Metrics and Quality Measures for Behavioral Health Clinics

Technical Specifications and Resource Manual

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I. BEHAVIORAL HEALTH CLINIC QUALITY MEASURES

Background

This manual provides the specifications for and general information related to quality measures and other metrics developed to be used at the provider level by Behavioral Health Clinics (BHCs). We refer to these collectively as measures in this document, unless there is a need to distinguish them (see Chapter II for a definition of each).

The measures included in this document 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). The measures in this document are intended for use by BHCs generally as well as by the CCBHCs. Where relevant, we indicate if the requirements placed on CCBHCs differ from the standards discussed in this introductory material or elsewhere in these specifications. Some of these quality measures are re-specifications of existing measures that are now designed to be used at the clinic level. Other measures are new and are designed to address aspects of care important for BHCs in general and the CCBHCs specifically. For more information on the requirements for quality measure reporting applicable to the CCBHCs, see Program Requirement 5 of the CCBHC Certification Criteria which identifies 32 specific measures, and the section of this Chapter entitled "The Behavioral Health Clinic Quality Measures," which clarifies changes made to those requirements. Of these quality measures, 11 will or may be used by states to make Quality Bonus Payments (QBPs) under the Section 223 behavioral health demonstration.

Data and quality measure reporting have multiple objectives. Collection and reporting of this information offer providers, states, and other stakeholders a better method for assessing the manner in which care is accessed and provided. The information can be used for internal quality improvement (QI) processes to determine the degree of progress achieved or to determine where new or additional improvement is needed. The data can be used for accountability, to grantors or regulatory entities, for example. Some quality measures can be used as part of incentive programs, such as the QBPs that are part of the Section 223 behavioral health demonstration Prospective Payment System (PPS) methodology. The data and measures reported also may be used to evaluate programs, such as the national evaluation of the CCBHC Demonstration Program. In general, the data collected will help states and the federal government to have a better understanding of the quality of health care that consumers at BHCs receive.

Specification sources. This manual includes specifications for quality measures derived from multiple sources. In most cases, the original measures were designed for reporting at the state or health plan level. Each measure has been re-specified to enable reporting at the BHC level. This manual includes the most current version of the measure specifications available as of December 2015, altered to enable reporting at the BHC level. For Healthcare Effectiveness Data and

Information Set (HEDIS) measures, this manual follows HEDIS 2016 specifications, with the exception of the Follow-Up After Emergency Department Visit for Mental Illness (FUM) and Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA) measures, which are draft 2017 HEDIS measures. For non-HEDIS measures, this manual includes the most applicable version of the specifications available from the measure steward for reporting 2015 data, re-specified where necessary at the BHC level. Some measures were developed by SAMHSA specifically for this document.

Measure testing on measures that are not derived from National Quality Forum (NQF)-endorsed measures is limited. Some of the measures that are derived from NQF-endorsed measures were originally specified at the health plan level and for purposes of this demonstration have been re-specified at the clinic level (e.g., PCR-BH). Data from these measures (and all of the quality measures) will be reviewed in an on-going manner to insure the integrity of the measures.

The Behavioral Health Clinic Quality Measures

Tables 1 and 2 identify the Behavioral Health Clinic measures. These measures are rooted in those specified in Program Requirement 5 of the CCBHC Certification Criteria for the Section 223 behavioral health demonstration. The measures that pertain to QBPs made through the CCBHC demonstration and the six measures which must be achieved in order for a clinic to receive a QBP payment (see PPS guidance, Table 3) are specifically identified. Table 1 is composed of BHC-lead measures while Table 2 lists measures requiring data collection by the state (state-lead measures).

Three primary changes have been made from the original measures identified in the CCBHC Certification Criteria. First, three measures (Patient Experience of Care Survey (PEC), Youth/Family Experience of Care Survey (Y/FEC), and Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-BH)) were specified in Program Requirement 5 of the CCBHC Certification Criteria as BHC-lead but have been moved from BHC reporting to state reporting. Second, two other measures enumerated in the Certification Criteria also have changed. The measure Cardiovascular Health Screening for People With Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications (NQF #1927) was dropped as it is no longer in accordance with treatment guidelines. The measure Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence was dropped and replaced with two measures, Follow-Up After Emergency Department Visit for Mental Illness (FUM) and Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA). The follow-up measure that originally was to be included is no longer maintained by the steward and is being replaced by the two newer measures designed to be used as HEDIS measures in 2017. The substitution of two measures does not expand the extent of reporting because the original measure contained 4 rates (7-day and 30-day follow-up after being seen in an emergency department for mental illness or, separately, alcohol and other drug dependence). The replacement measures merely separate the reasons for the emergency visit

into distinct measures. Third, the number of measures required as part of the CCBHC demonstration program is now 22. The remainder of the measures in this manual are available for use by states, BHCs or CCBHCs as states or other entities may wish. The lists of measures in Tables 1 and 2 identify those that are or are not required of CCBHCs.

The technical specifications in Chapters IV and V of this manual provide additional details for each measure.

