmacy claim for methadone would be indicative of treatment for pain rather than OUD.

Supplemental Materials for Follow-Up After Hospitalization for Mental Illness (FUH-AD AND FUH-CH)

Important Supplemental Materials for State-Collected Required BHC Measures derived from CMS Medicaid Adult and/or Child Core Set Measures (FUH-AD and FUH-CH)

These supplemental materials are necessary for implementation of the State-Collected Required BHC Measures that are derived from the CMS Medicaid Adult and/or Child Core Set Measures. This volume includes the exact specifications that are on the CMS website for the 2023 Medicaid Core Set, with simple modifications noted in the text. Limited additional needed modifications are included below, as well as supplemental useful materials.

1. **Measure FUH-AD: Follow-Up After Hospitalization for Mental Illness: Age 18 and Older**
2. **Measure FUH-CH: Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17**

Changes within the specifications: For both FUH measures, the changes within the CMS Medicaid Adult and Child Core Sets specifications reflect: (1) substitution of the word "client" for "beneficiary" or "patient", unless the latter is part of a copyrighted code description; (2) removal of age stratification in the adult measure (i.e., applicable to adults ages 18 years and older); and (3) removal of references to the Core Set.

Additional information: For both the FUH measures, the following material is provided to assist clinics in using the specifications and follows the numbering system used in the non-Medicaid Core Set-derived BHC specifications:

A. DESCRIPTION
Important Reporting Guidance:

- Both the FUH-AD and FUD-CH measures are to be used by states to measure performance related to clients seen at the Provider during the Measurement Year.
- Current value sets are available on the CMS Medicaid Adult Core Set Reporting Resource website and the CMS Medicaid Child Core Set Reporting Resource website. Use the version current for the year being reported.
- Both FUH-AD and FUH-CH are to be stratified separately based on whether the client is:
    - Medicaid only or Other (including those dually eligible for Medicare and Medicaid)

      AND
    - A member of which of the following ethnic groups: Not Hispanic or Latino, Hispanic or Latino, or Unknown

      AND
    - A member of which of the following racial groups: White or Caucasian, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or Other Pacific Islander, More than one race, or Unknown

- Refer to the specific data-reporting template for the reporting requirements applicable to each measure.

Measurement Period: The Measurement Period is the period for which data are required for reporting purposes. The FUH-AD and FUH-CH measure **denominators** are both January 1 through December 1, if the Measurement Year (MY) is the calendar year. The FUH-AD and FUH-CH measures include two submeasures, both of which are defined in the specification and both of which have a distinct Measurement Period for the **numerator**: (a) ***7-Day Follow-up*** (7 days after discharge date) and ***(b) 30-Day Follow-up*** (30 days after discharge date).

B. DEFINITIONS

TERM	DEFINITION
Measurement Period	The specific time period for which data are needed for the numerator and denominator of a given measure. The Measurement Period may differ for the numerator and denominator and for each measure and is specified in section A above.
Measurement Year	The standard 12-month reporting period common to all measures being reported by the Provider.
Percentage	A Percentage is calculated as follows: numerator divided by denominator (n/d).
Provider	The Provider entity that is being measured (i.e., BHC)

E. ADDITIONAL NOTES

Interpretation of scores: Better quality = Higher Percentage

F. FREQUENTLY ASKED QUESTIONS

None

Measure FUH-AD: Follow-Up After Hospitalization for Mental Illness: Age 18 and Older[8,16]

Based on a CMS Medicaid Adult Core Set Measure (2023), which is derived from a measure stewarded by the National Committee for Quality Assurance (NCQA)

A. DESCRIPTION

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

Percentage of discharges for which the ~~beneficiary~~ [client] received follow-up within 30 days after discharge

Percentage of discharges for which the ~~beneficiary~~ [client] received follow-up within 7 days after discharge

Data Collection Method: Administrative

[16] Aside from the minor modifications noted in this specification, this specification is taken directly from the 2023 CMS Medicaid Adult Core Set Measures. Use the most current version for the year being reported.

See also Important Supplemental Materials for State-Collected Required BHC Measures derived from CMS Medicaid Adult and/or Child Core Set Measures (in this manual immediately before this specification).

[8] The NCQA HEDIS® measure specification has been adjusted pursuant to NCQA's Rules for Allowable Adjustments of HEDIS.

Guidance for Reporting:

For HEDIS, this measure has three reportable age groups and a total rate: ages 6 to 17, ages 18 to 64, age 65 and older, and total (age 6 and older). The [Medicaid] Child Core Set measure applies to beneficiaries ages 6 to 17 and the {Medicaid] Adult Core Set measure applies to beneficiaries age 18 and older. ~~For the purpose of Adult Core Set reporting, states should calculate and report this measure for two age groups (as applicable): ages 18 to 64 and age 65 and older.~~ . [For the purpose of Behavioral Health Clinic (BHC) reporting, states should calculate and report this adult measure as one age group: clients ages 18 years and older.]

Follow the detailed specifications to (1) include the appropriate discharge when the ~~beneficiary~~ [client] was transferred directly or readmitted to an acute or non-acute care facility for a mental health diagnosis, and (2) exclude discharges in which the ~~beneficiary~~ [client] was transferred directly or readmitted to an acute or non-acute care facility for a non-mental health diagnosis.

The denominator for this measure should be the same for the 30-day rate and the 7-day rate.

The 30-day follow-up rate should be greater than or equal to the 7-day follow-up rate ~~within each age group~~.

This measure specifies that when a visit code or procedure code must be used in conjunction with a diagnosis code, both the visit/procedure code and the diagnosis code must be on the same claim or from the same visit.

This measure references value sets that include codes used on professional claims (e.g., CPT, HCPCS) and codes used on facility claims (e.g., UB). Diagnosis and procedure codes from both facility and professional claims should be used to identify services and diagnoses (the codes can be on the same claim or from the same visit).

For value sets that include codes used only on facility claims (e.g., UB), use facility claims only to identify services and diagnoses (the codes must be on the same claim).

Include all paid, suspended, pending, and denied claims.

This measure includes an optional exclusion for ~~beneficiaries~~ [clients] who die during the measurement year. For additional information, refer to the deceased ~~beneficiary~~ [client] exclusion guidance in ~~Section II. Data Collection and Reporting of the Adult Core Set~~ [Section III. Technical Specification Components].

Refer to [Appendix D of this manual] for the definition of a mental health provider. States must develop their own methods to identify mental health providers.

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-10-CM, ICD-10-PCS, POS, SNOMED, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Age	Age 18 and older as of date of discharge.
Continuous enrollment	Date of discharge through 30 days after discharge.
Allowable gap	No allowable gaps in the continuous enrollment period.
Anchor date	None.
Benefit	Medical and mental health (inpatient and outpatient).

Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)

Event/diagnosis	An acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm (Mental Illness Value Set; Intentional Self-Harm Value Set) on the discharge claim on or between January 1 and December 1 of the measurement year. To identify acute inpatient discharges: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). Identify the discharge date for the stay. The denominator for this measure is based on discharges, not on ~~beneficiaries~~ [clients]. If ~~beneficiaries~~ [clients] have more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year.
Acute readmission or direct transfer	Identify readmissions and direct transfers to an acute inpatient care setting during the 30-day follow-up period: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). 3. Identify the admission date for the stay (the admission date must occur during the 30-day follow-up period). 4. Identify the discharge date for the stay.
Acute readmission or direct transfer (continued)	Exclude both the initial discharge and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year. If the readmission/direct transfer to the acute inpatient care setting was for a principal diagnosis (use only the principal diagnosis on the discharge claim) of mental health disorder or intentional self-harm (Mental Health Diagnosis Value Set; Intentional Self-Harm Value Set), count only the last discharge. If the readmission/direct transfer to the acute inpatient care setting was for any other principal diagnosis (use only the principal diagnosis on the discharge claim) exclude both the original and the readmission/direct transfer discharge.
Nonacute readmission or direct transfer	Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period, regardless of principal diagnosis for the readmission. To identify readmissions and direct transfers to a nonacute inpatient care setting: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim. 3. Identify the admission date for the stay. These discharges are excluded from this measure because rehospitalization or direct transfer may prevent an outpatient follow-up visit from taking place.
Required exclusion	~~Beneficiaries~~ [Clients] in hospice or using hospice services anytime during the measurement year. For additional information, refer to the hospice exclusion guidance in ~~Section II. Data Collection and Reporting of the Adult Core Set~~ [Section III. Technical Specification Components].