Table 1. Behavioral Health Clinic, Clinic-Lead Measures

Measure Name	Measure Steward[a]	NQF #	CCBHC Demonstration Measure	CMS Medicaid Core Set	CCBHC QBM
Routine Care Needs (ROUT)	SAMHSA	NA	No	NA	NA
Time to Initial Evaluation (I-EVAL)	SAMHSA	NA	Yes	NA	NA
Time to Comprehensive Person and Family-Centered Diagnostic and Treatment Planning Evaluation (TX-EVAL)	SAMHSA	NA	No	NA	NA
Deaths by Suicide (SUIC)	SAMHSA	NA	No	NA	NA
Documentation of Current Medications in the Medical Records (DOC)	CMS	0419	No	NA	NA
Preventive Care and Screening: Adult Body Mass Index (BMI) Screening and Follow-Up (BMI-SF)	CMS	0421	Yes	NA	NA
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-BH)	NCQA	0024	Yes	Child Core	NA
Controlling High Blood Pressure (CBP-BH)	NCQA	0018	No	Adult Core	NA
Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC)	AMA-PCPI	0028	Yes	NA	NA
Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC)	AMA-PCPI	2152	Yes	NA	NA
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-BH-C)	AMA-PCPI	1365	Yes	Child Core	R
Major Depressive Disorder: Suicide Risk Assessment (SRA-A)	AMA-PCPI	0104	Yes	NA	R
Screening for Clinical Depression and Follow-Up Plan (CDF-BH)	CMS	0418	Yes	Adult Core	NR

Measure Name	Measure Steward[a]	NQF #	CCBHC Demonstration Measure	CMS Medicaid Core Set	CCBHC QBM
Depression Remission at Twelve Months (DEP-REM-12)	Minnesota Community Measurement	0710	Yes	NA	NR

Abbreviations: AMA-PCPI, American Medical Association-Physician Consortium for Performance Improvement; CMS, Centers for Medicare & Medicaid Services; NA, not applicable; NCQA, National Committee for Quality Assurance; NQF, National Quality Forum; NR, Not required to be a QBM; QBM, Quality Bonus Measure in the CCBHC Demonstration Program; R, Required; SAMHSA, Substance Abuse and Mental Health Services Administration

[a] 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.

Table 2. Behavioral Health Clinic State-Lead Measures

Measure Name	Measure Steward[a]	NQF #	CCBHC Demonstration Measure	CMS Medicaid Core Set	CCBHC QBM
Housing Status (HOU)	SAMHSA	NA	Yes	NA	NA
Suicide Attempts (SU-A)	SAMHSA	NA	No	NA	NA
Patient Experience of Care Survey (PEC)	SAMHSA	NA	Yes	NA	NA
Youth/Family Experience of Care Survey (Y/FEC)	SAMHSA	NA	Yes	NA	NA
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	NCQA	NA	Yes	NA	NA
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)	NCQA	NA	Yes	NA	NA
Plan All-Cause Readmission Rate (PCR-BH)	NCQA	1768	Yes	Adult Core	NR
Diabetes Screening for People with Schizophrenia or Bipolar Disorder who Are Using Antipsychotic Medications (SSD)	NCQA	1932	Yes	NA	NA

Measure Name	Measure Steward[a]	NQF #	CCBHC Demonstration Measure	CMS Medicaid Core Set	CCBHC QBM
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (SMI-PC)	NCQA	2607	No	NA	NA
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	NCQA	NA	No	NA	NA
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)	NCQA	1933	No	NA	NA
Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder (AMS-BD)	CMS	1880	No	NA	NA
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-BH)	CMS	NA	Yes	Adult Core	R
Follow-Up After Hospitalization for Mental Illness, ages 21+ (adult) (FUH-BH-A)	NCQA	0576	Yes	Adult Core	R
Follow-Up After Hospitalization for Mental Illness, ages 6 to 21 (child/adolescent) (FUH-BH-C)	NCQA	0576	Yes	Child Core	R
Follow-up care for children prescribed ADHD medication (ADD-BH)	NCQA	0108	Yes	Child Core	NR
Antidepressant Medication Management (AMM-BH)	NCQA	0105	Yes	Adult Core	NR
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-BH)	NCQA	0004	Yes	Adult Core	R

Abbreviations: CMS, Centers for Medicare & Medicaid Services; NA, not applicable; NCQA, National Committee for Quality Assurance; NQF, National Quality Forum; NR, Not required to be a QBM; QBM, Quality Bonus Measure in the CCBHC Demonstration Program; R, Required; SAMHSA, Substance Abuse and Mental Health Services Administration

[a]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.

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

To support consistency in reporting the BHC measures, this chapter provides general guidelines for data collection, preparation, and reporting. Technical specifications, which provide detailed information on how to calculate each measure, are presented in Chapters IV and V. For technical assistance with calculating and reporting these measures, contact the technical assistance (TA) mailbox at Section223Feedback@samhsa.hhs.gov.

Definitions

- **BHC.** A BHC is a Behavioral Health Clinic. These measures are broadly specified to be applicable to BHCs.
- **BHC Client, Consumer, or Patient.** An individual (adult or child) receiving services from a BHC program.
- **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 clinic certified by the state to participate in demonstration programs to improve community mental health services authorized by Section 223 of the federal Protecting Access to Medicare Act. See the Certification Criteria for more information.
- **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:
    A. Measurement Year: Identifies the year to which the report corresponds (e.g., Demonstration Year 1, Fiscal Year 2017)
    B. Data Source: Identifies whether the data are derived from administration claims data, medical records, a hybrid source, or a survey
    C. Date Range: Identifies the Measurement Period in which data were collected that are used in calculating the denominator and numerator (not necessarily the same as the Measurement Year)
    D. Performance Measure: The description of, and table for calculation of, the measure

E. 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

F. Additional Notes: Allows the reporter to provide additional information

- **Eligible Population for Measurement.** In the broadest sense, the eligible population for these measures includes all BHC consumers served by a BHC provider. The denominator-eligible population for each measure includes BHC consumers who satisfy the measure-specific eligibility criteria that may include requirements such as age and continuous enrollment. The specifications in Chapters IV and V indicate the population that should be included in each measure and the reporting unit for the measure. For all measures, the denominator includes consumers (or visits) that satisfy measure-specific eligibility criteria (e.g., all consumers aged 12 years and older seen at least once at the BHC during the measurement year (Suicide Attempts (SU-A)); all episodes of care during the measurement year for consumers 6–17 years of age with a new or recurrent episode of Major Depressive Disorder (Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-BH-C))).

  States will derive data on populations eligible for measurement from their Medicaid Management Information Systems (MMIS) for state-reported measures. Behavioral health clinics will rely on internal records for data to support BHC-reported measures. Because these measures are specified and aggregated at the BHC level, the eligible population differs from that in many of the source measures which are specified at the health plan level.

- **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.

- **Metric.** The word "metrics," as used in this manual, refers to statistics designed to allow the collection of data distinct from a quality or performance measure (e.g., the mean number of days until initial evaluation for new consumers (I-EVAL)). Unless the context makes it necessary to distinguish them, metrics in this manual are referred to as measures.

- **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 CCBHC Demonstration Program. These measures are discussed in more detail below in the section of this Chapter (II) related to Data Collection and Preparation for Reporting.

Data Collection and Preparation for Reporting

Data reporting time frames. Data reporting involves "measurement years." For reporting related to the CCBHC Demonstration Program, measurement year (MY) is defined as the Demonstration Year (DY) and is reported as DY1 or DY2. The CCBHC DYs will both be full 12 month years. Hence, if DY1 begins on March 1, 2017, it will continue through February 28, 2018. For non-CCBHC-related reporting, the entity requiring reporting will specify the period of time, but annual collection of data typically will align with the calendar year prior to the reporting year; for example, calendar year 2016 data would be reported for Federal Fiscal Year (FFY) 2017.

- ***Reporting:*** For all measures, states and BHCs should indicate start and end dates for the measurement year using Section A (Measurement Year) of the data-reporting templates. For CCBHCs, this time frame would be the 12-month period identified as DY1 or DY2. The data-reporting templates are discussed in detail below.

Data collection time frames. Data collection involves "measurement periods." A measurement period (MP) often corresponds with the measurement year. Some measurement periods, however, are indexed to a specific date or event or may require some other modification to collection that corresponds with the measurement year (e.g., Depression Remission at Twelve Months (DEP-REM-12), which is indexed to the time of diagnosis or recurrence of an episode of depression within the measurement year). States and BHCs should adhere to the measurement periods identified in the technical specification for each measure. In addition to information provided about measurement periods in each specification, measurement periods for each measure are summarized in Appendix A. For the sake of simplicity, examples in Appendix A reflect the calendar year. For a CCBHC, however, because the measurement year will vary by state in terms of start and end date (e.g., March 1, 2017 through February 28, 2018), the MP must be adjusted to reflect that measurement year. For example, for a measurement year beginning March 1, 2017, the MP for the denominator for Follow-up After Hospitalization for Mental Illness (FUH-BH-A) would run from March 1, 2017 until January 29, 2018 (the measurement year less 30 days). To assist CCBHCs where measurement years may begin at some point after January 1, MPs for all measures for DY1 and DY2 are provided in the final worksheet of the data-reporting templates, entitled "Measurement Periods."

- ***Reporting:*** For all measures, states and BHCs should indicate start and end dates for the MP for the denominator and numerator using Section C (Date Range) of the data-reporting templates. CCBHCs should use the final worksheet (Measurement Periods) in the templates for guidance on MPs.

Unit of reporting. The unit of reporting in 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 consumers that are served by the BHC and aggregate it at the BHC

level. In the case of the CCBHCs, the unit of reporting is at the CCBHC level regardless of how many clinics or entities comprise the CCBHC, and depending on the data required for the measure and the structure of the CCBHC, will include data from Designated Collaborating Organizations (DCOs) (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 other BHCs, the unit of reporting may be single clinics or groups of clinics, depending on the level of analysis that may be required by the state or other entity to which it is reported.

For state-lead measures, in particular, this is different than the norm, as states tend to report numbers aggregated from multiple sources encompassing the state's Medicaid program or health plans within the state Medicaid program. As a result, the state must be able to identify and attribute data to specific clinics and consumers at specific clinics (i.e., each clinic will need a unique identification number assigned to it by the state).