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerators

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

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

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

An outpatient visit (Visit Setting Unspecified Value Set) with (Outpatient POS Value Set) with a mental health provider

An outpatient visit (BH Outpatient Value Set) with a mental health provider

An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) with (Partial Hospitalization POS Value Set)

An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set)

A community mental health center visit (Visit Setting Unspecified Value Set; BH Outpatient Value Set; Observation Value Set; Transitional Care Management Services Value Set) with (Community Mental Health Center POS Value Set)

Electroconvulsive therapy (Electroconvulsive Therapy Value Set) with (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set)

A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set) with a mental health provider

An observation visit (Observation Value Set) with a mental health provider

Transitional care management services (Transitional Care Management Services Value Set) with a mental health provider

A visit in a behavioral healthcare setting (Behavioral Healthcare Setting Value Set)

A telephone visit (Telephone Visits Value Set) with a mental health provider

Psychiatric collaborative care management (Psychiatric Collaborative Care Management 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 discharge or within 7 days after discharge).

Measure FUH-CH: Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17[8,18]

Based on a CMS Medicaid Child Core Set Measure (2023), which is derived from a measure stewarded by the National Committee for Quality Assurance (NCQA)

A. DESCRIPTION

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

Percentage of discharges for which the ~~beneficiary~~ [client] received follow-up within 30 days after discharge

Percentage of discharges for which the ~~beneficiary~~ [client] received follow-up within 7 days after discharge

Data Collection Method: Administrative

Guidance for Reporting:

For HEDIS, this measure has three reportable age groups and a total rate: ages 6 to 17, ages 18 to 64, age 65 and older, and total (age 6 and older). The [Medicaid] Child Core Set measure applies to beneficiaries ages 6 to 17 and the [Medicaid] Adult Core Set measure applies to beneficiaries age 18 and older. [For the purpose of Behavioral Health Clinic (BHC) reporting, states should calculate and report this child measure as one age group: clients ages 6 to 17 years.]

Follow the detailed specifications to (1) include the appropriate discharge when the ~~beneficiary~~ [client] was transferred directly or readmitted to an acute or non-acute care facility for a mental health diagnosis, and (2) exclude discharges in which the ~~beneficiary~~ [client] was transferred directly or readmitted to an acute or non-acute care facility for a non-mental health diagnosis.

The denominator for this measure should be the same for the 30-day rate and the 7-day rate.

The 30-day follow-up rate should be greater than (or equal to) the 7-day follow-up rate.

This measure specifies that when a visit code or procedure code must be used in conjunction with a diagnosis code, both the visit/procedure code and the diagnosis code must be on the same claim or from the same visit.

This measure references value sets that include codes used on professional claims (e.g., CPT, HCPCS) and codes used on facility claims (e.g., UB). Diagnosis and procedure codes from both facility and professional claims should be used to identify services and diagnoses (the codes can be on the same claim or from the same visit).

For value sets that include codes used only on facility claims (e.g., UB), use facility claims only to identify services and diagnoses (the codes must be on the same claim).

[8]The NCQA HEDIS® measure specification has been adjusted pursuant to NCQA's Rules for Allowable Adjustments of HEDIS.

[18]Aside from the minor modifications noted in this specification, this specification is taken directly from the 2023 CMS Medicaid Child Core Set Measures. Use the most current version for the year being reported. See also Important Supplemental Materials for State-Collected Required BHC Measures derived from CMS Medicaid Adult and/or Child Core Set Measures (in this manual immediately before this specification).

Include all paid, suspended, pending, and denied claims. This measure includes an optional exclusion for ~~beneficiaries~~ [clients] who die during the measurement year. For additional information, refer to the deceased ~~beneficiary~~ [client] exclusion guidance in ~~Section II. Data Collection and Reporting of the Adult Core Set~~ [Section III. Technical Specification Components]. Refer to [Appendix D of this manual] for the definition of a mental health provider. States must develop their own methods to identify mental health providers.

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-10-CM, ICD-10-PCS, POS, SNOMED, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

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

Acute readmission or direct transfer (continued)	If the readmission/direct transfer to the acute inpatient care setting was for any other principal diagnosis (use only the principal diagnosis on the discharge claim) exclude both the original and the readmission/direct transfer discharge.
Nonacute readmission or direct transfer	Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period, regardless of principal diagnosis for the readmission. To identify readmissions and direct transfers to a nonacute inpatient care setting: Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 4. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim. 5. Identify the admission date for the stay. These discharges are excluded from this measure because rehospitalization or direct transfer may prevent an outpatient follow-up visit from taking place.
Required exclusion	~~Beneficiaries~~ [Clients] in hospice or using hospice services anytime during the measurement year. For additional information, refer to the hospice exclusion guidance in ~~Section II. Data Collection and Reporting of the Child Core Set~~ [Section III. Technical Specification Components].

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerators

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

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

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

An outpatient visit (Visit Setting Unspecified Value Set) with (Outpatient POS Value Set) with a mental health provider

An outpatient visit (BH Outpatient Value Set) with a mental health provider

An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) with (Partial Hospitalization POS Value Set)

An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set)

A community mental health center visit (Visit Setting Unspecified Value Set; BH Outpatient Value Set; Observation Value Set; Transitional Care Management Services Value Set) with (Community Mental Health Center POS Value Set)

Electroconvulsive therapy (Electroconvulsive Therapy Value Set) with (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set)

A telehealth visit (Visit Setting Unspecified Value Set) with (Telehealth POS Value Set) with a mental health provider

An observation visit (Observation Value Set) with a mental health provider

Transitional care management services (Transitional Care Management Services Value Set) with a mental health provider

A visit in a behavioral healthcare setting (Behavioral Healthcare Setting Value Set)

A telephone visit (Telephone Visits Value Set) with a mental health provider

Psychiatric collaborative care management (Psychiatric Collaborative Care Management 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 discharge or within 7 days after discharge).

Supplemental Materials for Follow-Up After Emergency Department Visit for Mental Illness FUM-AD AND FUM-CH)

Important Supplemental Materials for State-Collected Required BHC Measures derived from CMS Medicaid Adult and/or Child Core Set Measures (FUM-AD and FUM-CH)

These supplemental materials are necessary for implementation of the State-Collected Required BHC Measures that are derived from the CMS Medicaid Adult and/or Child Core Set Measures. This volume includes the exact specifications that are on the CMS website for the 2023 Medicaid Core Set, with simple modifications noted in the text. Limited additional needed modifications are included below, as well as supplemental useful materials.

1. **Measure FUM-AD: Follow-Up After Emergency Department Visit for Mental Illness: Age 18 and Older**
2. **Measure FUM-CH: Follow-Up After Emergency Department Visit for Mental Illness: Ages 6 TO 17**

For both FUM measures, the changes within the CMS Medicaid Adult and Child Core Sets specifications reflect: (1) substitution of the word "client" for "beneficiary" or "patient", unless the latter is part of a copyrighted code description; (2) removal of age stratification in the adult measure (i.e., applicable to adults ages 18 years and older); and (3) removal of references to the Core Set.

Additional information: For both the FUM measures, the following material is provided to assist clinics in using the specifications and follows the numbering system used in the non-Medicaid Core Set-derived BHC specifications:

A. DESCRIPTION

Important Reporting Guidance:

- Both the FUM-AD and FUM-CH measures are to be used by states to measure performance related to clients seen at the Provider during the Measurement Year.
- Current value sets are available on the CMS Medicaid Adult Core Set Reporting Resource website and the CMS Medicaid Child Core Set Reporting Resource website. Use the version current for the year being reported.
- Both FUM-AD and FUM-CH are to be stratified separately based on whether the client is:
    - Medicaid only or Other (including those dually eligible for Medicare and Medicaid)

      AND
    - A member of which of the following ethnic groups: Not Hispanic or Latino, Hispanic or Latino, or Unknown

      AND

  - A member of which of the following racial groups: White or Caucasian, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or Other Pacific Islander, More than one race, or Unknown
- Refer to the specific data-reporting template for the reporting requirements applicable to each measure.

Measurement Period: The Measurement Period is the period for which data are required for reporting purposes. The FUM-AD and FUM-CH measure **denominators** are both January 1 through December 1, if the Measurement Year (MY) is the calendar year. The FUM-AD and FUM-CH measure include two submeasures, both of which are defined in the specification and both of which have a distinct Measurement Period for the **numerator**: (a) ***7-Day Follow-up*** (ED visit date through 7 days after visit date) and (b) ***30-Day Follow-up*** (ED visit date through 30 days after visit date).