Consumer attribution. States or other entities requiring reporting may decide how to attribute consumers to BHCs depending on the specific impetus for data reporting. For the CCBHC Demonstration Program, attribution of consumers for purposes of data reporting required by the CCBHC criteria requires only one visit by a person to the CCBHC during the measurement period. The state is responsible for providing guidance to clinics on what activities constitute a visit that may be enumerated. 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 in some states that a consumer may visit more than one CCBHC during a year; the consumer will be attributed to both.

The population eligible for measurement. In the broadest sense, the eligible population for these measures includes all BHC consumers served by a BHC provider. The denominator includes BHC consumers who satisfy measure-specific eligibility criteria that may include requirements such as age and continuous enrollment. The specifications in Chapters IV and V indicate the population that should be included in each measure and the reporting unit for the measure.

BHCs should report data on all of the populations they serve and stratify the data according to whether clinic users are: (1) Medicaid beneficiaries including Title 19-eligible CHIP beneficiaries, (2) dually eligible under Medicare and Medicaid, and (3) others enrolled in neither program, including Title 21-eligible CHIP beneficiaries. 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. The distinction between Title 21 and Title 19-eligible CHIP beneficiaries is based upon the restrictions found in PAMA Section 223 (d)(5)(A). The requirement to report data stratified by insurance payer does not apply to reporting of data on housing status and the two patient experience of care measures.

- ***Reporting:*** If a state lacks access to data for dually eligible individuals, please note this in Section E of the data-reporting template (Adherence to Measure Specifications)

Continuous enrollment requirements apply to many measures, including some of the BHC-lead 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 any measure with a continuous enrollment requirement that is BHC-reported, Medicaid enrollees and those who are dual enrollees in Medicare and Medicaid 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 counted in the "other" category.

For purposes of CCBHC QBM/QBP reporting and payment, only consumers who are Medicaid beneficiaries, including Title 19-eligible CHIP beneficiaries, will be counted towards payment. Data will be drawn from the stratified rates for those groups. Reporting on all consumers, stratified by payer category, is required for CCBHC-reported measures.

- ***Reporting:*** Section E of the data-reporting template (Adherence to Measure Specifications) provides space for the state or BHC to clearly report if only certain payer categories are included in the measure calculation.

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. For a measure based on administrative data, all BHC consumers 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 purposes of the CCBHC Demonstration Program, all measures must be reported regardless of the size of the eligible population. However, if the denominator is less than 30, measure results will not be used for any public reporting or for purposes of the national evaluation.

- ***Reporting:*** 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, please note this in Section E of the data-reporting template (Adherence to Measure Specifications) and specify the denominator size.

Data collection methods. Other than the patient experience of care measures, the measures included in this manual have three possible data collection methods: administrative, hybrid, and medical records, the latter of which may include electronic health records (e-measures). The specifications for each measure indicate which method is to be used.

- ***Administrative:*** The administrative method uses transaction data (for example, claims or encounters) or other administrative data sources to calculate the measure. These data can be used in cases where the data are known to be complete, valid, and reliable. When administrative data are used, the entire eligible population is included in the denominator.
- ***Hybrid:*** The hybrid method uses both administrative data sources and medical record (paper or electronic health records (EHRs) or registry) data to determine numerator compliance. The denominator sometimes consists of a sample of the measure's eligible population. When possible, the hybrid method should be used when administrative data are incomplete or may be of poor quality or the data elements for the measure are not captured in administrative data (e.g., Controlling High Blood Pressure [CBP-BH] measure). Samples should be representative of the eligible population, including, when stratified by age, the relevant age groups.
- ***Medical records:*** 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. The e-measure method uses medical record data only, including data from EHRs, to calculate the measure. This electronic data collection method applies to the Child and Adolescent Suicide Risk Assessment measure (SRA-BH-C) and is an option for the collection of the Adult Major Depressive Disorder (MDD): Suicide Risk Assessment measure (SRA-A).
- ***Reporting:*** The method used should be reported in Section B of the data-reporting template (Data Source).

Sampling. For measures that use the hybrid method and that require sampling, sampling guidance is included in the technical specification if available from the measure steward. 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 age group, to insure sufficient sample size of each age group.

- ***HEDIS measures:*** For HEDIS measures that use the hybrid method, the sample size should be 411, unless special circumstances apply. If a BHC has less than 411 consumers, all consumers should be included in the denominator. States and BHC providers may reduce the sample size using information from the current year's administrative rate or the prior year's audited hybrid rate, if one exists. Regardless of the selected sample size, the National Committee for Quality Assurance (NCQA) recommends an oversample to allow for substitution in the event that cases in the original sample turn out to be ineligible for the measure. For additional information on using a reduced sample size, refer to Appendix C, Guidance for Selecting Sample Sizes for Hybrid Measures.

- ***Technical Assistance:*** 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).[1]

- ***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 size of the measure-eligible population in Section B (Data Source) in the data-reporting template.

Alternative data collection methods and data sources. States and BHCs should report the measures using the methods listed in the specifications to the extent possible, or using an alternative method (e.g., medical record review without systematic sample) or data source if the specified method or source are not feasible.

- ***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).

- **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 such measures, the inclusion of all claims would be appropriate, regardless of whether they were paid, denied, or voided. For HEDIS measures that rely on claims as a data source, the HEDIS Volume 2 manual, available on the NCQA HEDIS 2016 web page, provides guidance on which claims to include. The specifications acknowledge that it may be difficult to obtain all such data and indicate that the reporter should, to the extent possible, include all paid, suspended, pending, and denied claims.

Value sets and codes. Many measures require the use of billing or diagnostic codes for calculation. Many measures rely on value sets to identify codes required for calculation. A value set is the complete set of codes used to identify a service or condition included in a measure. Where required, either value set references or codes are included for all technical specifications. Value set references are underlined in the specifications (e.g., BMI Percentile Value Set). Value set information for measures derived from different sources is provided below:

- ***HEDIS-derived measures:*** HEDIS Value sets are available from NCQA HEDIS 2016 for all 2016 HEDIS measures. Two measures, Follow-up After Emergency Department Visit for Mental Illness (FUM) and Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA), are derived from draft 2017 HEDIS measures and value sets will be available for those on at NCQA HEDIS 2017.

[1] Medicaid Core Measure Technical Assistance briefs can be found at the Medicaid quality website.

- ***Other measures:***
    - Value sets for the e-measure specifications of the Child and Adolescent Suicide Risk Assessment (SRA-BH-C) and the Adult Suicide Risk Assessment (SRA-A) measures are available from the U.S. National Library of Medicine Value Set Authority Center (VSAC). Access to the VSAC requires a Unified Medical Language System (UMLS) license; states or BHCs may apply for a UMLS license on the UMLS Metathesaurus License webpage. When searching for value sets for the SRA-BH-C measure, use the measure's associated e-Measure number (177) or NQF number (1365). For the SRA-A measure, use the measure's associated e-Measure number (161) or NQF number (0104).
    - Values sets for the Depression Remission at Twelve Months (DEP-REM-12) measure are available from the website of the measure steward, Minnesota Community Measurement, at the Cycle A DDS Guides page on the MN Community Measurement.
    - Value sets for the Diabetes Care For People With Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (SMI-PC) measure have not been updated for public use and are not publically available at this point.
- ***Measures without value sets:*** Measure specifications without value sets incorporate either the pertinent diagnostic and procedure codes or include links to the source measures where those codes are provided.

Risk adjustment. Among the measures that are part of the Medicaid Core Set, one measure, Plan All-Cause Readmissions (PCR-BH), requires risk adjustment. This measure currently does not have a risk adjustor specific to the Medicaid population. It is suggested that states and BHCs report unadjusted rates for this measure until a standardized risk adjustor is made available. Please note that the specification for this measure includes, in Appendix PCR-BH, two tables (PCR-A and PCR-B). Those tables are part of the original measure and are retained in this manual to avoid modification that alters the original measure specification. Because the information that would be included in those tables is either unavailable because of lack of risk adjustment or duplicated in the data-reporting templates, the reporter should focus on completing the data-reporting template rather than the tables in Appendix PCR-BH unless and until risk adjustment is available.

Reporting and Submission of Measures

Procedures for reporting the BHC measures are provided below.

Submission deadline. For non-CCBHC reporting, data should be submitted as required by the state or other entity to which it is reported. For the CCBHC Demonstration Program, data for the BHC-lead measures should be submitted within 9 months after the end of the DY and for the

state-lead measures within 12 months after the end of the DY. 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.

Who collects and reports the data. These measures 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. The division of responsibility for calculation and reporting reflects the fact that some measures require access to data that the BHCs will not have (e.g., Number of Suicide Attempts Requiring Medical Services by Patients Engaged in Behavioral Health Treatment).

- ***BHC-responsibilities:*** For BHC-lead measures (Table 1), the BHC should report the measures to the entity that requested it. In the case of the CCBHC Demonstration Program, 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 consumers who are Medicaid eligible, including Title 19-eligible 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 CCBHC Demonstration Program, 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. As aggregated at the CCBHC level in the templates, the data will not permit the identification of individuals served by the CCBHC.

Data-reporting templates. Data-reporting templates have been developed for each measure. For the CCBHC Demonstration Program, CCBHCs and states reporting the measures must use the templates to report on the measures. 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 provided in this document, detailed instructions for completion of the templates are included in the template document. For purposes of the CCBHC Demonstration Program, 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 BHC-reported and state-reported measures, both of which 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 each measure.

- ***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 and 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.

III. TECHNICAL SPECIFICATION COMPONENTS

This chapter presents the technical specification components for the measures specified for BHCs. 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. For BHC-reported measures, examples typically also are provided. A brief introduction to each component of the specifications follows this paragraph, with the technical specifications themselves found in Chapters IV and V.

Description. The description section in each specification includes a narrative description of the measure, the applicable data collection method, guidance on reporting, and an explanation of the measurement period. The applicable data collection method is either administrative, hybrid, medical records, or survey. Topics included in guidance on reporting vary by measure, but they typically address the following components: 1) stratification by payer and/or age particular to the measure; 2) information about multiple rates included in the measure, if applicable; 3) information on potential sources of data for BHC-reported measures; 4) information on relevant 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) miscellaneous relevant information. The explanation of the measurement period provides information on the time period(s) for data used to compute the denominator and numerator, respectively, information that also is available in a succinct table in Appendix A.

Definitions. The definitions section of the specification defines key terms relevant to the measure.