B. DEFINITIONS

TERM	DEFINITION
Measurement Period	The specific time period for which data are needed for the numerator and denominator of a given measure. The Measurement Period may differ for the numerator and denominator and for each measure and is specified in section A above.
Measurement Year	The standard 12-month reporting period common to all measures being reported by the Provider.
Percentage	A Percentage is calculated as follows: numerator divided by denominator (n/d).
Provider	The Provider entity that is being measured (i.e., BHC)

E. ADDITIONAL NOTES

Interpretation of scores: Better quality = Higher Percentage

F. FREQUENTLY ASKED QUESTIONS

None

Measure FUM-AD: Follow-Up After Emergency Department Visit for Mental Illness: Age 18 and Older[8,16]

Based on a CMS Medicaid Adult Core Set Measure (2023), which is derived from a measure stewarded by the National Committee for Quality Assurance (NCQA)[20]

A. DESCRIPTION

Percentage of emergency department (ED) visits for ~~beneficiaries~~ [clients] 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~~ [client] received follow-up within 30 days of the ED visit (31 total days)

Percentage of ED visits for mental illness for which the ~~beneficiary~~ [client] received follow-up within 7 days of the ED visit (8 total days)

Data Collection Method: Administrative

[16]Aside from the minor modifications noted in this specification, this specification is taken directly from the 2023 CMS Medicaid Adult Core Set Measures. Use the most current version for the year being reported.

See also Important Supplemental Materials for State-Collected Required BHC Measures derived from CMS Medicaid Adult and/or Child Core Set Measures (in this manual immediately before this specification).

[8]The NCQA HEDIS® measure specification has been adjusted pursuant to NCQA's Rules for Allowable Adjustments of HEDIS.

[20]Adapted from an NCQA measure with financial support from the Office of the Assistant Secretary for Planning and Evaluation (ASPE) under Prime Contract No. HHSP23320100019WI/HHSP23337001T, in which NCQA was a subcontractor to Mathematica. Additional financial support was provided by the Substance Abuse and Mental Health Services Administration (SAMHSA).

Follow-Up After Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD)

Guidance for Reporting:

For HEDIS, this measure has three reportable age groups and a total rate: ages 6 to 17, ages 18 to 64, age 65 and older, and total (age 6 and older). The [Medicaid] Child Core Set measure applies to beneficiaries ages 6 to 17 and the [Medicaid] Adult Core Set measure applies to beneficiaries age 18 and older. ~~For the purpose of Adult Core Set reporting, states should calculate and report this measure for two age groups (as applicable): ages 18 to 64 and age 65 and older.~~ [For the purpose of Behavioral Health Clinic (BHC) reporting, states should calculate and report this adult measure as one age group: clients ages 18 years and older.]

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 ~~within each age group~~.

When a visit code or procedure code must be used in conjunction with a diagnosis code, the codes must be on the same claim or from the same visit.

- If a value set includes codes used on professional claims (e.g., CPT, HCPCS) and includes codes used on facility claims (e.g., UB), use diagnosis and procedure codes from both facility and professional claims to identify services and diagnoses (the codes can be on the same claim or from the same visit).
- If a value set includes codes used only on facility claims (e.g., UB) then only use facility claims to identify services and diagnoses (the codes must be on the same claim).

Include all paid, suspended, pending and denied claims.

This measure includes an optional exclusion for ~~beneficiaries~~ [clients] who die during the measurement year. For additional information, refer to the deceased ~~beneficiary~~ [client] exclusion guidance in ~~Section II. Data Collection and Reporting of the Adult Core Set~~ [Section III. Technical Specification Components].

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-10-CM, ICD-10-PCS, POS, SNOMED, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Age	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~~ [client] was age 18 or older on the date of the visit. The denominator for this measure is based on ED visits, not on ~~beneficiaries~~ [clients]. If a ~~beneficiary~~ [client] 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~~ [client] has more than one ED visit in a 31-day period, include only the first eligible ED visit. For example, if a ~~beneficiary~~ [client] 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 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: 2. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 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.
Required exclusion	~~Beneficiaries~~ [Clients] in hospice or using hospice services anytime during the measurement year. For additional information, refer to the hospice exclusion guidance in ~~Section II. Data Collection and Reporting of the Adult Core Set~~ [Section III. Technical Specification Components].

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).

Measure FUM-CH: Follow-Up After Emergency Department Visit for Mental Illness: Ages 6 to 17[8,18]

Based on a CMS Medicaid Child Core Set Measure (2023), which is derived from a measure stewarded by the National Committee for Quality Assurance (NCQA)[20]

A. DESCRIPTION

Percentage of emergency department (ED) visits for ~~beneficiaries~~ [clients] ages 6 to 17 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~~ [client] received follow-up within 30 days of the ED visit (31 total days)

Percentage of ED visits for mental illness for which the ~~beneficiary~~ [client] received follow-up within 7 days of the ED visit (8 total days)

Data Collection Method: Administrative

Guidance for Reporting:

For HEDIS, this measure has three reportable age groups and a total rate: ages 6 to 17, ages 18 to 64, age 65 and older, and total (age 6 and older). The {Medicaid] Child Core Set measure applies to beneficiaries ages 6 to 17 and the [Medicaid] Adult Core Set measure applies to beneficiaries age 18 and older. [For the purpose of Behavioral Health Clinic (BHC) reporting, states should calculate and report this child measure as one age group: clients ages 6 to 17 years.]

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 within each age group~~.

When a visit code or procedure code must be used in conjunction with a diagnosis code, the codes must be on the same claim or from the same visit.

- If a value set includes codes used on professional claims (e.g., CPT, HCPCS) and includes codes used on facility claims (e.g., UB), use diagnosis and procedure codes from both facility and professional claims to identify services and diagnoses (the codes can be on the same claim or from the same visit).
- If a value set includes codes used only on facility claims (e.g., UB) then only use facility claims to identify services and diagnoses (the codes must be on the same claim).

Include all paid, suspended, pending and denied claims.

This measure includes an optional exclusion for ~~beneficiaries~~ [clients] who die during the measurement year. For additional information, refer to the deceased ~~beneficiary~~ [client] exclusion guidance in ~~Section II. Data Collection and Reporting of the Child Core Set~~ [Section III. Technical Specification Components].

[8]The NCQA HEDIS® measure specification has been adjusted pursuant to NCQA's Rules for Allowable Adjustments of HEDIS.

[18]Aside from the minor modifications noted in this specification, this specification is taken directly from the 2023 CMS Medicaid Child Core Set Measures. Use the most current version for the year being reported. See also Important Supplemental Materials for State-Collected Required BHC Measures derived from CMS Medicaid Adult and/or Child Core Set Measures (in this manual immediately before this specification).

[20]Adapted from an NCQA measure with financial support from the Office of the Assistant Secretary for Planning and Evaluation (ASPE) under Prime Contract No. HHSP23320100019WI/HHSP23337001T, in which NCQA was a subcontractor to Mathematica. Additional financial support was provided by the Substance Abuse and Mental Health Services Administration (SAMHSA).

Follow-Up After Emergency Department Visit for Mental Illness: Ages 6 to 17 (FUM-CH)

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-10-CM, ICD-10-PCS, POS, SNOMED, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Age	Ages 6 to 17 as of 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~~ [client] was between ages 6 and 17 on the date of the visit. The denominator for this measure is based on ED visits, not on ~~beneficiaries~~ [clients]. If a ~~beneficiary~~ [client] 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~~ [client] has more than one ED visit in a 31-day period, include only the first eligible ED visit. For example, if a ~~beneficiary~~ [client] 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 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: Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 6. 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.
Required exclusion	~~Beneficiaries~~ [Clients] in hospice or using hospice services anytime during the measurement year. For additional information, refer to the hospice exclusion guidance in ~~Section II. Data Collection and Reporting of the Child Core Set~~ [Section III. Technical Specification Components].

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).

Supplemental Materials For Follow-Up After Emergency Department Visit For Substance Use (FUA-AD AND FUA-CH)

Important Supplemental Materials for State-Collected Required BHC Measures derived from CMS Medicaid Adult and/or Child Core Set Measures (FUA-AD and FUA-CH)

These supplemental materials are necessary for implementation of the State-Collected Required BHC Measures that are derived from the CMS Medicaid Adult and/or Child Core Set Measures. This volume includes the exact specifications that are on the CMS website for the 2023 Medicaid Core Set, with simple modifications noted in the text. Limited additional needed modifications are included below, as well as supplemental useful materials.