Eligible Population. The section defining the eligible population provides information on computation of the denominator, including relationship to the clinic, age, and insurance requirements for claims-based data, and a step-by-step guide (Event/Diagnosis) for determining the eligible population.

- ***Age requirements and stratification:*** The age criteria vary by measure. Some measures have an upper age limit, while others include an age range above age 64 and/or under age 18. States and BHCs should calculate and report rates for the total age-eligible population and, if age-stratified, any age group indicated in the measure specification.
- ***Insurance requirements:*** Some measures include requirements related to continuous enrollment in Medicaid or dually in Medicare and Medicaid, allowable insurance gaps, and an anchor date. A few of those measures specify when those requirements are to be entered into the process of determining the eligible population. For the majority of measures which do not, continuous enrollment, allowable gap and anchor date should enter the calculation of the eligible population as early in the process as possible.
    - ***Continuous enrollment:*** This requirement refers to the time frame during which a consumer must be enrolled for Medicaid benefits or dually eligible for Medicare and Medicaid benefits to be included in the eligible population. The technical specifications provide the continuous enrollment requirement for each measure, if applicable.
    - ***Allowable gap:*** Some measures specify an allowable gap that can occur during continuous enrollment for Medicaid, or for dually eligible Medicare and Medicaid enrollment. For example, the Controlling High Blood Pressure (CBP) measure, which requires continuous enrollment throughout the measurement year (using the calendar year, January 1–December 31), allows one gap in enrollment of up to 45 days. Thus, a BHC consumer who enrolls in Medicaid 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 consumer has one 38-day gap (January 1, 2017-February 7, 2017).
    - ***Anchor date:*** 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 that date; the individual must have the benefit on that 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.

- ***Exclusions:*** Some measure specifications contain required or optional exclusions. A BHC consumer 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. Some exclusions are optional. Three measures (ASC, TSC, and BMI-SF) exclude individuals for whom certain documentation is not available in the medical record. This is not a general practice but is used by the original stewards for these measures only.
- ***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.

Other Information. This section contains additional information relevant to the measure such as measure interpretation and measure limitations.

Example Calculation. For most BHC-reported measures, simple examples are provided of the calculation process for the measure in measure-specific appendices. Examples are not provided for the BHC-reported measures that are stewarded by NCQA. For e-Measures, flow diagrams are provided.

IV. TECHNICAL SPECIFICATIONS -- CLINIC-REPORTED MEASURES

Routine Care Needs (ROUT)

SAMHSA-Developed Metric

A. DESCRIPTION

Percentage of new consumers requesting services who were determined to need routine care

Data Collection Method: Medical Records

Guidance for Reporting:

- This metric is stratified by whether the consumer is a Medicaid beneficiary, eligible for both Medicare and Medicaid, and other.
- Provider entities 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
    - An electronic scheduling system that is separate from the medical record and that is used to schedule and monitor appointments and critical time frames
    - A system similar to one developed by NIATx (the NIATx Outpatient Spreadsheet).
- Refer to the specific data-reporting template for the reporting requirements applicable to each measure and to the Appendices in Volume 2 of this manual.

Measurement Period: The measurement period for the denominator is the measurement year plus the preceding 6 months. The measurement period for the numerator is the measurement year.

B. DEFINITIONS

TERM	DEFINITION
New Consumer	An individual not seen at the clinic in the past 6 months
Provider Entity	The provider entity that is being measured (i.e., BHC)

TERM	DEFINITION
Routine Care Needs	Care needs that, based upon a preliminary screening and risk assessment, are determined not to be of an emergency or urgent nature, within the commonly accepted meaning of those terms in a behavioral health setting

C. ELIGIBLE POPULATION

CRITERIA	REQUIREMENTS
Age	Consumers of all ages
Event/Diagnosis	Follow the steps below to identify the eligible population: ***Step 1*** Identify new consumers who contacted the provider entity seeking services during the measurement year.

D. MEDICAL RECORD SPECIFICATION

Denominator

The number of consumers in the eligible population (Section C)

Note: Although the denominator measures those who made first contact during the measurement year, the clinic must look back 6 months from the point of first contact during that time to determine if the person is a new consumer.

Numerator

The number of new consumers in the eligible population during the measurement year who were determined to need routine care.

Note: The numerator calculation considers data only from the measurement year.

Exclusions

None.

Example Calculation

See Appendix ROUT to this measure.

E. ADDITIONAL NOTES

This measure is designed to require provider-level reporting but is not tested at the provider level.

Interpretation of score:

> This percentage cannot be viewed as representing either high or low quality; rather it provides a snapshot of new consumer acuity.

Time to Initial Evaluation (I-EVAL)

SAMHSA-Developed Metric

A. DESCRIPTION

Metric #1: The percentage of new consumers with initial evaluation provided within 10 business days of first contact

Metric #2: The mean number of days until initial evaluation for new consumers

Data Collection Method: Medical Records

Guidance for Reporting:

- This is a two-part measure and requires two different calculations.
- This metric is stratified by age (12–17 years, 18 years and older) and by whether the consumer is a Medicaid beneficiary, eligible for both Medicare and Medicaid, and other.
- Provider entities 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
    - An electronic scheduling system that is separate from the medical record and that is used to schedule and monitor appointments and critical time frames
    - A system similar to one developed by NIATx (the NIATx Outpatient Spreadsheet)
- Refer to the specific data-reporting template for the reporting requirements applicable to each measure and to the Appendices in Volume 2 of this manual.

Measurement Period: For both metrics, the measurement period for the denominator is the measurement year excluding the last 30 days of the measurement year and

including the 6 months preceding the measurement year. The measurement period for the numerator is the measurement year.

B. DEFINITIONS

TERM	DEFINITION
Business Days	Monday through Friday, excluding state and federal holidays (regardless of days of operation)
Initial Evaluation	Some certification standards, such as the CCBHC certification criteria, require that an initial evaluation be carried out for new consumers 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 this specification. Other standards may exist for other entities and this specification can be adapted accordingly.
New Consumer	An individual not seen at the clinic in the past 6 months
Provided	As used in the context of the initial evaluation being "provided" by the clinic, the word "provided" means "received." The clinic is to record the number of business days from initial contact until the initial evaluation was received by or completed for the consumer.
Provider Entity	The provider entity that is being measured (i.e., BHC)

C. ELIGIBLE POPULATION

CRITERIA	REQUIREMENTS
Age	Report two age stratifications and a total rate: • 12–17 years as of the end of the measurement year • 18 years and older as of the end of the measurement year • Total (both age groups)

CRITERIA	REQUIREMENTS
Event/Diagnosis	Follow the steps below to identify the eligible population: ***Step 1*** Identify new consumers who contacted the provider entity seeking services during the measurement year. ***Step 2*** Identify consumers from step 1 aged 12 years and older as of the end of the measurement year.

D. MEDICAL RECORD METRIC SPECIFICATION #1

Percentage of new consumers with initial evaluation provided within 10 business days of first contact

Denominator

The number of consumers in the eligible population (Section C)

Note: The measurement period for the denominator is the measurement year excluding the last 30 days of the measurement year and including the 6 months preceding the measurement year.

Numerator

The number of consumers in the eligible population who received an initial evaluation within 10 business days of the first contact with the provider entity during the measurement year.

Note: The measurement period for the numerator is the measurement year.

Exclusions

None.

Example Calculation

See Appendix I-EVAL to this measure.

E. MEDICAL RECORD METRIC SPECIFICATION #2

The mean number of days until initial evaluation for new consumers

Denominator

The number of consumers in the eligible population (Section C)

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 eligible population seen at the provider entity during the measurement year

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 initial contact.

Exclusions

None.

Example Calculation

See Appendix I-EVAL to this measure.

F. ADDITIONAL NOTES

This measure is designed to require provider-level reporting but is not tested at the provider level.

It is likely that some new consumers will not have an appointment within 10 days because of their own schedules and non-urgent need. This situation is a recognized limitation of this measure that will affect all clinics. Trying to adjust for non-consumers who are offered but do not accept an appointment within 10 business days complicates the calculation unnecessarily.

Interpretation of scores:

> **Percentage of new consumers with initial evaluation provided within 10 business days:** Better quality = Higher score
>
> **Mean number of days until initial evaluation for new consumers:** Better quality = Lower number

Time to Comprehensive Person- and Family-Centered Diagnostic and Treatment Planning Evaluation (TX-EVAL)

SAMHSA-Developed Metric

A. DESCRIPTION

The mean number of days after first contact until comprehensive person-centered and family-centered diagnostic and treatment planning evaluation is performed for new consumers

Data Collection Method: Medical Records

Guidance for Reporting:

- This metric is stratified by age (12–17 years, 18 years and older) and by whether the consumer is a Medicaid beneficiary, eligible for both Medicare and Medicaid, and other.
- Provider entities 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
  - An electronic scheduling system that is separate from the medical record and that is used to schedule and monitor appointments and critical time frames
  - A system similar to one developed by NIATx (the NIATx Outpatient Spreadsheet)
- Refer to the specific data-reporting template for the reporting requirements applicable to each measure and to the Appendices in Volume 2 of this manual.

Measurement Period: The measurement period for the denominator is the measurement year excluding the last 90 days of the measurement year and including the 6 months preceding the measurement year. The measurement period for the numerator is the measurement year.

B. DEFINITIONS

TERM	DEFINITION
Comprehensive Person-Centered and Family-Centered Diagnostic and Treatment Planning Evaluation	Some certification standards, such as the CCBHC certification criteria, establish time requirements for completion of comprehensive treatment planning evaluations. In the case of a CCBHC, the certification criteria require that all new consumers receive a comprehensive person-centered and family-centered diagnostic and treatment planning evaluation to be completed within 60 calendar days of the first request for services. That standard is used in this specification. Other standards may exist for other entities and this specification can be adapted accordingly.
New Consumer	An individual not seen at the clinic in the past 6 months
Provider Entity	The provider entity that is being measured (i.e., BHC)

C. ELIGIBLE POPULATION

CRITERIA	REQUIREMENTS
Age	Report two age stratifications and a total rate: • 12–17 years as of the end of the measurement year • 18 years and older as of the end of the measurement year • Total (both age groups)
Event/Diagnosis	Follow the steps below to identify the eligible population: ***Step 1*** Identify new consumers who contacted the provider entity seeking services during the measurement year. ***Step 2*** Identify consumers from step 1 aged 12 years and older as of the end of the measurement year.