1. **Measure FUA-AD: Follow-Up After Emergency Department Visit for Substance Use: Age 18 and Older**
2. **Measure FUA-CH: Follow-Up After Emergency Department Visit for Substance Use: Ages 6 TO 17**

For both FUA measures, the changes within the CMS Medicaid Adult and Child Core Sets specifications reflect: (1) substitution of the word "client" for "beneficiary" or "patient", unless the latter is part of a copyrighted code description; (2) removal of age stratification in the adult measure (i.e., applicable to adults ages 18 years and older); and (3) removal of references to the Core Set.

Additional information: For both the FUA measures, the following material is provided to assist clinics in using the specifications and follows the numbering system used in the non-Medicaid Core Set-derived BHC specifications

A. DESCRIPTION

Important Reporting Guidance:

- The FUA-AD and FUA-CH measures are to be used by states to measure performance related to clients seen at the Provider during the Measurement Year.
- Current value sets are available on the CMS Medicaid Adult Core Set Reporting Resource website and the CMS Medicaid Child Core Set Reporting Resource website. Use the version current for the year being reported.
- Both FUH-AD and FUD-CH are to be stratified separately based on whether the client is:
    - Medicaid only or Other (including those dually eligible for Medicare and Medicaid)

      AND
    - A member of which of the following ethnic groups: Not Hispanic or Latino, Hispanic or Latino, or Unknown

      AND
    - A member of which of the following racial groups: White or Caucasian, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or Other Pacific Islander, More than one race, or Unknown

- Refer to the specific data-reporting template for the reporting requirements applicable to each measure.

Measurement Period: The Measurement Period is the period for which data are required for reporting purposes. The FUA-AD and FUA-CH measure **denominators** are both January 1 through December 1, if the Measurement Year (MY) is the calendar year. The FUA-AD and FUA-CH measures include two submeasures, both of which are defined in the specification and both of which have a distinct Measurement Period for the **numerator**: (a) ***7-Day Follow-up*** (ED visit date through 7 days after visit date) and (b) ***30-Day Follow-up*** (ED visit date through 30 days after visit date).

B. DEFINITIONS

TERM	DEFINITION
Measurement Period	The specific time period for which data are needed for the numerator and denominator of a given measure. The Measurement Period may differ for the numerator and denominator and for each measure and is specified in section A above.
Measurement Year	The standard 12-month reporting period common to all measures being reported by the Provider.
Percentage	A Percentage is calculated as follows: numerator divided by denominator (n/d).
Provider	The Provider entity that is being measured (i.e., BHC)

E. ADDITIONAL NOTES

Interpretation of scores: Better quality = Higher Percentage

F. FREQUENTLY ASKED QUESTIONS

None

Measure FUA-AD: Follow-up After Emergency Department Visit for Substance Use: Age 18 and Older[8,16]

Based on a CMS Medicaid Adult Core Set Measure (2023), which is derived from a measure stewarded by the National Committee for Quality Assurance (NCQA)[20]

A. DESCRIPTION

Percentage of emergency department (ED) visits for ~~beneficiaries~~ [clients] age 18 and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up. Two rates are reported:

Percentage of ED visits for which the ~~beneficiary~~ [client] received follow-up within 30 days of the ED visit (31 total days)

Percentage of ED visits for which the ~~beneficiary~~ [client] follow-up within 7 days of the ED visit (8 total days)

Data Collection Method: Administrative

Guidance for Reporting:

For HEDIS, this measure has three reportable age groups and a total rate: ages 13 to 17, ages 18 to 64, age 65 and older, and total (age 13 and older). The [Medicaid] Child Core Set measure applies to beneficiaries ages 13 to 17 and the [Medicaid] Adult Core Set measure applies to beneficiaries age 18 and older. ~~For the purpose of Adult Core Set reporting, states should calculate and report this measure for two age groups (as applicable): ages 18 to 64 and age 65 and older.~~ [For the purpose of Behavioral Health Clinic (BHC) reporting, states should calculate and report this adult measure as one age group: clients ages 18 years and older.]

The denominator should be the same for the 30-day rate and the 7-day rate ~~within each age group~~.

The 30-day follow-up rate should be greater than or equal to the 7-day follow-up rate.

When a visit code or procedure code must be used in conjunction with a diagnosis code, the codes must be on the same claim or from the same visit.

If a value set includes codes used on professional claims (e.g., CPT, HCPCS) and includes codes used on facility claims (e.g., UB), use diagnosis and procedure codes from both facility and professional claims to identify services and diagnoses (the codes can be on the same claim or from the same visit).

If a value set includes codes used only on facility claims (e.g., UB) then use only facility claims to identify services and diagnoses (the codes must be on the same claim).

[16]Aside from the minor modifications noted in this specification, this specification is taken directly from the 2023 CMS Medicaid Adult Core Set Measures. Use the most current version for the year being reported.

See also Important Supplemental Materials for State-Collected Required BHC Measures derived from CMS Medicaid Adult and/or Child Core Set Measures (in this manual immediately before this specification).

[8]The NCQA HEDIS® measure specification has been adjusted pursuant to NCQA's Rules for Allowable Adjustments of HEDIS.

[20]Adapted from an NCQA measure with financial support from the Office of the Assistant Secretary for Planning and Evaluation (ASPE) under Prime Contract No. HHSP23320100019WI/HHSP23337001T, in which NCQA was a subcontractor to Mathematica. Additional financial support was provided by the Substance Abuse and Mental Health Services Administration (SAMHSA).

Follow-Up After Emergency Department Visit For Substance Use: Age 18 And Older (FUA-AD)

Include all paid, suspended, pending, and denied claims. Refer to [Appendix D of this manual] for the definition of a mental health provider. States must develop their own methods to identify mental health providers. NCQA's Medication List Directory (MLD) for Alcohol Use Disorder Treatment and Opioid Use Disorder Treatment medications *are available to order free of charge in the NCQA Store* (https://store.ncqa.org/hedis-my-2022-medication-list-directory.html). [Use version current for year reporting.] **Once ordered, the Medication List Directory can be accessed through the NCQA Download Center** (https://my.ncqa.org/Downloads). This measure includes an optional exclusion for ~~beneficiaries~~ [clients] who die during the measurement year. For additional information, refer to the deceased ~~beneficiary~~ [client] exclusion guidance in ~~Section II. Data Collection and Reporting of the Adult Core Set~~ [Section III. Technical Specification Components].

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. The Medication List Directory includes the following coding systems for medications: NDC and RxNorm. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Age	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, chemical dependency, and pharmacy. Note: ~~Beneficiaries~~ [Clients] with detoxification-only chemical dependency benefits do not meet these criteria.
Event/diagnosis	An ED visit (ED Value Set) with a principal diagnosis of SUD (AOD Abuse and Dependence Value Set) or any diagnosis of drug overdose (Unintentional Drug Overdose Value Set) on or between January 1 and December 1 of the measurement year where the ~~beneficiary~~ [client] was age 18 or older on the date of the visit. The denominator for this measure is based on ED visits, not on ~~beneficiaries~~ [clients]. If a ~~beneficiary~~ [client] 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~~ [client] has more than one ED visit in a 31-day period, include only the first eligible ED visit. For example, if a ~~beneficiary~~ [client] 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.
Required exclusion	~~Beneficiaries~~ [Clients] in hospice or using hospice services anytime during the measurement year. For additional information, refer to the hospice exclusion guidance in ~~Section II. Data Collection and Reporting of the Child Core Set~~ [Section III. Technical Specification Components].

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

30-Day Follow-Up

A follow-up visit or pharmacotherapy dispensing event within 30 days after the ED visit (31 total days). Include visits and pharmacotherapy events that occur on the date of the ED visit.

7-Day Follow-Up

A follow-up visit or pharmacotherapy dispensing event within 7 days after the ED visit (8 total days). Include visits and pharmacotherapy events 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 any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set)

An outpatient visit (Visit Setting Unspecified Value Set) with (Outpatient POS Value Set) with a mental health provider

Follow-Up After Emergency Department Visit For Substance Use: Age 18 And Older (FUA-AD)

An outpatient visit (BH Outpatient Value Set) with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set)

An outpatient visit (BH Outpatient Value Set) with a mental health provider

An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) with (Partial Hospitalization POS Value Set) with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set)

An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) with (Partial Hospitalization POS Value Set) with a mental health provider

An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set)

An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) with a mental health provider

A non-residential substance abuse treatment facility visit (Visit Setting Unspecified Value Set) with (Non-residential Substance Abuse Treatment Facility POS Value Set) with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set)

A non-residential substance abuse treatment facility visit (Visit Setting Unspecified Value Set) with (Non-residential Substance Abuse Treatment Facility POS Value Set) with a mental health provider

A community mental health center visit (Visit Setting Unspecified Value Set) with (Community Mental Health Center POS Value Set) with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set)

A community mental health center visit (Visit Setting Unspecified Value Set) with (Community Mental Health Center POS Value Set) with a mental health provider

An observation visit (Observation Value Set) with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set)

An observation visit (Observation Value Set) with a mental health provider

A peer support service (Peer Support Services Value Set) with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set)

An opioid treatment service that bills monthly or weekly (OUD Weekly Non Drug Service Value Set; OUD Monthly Office Based Treatment Value Set) with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set)

A telehealth visit (Visit Setting Unspecified Value Set) with (Telehealth POS Value Set) with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set)

A telehealth visit (Visit Setting Unspecified Value Set) with (Telehealth POS Value Set) with a mental health provider

A telephone visit (Telephone Visits Value Set), with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set)

A telephone visit (Telephone Visits Value Set), with a mental health provider

An e-visit or virtual check-in (Online Assessments Value Set), with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set)

An e-visit or virtual check-in (Online Assessments Value Set), with a mental health provider

A substance use disorder service (Substance Use Disorder Services Value Set)

A behavioral health screening or assessment for SUD or mental health disorders (Behavioral Health Assessment Value Set)

A substance use service (Substance Use Services Value Set)

A pharmacotherapy dispensing event (Alcohol Use Disorder Treatment Medications List, Opioid Use Disorder Treatment Medications List, see link to the Medication List Directory in Guidance for Reporting above) or medication treatment event (AOD Medication Treatment Value Set; OUD Weekly Drug Treatment Service 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).

Measure FUA-CH: Follow-Up After Emergency Department Visit for Substance Use: Ages 13 to 17[8,18]

Based on a CMS Medicaid Child Core Set Measure (2023), which is derived from a measure stewarded by the National Committee for Quality Assurance (NCQA)[20]

A. DESCRIPTION

Percentage of emergency department (ED) visits for ~~beneficiaries~~ [clients] ages 13 to 17 years with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up. Two rates are reported:

- Percentage of ED visits for which the ~~beneficiary~~ [client] received follow-up within 30 days of the ED visit (31 total days)
- Percentage of ED visits for which the ~~beneficiary~~ [client] received follow-up within 7 days of the ED visit (8 total days)

Data Collection Method: Administrative

[8]The NCQA HEDIS® measure specification has been adjusted pursuant to NCQA's Rules for Allowable Adjustments of HEDIS.

[20]Adapted from an NCQA measure with financial support from the Office of the Assistant Secretary for Planning and Evaluation (ASPE) under Prime Contract No. HSP23320100019WI/HHSP23337001T, in which NCQA was a subcontractor to Mathematica. Additional financial support was provided by the Substance Abuse and Mental Health Services Administration (SAMHSA).

[18]Aside from the minor modifications noted in this specification, this specification is taken directly from the 2023 CMS Medicaid Child Core Set Measures. Use the most current version for the year being reported. See also Important Supplemental Materials for State-Collected Required BHC Measures derived from CMS Medicaid Adult and/or Child Core Set Measures (in this manual immediately before this specification).

Guidance for Reporting:

- For HEDIS, this measure has three reportable age groups and a total rate: ages 13 to 17, ages 18 to 64, age 65 and older, and total (age 13 and older). The [Medicaid] Child Core Set measure applies to beneficiaries ages 13 to 17 and the [Medicaid] Adult Core Set measure applies to beneficiaries age 18 and older. [For the purpose of Behavioral Health Clinic (BHC) reporting, states should calculate and report this child measure as one age group: clients ages 13 to 17 years.]
- The denominator should be the same for the 30-day rate and the 7-day rate ~~within each age group~~.
- The 30-day follow-up rate should be greater than or equal to the 7-day follow-up rate.
- When a visit code or procedure code must be used in conjunction with a diagnosis code, the codes must be on the same claim or from the same visit.
  - If a value set includes codes used on professional claims (e.g., CPT, HCPCS) and includes codes used on facility claims (e.g., UB), use diagnosis and procedure codes from both facility and professional claims to identify services and diagnoses (the codes can be on the same claim or from the same visit).
  - If a value set includes codes used only on facility claims (e.g., UB) then use only facility claims to identify services and diagnoses (the codes must be on the same claim).
- Include all paid, suspended, pending and denied claims.
- Refer to [Appendix D of this manual] for the definition of a mental health provider. States must develop their own methods to identify mental health providers.
- NCQA's Medication List Directory (MLD) for Alcohol Use Disorder Treatment and Opioid Use Disorder Treatment medications *are available to order free of charge in the NCQA Store* (https://store.ncqa.org/hedis-my-2022-medication-list-directory.html). [Use version current for year reporting.] **Once ordered, the Medication List Directory can be accessed through the NCQA Download Center** (https://my.ncqa.org/Downloads).
- This measure includes an optional exclusion for ~~beneficiaries~~ [clients] who die during the measurement year. For additional information, refer to the deceased ~~beneficiary~~ [client] exclusion guidance in ~~Section II. Data Collection and Reporting of the Child Core Set~~ [Section III. Technical Specification Components].

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. The Medication List Directory includes the following coding systems for medications: NDC and RxNorm. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Age	Ages 13 to 17 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, chemical dependency, and pharmacy. Note: ~~Beneficiaries~~ [Clients] with detoxification-only chemical dependency benefits do not meet these criteria.

Event/diagnosis	An ED visit (ED Value Set) with a principal diagnosis of SUD (AOD Abuse and Dependence Value Set) or any diagnosis of drug overdose (Unintentional Drug Overdose Value Set) on or between January 1 and December 1 of the measurement year where the ~~beneficiary~~ [client] was between ages 13 and 17 on the date of the visit. The denominator for this measure is based on ED visits, not on ~~beneficiaries~~ [clients]. If a ~~beneficiary~~ [client] 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~~ [client] has more than one ED visit in a 31-day period, include only the first eligible ED visit. For example, if a ~~beneficiary~~ [client] 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: 7. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 8. 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.
Required exclusion	~~Beneficiaries~~ [Clients] in hospice or using hospice services anytime during the measurement year. For additional information, refer to the hospice exclusion guidance in ~~Section II. Data Collection and Reporting of the Child Core Set~~ [Section III. Technical Specification Components].

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

30-Day Follow-Up

A follow-up visit or pharmacotherapy dispensing event within 30 days after the ED visit (31 total days). Include visits and pharmacotherapy events that occur on the date of the ED visit.

7-Day Follow-Up

A follow-up visit or pharmacotherapy dispensing event within 7 days after the ED visit (8 total days). Include visits and pharmacotherapy events 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 any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set)
- An outpatient visit (Visit Setting Unspecified Value Set) with (Outpatient POS Value Set) with a mental health provider
- An outpatient visit (BH Outpatient Value Set) with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set)
- An outpatient visit (BH Outpatient Value Set) with a mental health provider
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) with (Partial Hospitalization POS Value Set) with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set)
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) with (Partial Hospitalization POS Value Set) with a mental health provider
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set)
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) with a mental health provider
- A non-residential substance abuse treatment facility visit (Visit Setting Unspecified Value Set) with (Non-residential Substance Abuse Treatment Facility POS Value Set) with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set)
- A non-residential substance abuse treatment facility visit (Visit Setting Unspecified Value Set) with (Non-residential Substance Abuse Treatment Facility POS Value Set) with a mental health provider
- A community mental health center visit (Visit Setting Unspecified Value Set) with (Community Mental Health Center POS Value Set) with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set)
- A community mental health center visit (Visit Setting Unspecified Value Set) with (Community Mental Health Center POS Value Set) with a mental health provider
- An observation visit (Observation Value Set) with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set)
- An observation visit (Observation Value Set) with a mental health provider
- A peer support service (Peer Support Services Value Set) with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set)

- An opioid treatment service that bills monthly or weekly (OUD Weekly Non Drug Service Value Set; OUD Monthly Office Based Treatment Value Set) with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set)
- A telehealth visit (Visit Setting Unspecified Value Set) with (Telehealth POS Value Set) with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set)
- A telehealth visit (Visit Setting Unspecified Value Set) with (Telehealth POS Value Set) with a mental health provider
- A telephone visit (Telephone Visits Value Set), with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set)
- A telephone visit (Telephone Visits Value Set), with a mental health provider
- An e-visit or virtual check-in (Online Assessments Value Set), with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set)
- An e-visit or virtual check-in (Online Assessments Value Set), with a mental health provider
- A substance use disorder service (Substance Use Disorder Services Value Set)
- A behavioral health screening or assessment for SUD or mental health disorders (Behavioral Health Assessment Value Set)
- A substance use service (Substance Use Services Value Set)
- A pharmacotherapy dispensing event (Alcohol Use Disorder Treatment Medications List, Opioid Use Disorder Treatment Medications List, see link to the Medication List Directory in Guidance for Reporting above) or medication treatment event (AOD Medication Treatment Value Set; OUD Weekly Drug Treatment Service Value Set)

D. ADDITIONAL NOTES

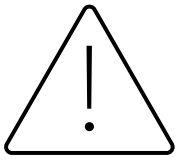
There may be different methods for billing intensive outpatient visits and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date, and units 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).

State-Collected Measures Optional for Submission as Part of CCBHC Demonstration

This section of Chapter V includes the following State-Collected optional measures:

1. Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH) — including supplemental materials
2. Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH) — including supplemental materials

Supplemental Materials for State-Collected Measures Optional for Submission as Part of CCBHC Demonstration (APP-CH and APM-CH)



Important Supplemental Materials for State-Collected Optional BHC Measures derived from CMS Medicaid Adult and/or Child Core Set Measures (APP-CH and APM-CH)

These supplemental materials are necessary for implementation of the State-Collected Optional BHC Measures that are derived from the CMS Medicaid Adult and/or Child Core Set Measures. This volume includes the exact specifications that are on the CMS website for the 2023 Medicaid Core Set, with all simple modifications noted in the text. Additional needed modifications are included below, as well as supplemental useful materials.

1. **Measure APP-CH: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics**
2. **Measure APM-CH: Metabolic Monitoring for Children and Adolescents on Antipsychotics**

Changes within the specification: For both the APP-CH and APM-CH measures, the changes in the specification from the CMS Medicaid Child Core Set reflects: (1) substitution of the word "client" for "beneficiary" or "patient", unless the latter is part of a copyrighted code description; (2) removal of age stratification included in the Core Set measures (i.e., applicable here to children ages 1 to 17 years); and (3) removal of references to the Core Set.

Additional information: For both the APP-CH and APM-CH measures, the following material is provided to assist clinics using the specifications and follows the numbering system used in the non-Core derived BHC specifications:

A. DESCRIPTION
Important Reporting Guidance:

- Both the APP-CH and APM-CH measures are optionally available to be used by states to measure performance related to clients seen at the Provider during the Measurement Year.
- Current value sets are available on the CMS Medicaid Child Core Set Reporting Resource website. Use the version current for the year being reported.
- Both APP-CH and APM-CH may be stratified separately based on whether the client is:
  - Medicaid only or Other (including those dually eligible for Medicare and Medicaid)
    AND
  - A member of which of the following ethnic groups: Not Hispanic or Latino, Hispanic or Latino, or Unknown
    AND

  - A member of which of the following racial groups: White or Caucasian, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or Other Pacific Islander, More than one race, or Unknown
- Refer to the specific data-reporting template for the reporting requirements applicable to each measure.

Measurement Period: The Measurement Period is the period for which data are required for reporting purposes.

- The APP-CH Measurement Period for the **denominator** has two components: (1) the ***Index Prescription Start Date (IPSD)***, which is January 1 through December 1, if the Measurement Year is the Calendar Year; and (2) the period of ***Negative Medication Review***, which is the 120 days before the IPSD. The Measurement Period for the **numerator** is 90 days prior to the IPSD through 30 days after the IPSD.
- The APM-CH Measurement Period for both the **denominator** and **numerator** are the Measurement Year.

B. DEFINITIONS

TERM	DEFINITION
Measurement Period	The specific time period for which data are needed for the numerator and denominator of a given measure. The Measurement Period may differ for the numerator and denominator and for each measure and is specified in section A above.
Measurement Year	The standard 12-month reporting period common to all measures being reported by the Provider.
Percentage	A Percentage is calculated as follows: numerator divided by denominator (n/d).
Provider	The Provider entity that is being measured (i.e., BHC)

E. ADDITIONAL NOTES

Interpretation of scores: Better quality = Higher Percentage

F. FREQUENTLY ASKED QUESTIONS

None

Measure APP-CH: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

Measure APP-CH: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics[8,18]

Based on a CMS Medicaid Child Core Set Measure (2023), which is derived from a measure stewarded by the National Committee for Quality Assurance (NCQA)[21]

A. DESCRIPTION

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

Data Collection Method: Administrative

Guidance for Reporting:

This measure applies to ~~beneficiaries~~ [clients] ages 1 to 17. For the purpose of [Medicaid] Child Core Set reporting, states ~~should~~ calculate and report this measure for two age groups and a total rate: ages 1 to 11, ages 12 to 17, and total (ages 1 to 17). [For the purpose of Behavioral Health Clinic reporting, states should report only the total rate.]

This measure intends to assess use of psychosocial care as a first-line treatment for conditions for which antipsychotic medications are not indicated. This measure's value set contains typical forms of psychological services, such as behavioral interventions, psychological therapies, and crisis intervention.

Include all paid, suspended, pending, and denied claims.

This measure includes an optional exclusion for ~~beneficiaries~~ [clients] who die during the measurement year. For additional information, refer to the deceased ~~beneficiary~~ [client] exclusion guidance in ~~Section II. Data Collection and Reporting of the Child Core Set~~ [Section III. Technical Specification Components].

NCQA's Medication List Directory (MLD) for Antipsychotic Medications and Antipsychotic Combination Medications *is available to order free of charge in the NCQA Store* (https://store.ncqa.org/hedis-my-2022-medication-list-directory.html*).* **[**Use version current for year reporting.] **Once ordered, the Medication List Directory can be accessed through the NCQA Download Center (**https://my.ncqa.org/Downloads**).**

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-10-CM, ICD-10-PCS, POS, SNOMED, and UB. The Medication List Directory includes the following coding systems for medications: NDC and RxNorm. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Intake Period	January 1 through December 1 of the measurement year.

[18]Aside from the minor modifications noted in this specification, this specification is taken directly from the 2023 CMS Medicaid Child Core Set Measures. Use the most current version for the year being reported. See also Important Supplemental Materials for State-Collected Optional BHC Measures derived from CMS Medicaid Adult and/or Child Core Set Measures (in this manual immediately before this specification).

[8]The NCQA HEDIS® measure specification has been adjusted pursuant to NCQA's Rules for Allowable Adjustments of HEDIS.

[21]The original measure was developed with financial support from the Agency for Healthcare Research and Quality (AHRQ) and CMS under the CHIPRA Pediatric Quality Measures Program Centers of Excellence grant number U18 HS020503, from a measure developed by MedNet Medical Solutions.

IPSD	Index Prescription Start Date (IPSD). The earliest prescription dispensing date for an antipsychotic medication where the date is in the Intake Period and there is a Negative Medication History.
Negative Medication History	A period of 120 days (4 months) prior to the IPSD when the ~~beneficiary~~ [client] had no antipsychotic medications dispensed for either new or refill prescriptions.

C. ELIGIBLE POPULATION

Age	Ages 1 to 17 as of December 31 of the measurement year.
Continuous enrollment	120 days (4 months) prior to the IPSD through 30 days after the IPSD.
Allowable gap	No allowable gaps in the continuous enrollment period.
Anchor date	IPSD.
Benefit	Medical, mental health, and pharmacy.
Event/diagnosis	Follow the steps below to identify the eligible population. Step 1 Identify all ~~beneficiaries~~ [clients] in the specified age range who were dispensed an antipsychotic medication (Antipsychotic Medications List and Antipsychotic Combination Medications List, see link to the Medication List Directory in Guidance for Reporting above) during the Intake Period. Step 2 Test for Negative Medication History. For each ~~beneficiary~~ [client] identified in step 1, test each antipsychotic prescription for a Negative Medication History. The IPSD is the dispensing date of the earliest antipsychotic prescription in the Intake Period with a Negative Medication History. Step 3 Calculate continuous enrollment. ~~Beneficiaries~~ [Clients] must be continuously enrolled for 120 days (4 months) prior to the IPSD through 30 days after the IPSD. Step 4: Required exclusions Exclude ~~beneficiaries~~ [clients] for whom first-line antipsychotic medications may be clinically appropriate. Any of the following during the measurement year meet criteria: At least one acute inpatient encounter with a diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder, other psychotic disorder, autism, or other developmental disorder during the measurement year. Either of the following code combinations meet criteria: BH Stand Alone Acute Inpatient Value Set with (Schizophrenia Value Set; Bipolar Disorder Value Set; Other Psychotic and Developmental Disorders Value Set). Visit Setting Unspecified Value Set with Acute Inpatient POS Value Set with (Schizophrenia Value Set; Bipolar Disorder Value Set; Other Psychotic and Developmental Disorders Value Set).

Event/diagnosis (continued)	At least two visits in an outpatient, intensive outpatient, or partial hospitalization setting, on different dates of service, with a diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder, other psychotic disorder, autism, or other developmental disorder during the measurement year. Any of the following code combinations with (Schizophrenia Value Set; Bipolar Disorder Value Set; Other Psychotic and Developmental Disorders Value Set), meet criteria: An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set). An outpatient visit (BH Outpatient Value Set). An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set). An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set). A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set). Electroconvulsive therapy (Electroconvulsive Therapy Value Set). An observation visit (Observation Value Set). A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set). A telephone visit (Telephone Visits Value Set). An e-visit or virtual check-in (Online Assessments Value Set). ~~Beneficiaries~~ [Clients] in hospice or using hospice services anytime during the measurement year. For additional information, refer to the hospice exclusion guidance in ~~Section II. Data Collection and Reporting of the Child Core Set~~ [Section III. Technical Specification Components].

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

Documentation of psychosocial care (Psychosocial Care Value Set) in the 121-day period from 90 days prior to the IPSD through 30 days after the IPSD.

Measure APM-CH: Metabolic Monitoring for Children and Adolescents on Antipsychotics

Measure APM-CH: Metabolic Monitoring for Children and Adolescents on Antipsychotics[8,18]

Based on a CMS Medicaid Child Core Set Measure (2023), which is derived from a measure stewarded by the National Committee for Quality Assurance (NCQA)[21]

A. DESCRIPTION

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

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

Percentage of children and adolescents on antipsychotics who received cholesterol testing

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

Data Collection Method: Administrative[22]

Guidance for Reporting:

This measure applies to ~~beneficiaries~~ [clients] ages 1 to 17. For the purpose of [Medicaid] Child Core Set reporting, states ~~should~~ calculate and report this measure for two age groups and a total rate: ages 1 to 11, ages 12 to 17, and total (ages 1 to 17). [For the purpose of Behavioral Health Clinic reporting, states should report only the total rate.]

Include all paid, suspended, pending, and denied claims.

This measure includes an optional exclusion for ~~beneficiaries~~ [clients] who die during the measurement year. For additional information, refer to the deceased ~~beneficiary~~ [client] exclusion guidance in ~~Section II. Data Collection and Reporting of the Child Core Set~~ [Section III. Technical Specification Components].

NCQA's Medication List Directory (MLD) for Antipsychotic, Antipsychotic Combination, and Prochlorperazine medications *are available to order free of charge in the NCQA Store (*https://store.ncqa.org/hedis-my-2022-medication-list-directory.html*).* [Use version current for year reporting.] **Once ordered, the Medication List Directory can be accessed through the NCQA Download Center** (https://my.ncqa.org/Downloads).

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, LOINC, SNOMED, and UB. The Medication List Directory includes the following coding systems for medications: NDC and RxNorm. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

[18]Aside from the minor modifications noted in this specification, this specification is taken directly from the 2023 CMS Medicaid Child Core Set Measures. Use the most current version for the year being reported. See also Important Supplemental Materials for State-Collected Optional BHC Measures derived from CMS Medicaid Adult and/or Child Core Set Measures (in this manual immediately before the APP-CH specification).

[8]The NCQA HEDIS® measure specification has been adjusted pursuant to NCQA's Rules for Allowable Adjustments of HEDIS.

[21]The original measures was developed with financial support from the Agency for Healthcare Research and Quality (AHRQ) and CMS under the CHIPRA Pediatric Quality Measures Program Centers of Excellence grant number U18 HS020503, from a measure developed by MedNet Medical Solutions.

[22]The Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) measure is also specified for Electronic Clinical Data System (ECDS) reporting for HEDIS. ECDS specifications are not currently available for Child Core Set reporting.

Measure APM-CH: Metabolic Monitoring for Children and Adolescents on Antipsychotics

B. ELIGIBLE POPULATION

Age	Ages 1 to 17 as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement year.
Anchor date	December 31 of the measurement year.
Benefit	Medical and pharmacy.
Event/diagnosis	At least two antipsychotic medication dispensing events (Antipsychotic Medications List, Antipsychotic Combination Medications List, Prochlorperazine Medications List, see link to the Medication List Directory in Guidance for Reporting above) of the same or different medications, on different dates of service during the measurement year.
Required exclusion	~~Beneficiaries~~ [Clients] in hospice or using hospice services anytime during the measurement year. For additional information, refer to the hospice exclusion guidance in ~~Section II. Data Collection and Reporting of the Child Core Set~~ [Section III. Technical Specification Components].

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

Blood Glucose

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

Cholesterol

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

Blood Glucose and Cholesterol

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

At least one test for blood glucose (Glucose Lab Test Value Set, Glucose Test Result or Finding Value Set) or HbA1c (HbA1c Lab Test Value Set, HbA1c Test Result or Finding Value Set).

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

VI. Appendices

Appendix A. Glossary of Terms
Appendix B. Denominator and Numerator Measurement Periods for BHC Quality Measures
Appendix C. Guidance for Selecting Sample Sizes for Hybrid Measures
Appendix D. Definitions of Medicaid/CHIP Core Set Practitioner Types
Appendix E. Core Set Value Set Directory User Manual

Appendix A. Glossary of Terms

Appendix A. Glossary of Terms

BHC. A BHC is a Behavioral Health Clinic (including but not limited to CCBHCs and CCBHC-Es). BHC measures are broadly specified to be calculated at the BHC level.

BHC Provider. Any entity (provider) engaged in the delivery of health care services and who is legally authorized to do so by the state in which the individual or entity delivers the services and who delivers services as a BHC (entity) or part of a BHC (provider). See Appendix D for definitions of certain practitioner types.

CCBHC. A Certified Community Behavioral Health Clinic (CCBHC) is a BHC certified by the state to participate in the Section 223 Demonstration to improve community mental health services authorized by Section 223 of the federal Protecting Access to Medicare Act (PAMA). See the CCBHC Certification Criteria for more information.

CCBHC-E. A CCBHC-E is a BHC that has received a SAMHSA discretionary grant to operate as a CCBHC-Expansion clinic and that has self-attested to meeting the CCBHC Certification Criteria. Some CCBHC-Es may be required by the terms of their grant to report clinic-reported quality measures. Additionally, some CCBHC-Es also are Section 223 Demonstration CCBHCs and, therefore, required to report according to that Demonstration.

Client, Patient, or Person Receiving Services. An individual (adult or child) receiving services from a BHC program.

Data-Reporting Template. In addition to the measures specified in this manual, data-reporting templates have been developed for reporting these measures. Those templates will be available on the SAMHSA website. Within each template, specific fields are provided for required data elements. Those fields are as follows:

- Measurement Year: Identifies the year to which the report corresponds (e.g., Demonstration Year 6, Fiscal Year 2023)
- Data Source: Identifies whether the data are derived from administration claims data, medical records, a hybrid source, or a survey
- Date Range for Measurement Period: Identifies the Measurement Period in which data were collected that are used in calculating the denominator and numerator of a measure (not necessarily the same as the Measurement Year)
- Performance Measure: The description of, and table for calculation of and reporting, the measure rate
- Adherence to Measure Specifications: Allows the reporter to indicate the population measured and ways in which data collection or reporting might differ

from the specifications

- Additional Notes: Allows the reporter to provide additional information

Designated Collaborating Organization. Briefly, a Designated Collaborating Organization (DCO) is an entity that is not under the direct supervision of the CCBHC but is engaged in a formal relationship with the CCBHC to deliver one or more (or elements of) of the required services as described in CCBHC certification criteria 4. Appendix A of the CCBHC certification criteria include a full definition.

Eligible Population for Measurement. In the broadest sense, the eligible population for these measures includes all BHC clients served by a BHC provider. The

- denominator-eligible population for each measure includes BHC clients who satisfy the measure-specific eligibility criteria, which may include requirements such as age or continuous enrollment. The specifications in Chapters IV and V indicate the population that should be included in each measure. For all measures, the denominator includes clients (or visits) that satisfy measure-specific eligibility criteria (e.g., all clients aged 18 years and older who were seen at the BHC during the Measurement Year for a specified number of coded encounters (Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling (ASC)).
- States will, for all state-collected measures, except the experience of care survey measures (PEC and Y/FEC), obtain data on populations eligible for measurement from claims and encounter data in their Transformed Medicaid Statistical Information System (T-MSIS). Behavioral health clinics will rely on internal records for data to support clinic-collected measures.

Measure. Quality or performance measures follow a particular formula; the denominator indicates the eligible population (with the exceptions of any exclusions specific to the measure), and the numerator indicates the part of the eligible population that received the service or had the outcome to which the measure relates. There are a few exceptions included in the BHC measures, including I-SERV, PEC, and Y/FEC, where the denominator and numerator do not follow this formula.

Measure Steward. The measure steward is the organization responsible for maintaining a particular measure or measure set. Responsibilities of the measure steward include updating codes that are included in technical specifications and adjusting measures as the clinical evidence changes.

Measurement Period. The specific time period for which data are needed for the numerator and denominator of a given measure. Measurement Periods may differ for the numerator and denominator or they may be the same and they may or may not be the same

as the Measurement Year.

Measurement Year. The standard 12-month reporting period common to all measures being reported by the Provider.

Quality Bonus Measure (QBM). QBMs are the subset of measures that have been selected for incentive payments (Quality Bonus Payments or QBPs) as part of the Section 223 Demonstration Program (see Tables 1 and 2 in this manual).

Appendix B. Denominator and Numerator Measurement Periods for BHC Quality Measures

Appendix B. Denominator and Numerator Measurement Periods for BHC Quality Measures

For all BHC measures sourced from the CMS Medicaid Adult and/or Child Core Set Measures, **please see the most current information on measure-specific Measurement Periods on the CMS website** at Link to CMS Adult and Child Health Care Quality Measures.

For the FFY 2023 Measurement Period Tables, which correspond to the BHC measures as published in 2023, links to the tables are at Link to Adult Medicaid Core Set Measurement Period Table and Link to Child Medicaid Core Set Measurement Period Table.

For the BHC measures, as published in 2023, the measures sourced from the Medicaid Core Sets include those listed in ***Table B1***.

Table B1. BHC Measures Sourced from CMS Medicaid Adult and/or Child Core Sets in 2023

Clinic-Collected Measures
Screening for Clinical Depression and Follow-Up Plan (CDF-AD and CDF-CH)
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-CH) (optional for clinics)
Controlling High Blood Pressure (CBP-AD) (optional for clinics)
State-Collected Measures
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)
Follow-Up After Hospitalization for Mental Illness, ages 18+ (adult) (FUH-AD and FUH-CH)
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD)
Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD and FUM-CH)
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA-AD and FUA-CH)
Plan All-Cause Readmissions Rate (PCR-AD)
Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder (ADHD) Medication (ADD-CH)
Antidepressant Medication Management (AMM-BH)
Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)
Hemoglobin A1c Control for Patients with Diabetes (HBD-AD)
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH) (optional for states)
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH) (optional for states)

The Measurement Periods for all other BHC measures are identified in ***Table B2***.

Appendix B. Denominator and Numerator Measurement Periods for BHC Quality Measures

Table B2. Measurement Periods for BHC Measures NOT Sourced from CMS Medicaid Adult and/or Child Core Set Measures

Measure	Denominator	Numerator
Clinic-Collected Measures		
Time to Services (I-SERV)		
• I-SERV Submeasures 1 and 2	MY, excluding the last month of the MY, and including the 6 months preceding the MY	MY
• I-SERV Submeasure 3	MY, excluding the last 24 hours, and including the 24 hours immediately preceding the MY	MY
Depression Remission at Six Months (DEP-REM-6)	MY	Four months after the beginning of the MY through eight (8) months past the end of the MY
Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC)	MY	MY and the prior year
Screening for Social Drivers of Health (SDOH)	MY	MY
Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC) (optional for clinics)		
• TSC Submeasure 1	MY	MY
• TSC Submeasures 2 and 3	MY	MY and the prior 6 months
Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-A) (optional for clinics)	MY	MY and the prior 105 days
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-C) (optional for clinics)	MY	MY
State-Collected Measures		
Patient Experience of Care Survey (PEC)	MY	MY
Youth/Family Experience of Care Survey (Y/FEC)	MY	MY

Key: MY, Measurement Year

Appendix C. Guidance for Selecting Sample Sizes for Hybrid Measures

Appendix C. Guidance for Selecting Sample Sizes for Hybrid Measures

Three of the BHC measures include options to collect data and calculate using a hybrid approach, along with other options. The three measures are all sourced from the CMS Medicaid Adult Core Set Measures (as of 2023). They are identified in ***Table C1***.

Table C1. BHC Measures with Option to Use a Hybrid Approach

Measure
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-CH) (measure optional for clinics)
Controlling High Blood Pressure (CBP-AD) (measure optional for clinics)
Hemoglobin A1c Control for Patients with Diabetes (HBD-AD) (measure required for states)

For these three BHC measures that are sourced from the CMS Medicaid Adult Core Set Measures, **please see the most current information from CMS on Selecting Sample Sizes for HEDIS® Hybrid Measures on the CMS website** at Link to CMS Adult and Child Health Care Quality Measures.

As of 2023, the current information is in Appendix B of the Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set), Technical Specifications and Resource Manual for Federal Fiscal Year 2023 Reporting.

Additional guidance on sampling for hybrid measures is available in the following CMS technical assistance brief designed to assist reporters of the CMS Child or Adult Core Sets for Medicaid/CHIP measures: "Approaches to Using the Hybrid Method to Calculate Measures from the Child and Adult Core Sets" (October 2014).[4]

[4]Medicaid Core Measure Technical Assistance briefs can be found at the Adult and Child Health Care Quality Measures website.

Appendix D. Definitions of Medicaid/CHIP Core Set Practitioner Types

Appendix D. Definitions of Medicaid/CHIP Core Set Practitioner Types

In many of the BHC measure specifications that are sourced from the CMS Medicaid Adult and/or Child Core Set Measures references are made to definitions of Medicaid/CHIP Core Set practitioner types.

For those, **please see the most current information from CMS on Definitions of Medicaid/CHIP Core Set Practitioner Types on the CMS website** at Link to CMS Adult and Child Health Care Quality Measures.

As of 2023, the current information is in:
Appendix E of the Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set), Technical Specifications and Resource Manual for Federal Fiscal Year 2023 Reporting
and in
Appendix C of the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set), Technical Specifications and Resource Manual for Federal Fiscal Year 2023 Reporting.

Appendix E. Core Set Value Set Directory User Manual

Appendix E. Core Set Value Set Directory User Manual

Many of the BHC measure specifications that are sourced from the CMS Medicaid Adult and/or Child Core Set Measures reference value sets that are identified in the specification, for example, as follows: Schizophrenia Value Set.

For assistance with use of value sets in BHC measure specifications that are sourced from the CMS Medicaid Adult and/or Child Core Sets, **please see the most current information from CMS in the Core Set HEDIS® Value Set Directory User Manual on the CMS website** at Link to CMS Adult and Child Health Care Quality Measures.

As of 2023, the current information is in
Appendix A of the Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set), Technical Specifications and Resource Manual for Federal Fiscal Year 2023 Reporting
and in
Appendix A of the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set), Technical Specifications and Resource Manual for Federal Fiscal Year 2023 Reporting.

Photos are for illustrative purposes only.

Any person depicted in a photo is a model.

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SAMHSA's mission is to lead public health and service delivery efforts that promote mental health, prevent substance misuse, and provide treatments and supports to foster recovery while ensuring equitable access and better outcomes.

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