D. MEDICAL RECORD SPECIFICATION

Denominator

The number of consumers in the eligible population (Section C)

Note: The measurement period for the denominator is the measurement year excluding the last 90 days of the measurement year and including the 6 months preceding the measurement year.

Numerator

The total number of days between first contact and completion of the comprehensive person-centered and family-centered diagnostic and treatment planning evaluation for all members of the eligible population seen at the provider entity during the measurement year

Note: The measurement period for the numerator is the measurement year. Any who received a comprehensive evaluation after the first 90 days of the following year are treated as having been evaluated 91 days after initial contact.

Exclusions

None.

Example Calculation

See Appendix TX-EVAL to this measure.

E. ADDITIONAL NOTES

This measure is designed to require provider-level reporting but is not tested at the provider level.

Interpretation of score:

> **Mean number of days until comprehensive diagnostic and treatment planning evaluation for new consumers:** Better quality = A number less than or equal to 60 days. For some consumers, it may take up to 60 days to develop a comprehensive diagnostic and treatment planning evaluation, so the objective is not to get the lowest possible number. Of course, it is important that the consumer receive services in the interim as the evaluation is being completed.

Deaths by Suicide (SUIC)

SAMHSA-Developed Metric

A. DESCRIPTION

Percentage of consumers aged 12 years and older who died by suicide during the measurement year

Data Collection Method: Medical Records

Guidance for Reporting:

- This metric is stratified by age (12–17 years, 18–64 years, 65 years and older) and by whether the consumer is a Medicaid beneficiary, eligible for both Medicare and Medicaid, and other. An exclusion applies if the provider entity does not know the consumer's cause of death.
- Provider entities 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
- Refer to the specific data-reporting template for the reporting requirements applicable to each measure and to the Appendices in Volume 2 of this manual.

Measurement Period: The measurement period for the denominator and numerator is the measurement year.

B. DEFINITIONS

TERM	DEFINITION
Provider Entity	The provider entity that is being measured (i.e., BHC)

TERM	DEFINITION
Suicide	Death caused by self-directed, injurious behavior with any intent to die as a result of the behavior

C. ELIGIBLE POPULATION

CRITERIA	REQUIREMENTS
Age	All consumers aged 12 years and older as of the end of the measurement year. Report three age stratifications and a total rate: • 12–17 years • 18–64 years • 65 years and older • Total (all age groups)
Event/Diagnosis	Follow the steps below to identify the eligible population: ***Step 1*** Identify consumers seen at the provider entity at least once during the measurement year. ***Step 2*** Identify consumers from step 1 aged 12 years and older as of the end of the measurement year.

D. MEDICAL RECORDS SPECIFICATION

Denominator

The number of consumers in the eligible population (Section C)

Numerator

The number of consumers in the eligible population who were identified as dying by suicide during the measurement year.

Exclusions

Deaths where cause of death is unknown to provider entity.

Example Calculation

See Appendix SUIC to this measure.

E. ADDITIONAL NOTES

This measure is designed to require provider-level reporting but is not tested at the provider level.

This measure has the following limitations. Complete accuracy depends on knowledge of consumer intent and cause of death for all consumers seen in the measurement year. We acknowledge that coroner's data will be more accurate and states should feel free to compare the results of this metric to those data. The data reported for this metric, however, should follow the specifications herein.

Interpretation of score: Better quality = Lower score. The goal is zero.

Documentation of Current Medications in the Medical Record (DOC)

Based on a measure stewarded by the Centers for Medicare & Medicaid Services
(NQF #0419, PQRS #130)

A. DESCRIPTION

Percentage of visits for consumers aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency, and route of administration.

Data Collection Method: Medical Records

Guidance for Reporting:

- This measure is stratified by whether the consumer is a Medicaid beneficiary, eligible for both Medicare and Medicaid, and other.
- This measure is to be reported for every encounter during the measurement year.
- If documentation is not available for one or more numerator or exclusion data elements for a specific visit, the consumer is considered to not meet the criteria for the numerator or exclusion, respectively.
- Provider entities 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
- Please refer to the most recent source measure PQRS #130 at PQRS Measures for codes needed to calculate this measure.
- Refer to the specific data-reporting template for the reporting requirements applicable to each measure and to the Appendices in Volume 2 of this manual.

Measurement Period: The measurement period for both the denominator and the numerator is the measurement year.

B. DEFINITIONS

TERM	DEFINITION
Current Medications	Medications the consumer is presently taking, including all prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements with each medication's name, dosage, frequency and administered route.
Eligible Professional	A licensed professional eligible to prescribe medication as defined by the respective state in which the provider entity is located
Provider Entity	The provider entity that is being measured (i.e., BHC)
Route	Documentation of the way the medication enters the body (some examples include but are not limited to: oral, sublingual, subcutaneous injections, and/or topical).

C. ELIGIBLE POPULATION

CRITERIA	REQUIREMENTS
Age	Consumers aged 18 years or older on the date of the encounter

CRITERIA	REQUIREMENTS
Event/Diagnosis	Follow the steps below to identify the eligible population: ***Step 1*** Identify consumers who had an encounter at the provider entity during the measurement year. **Relevant codes (Current Procedural Terminology [CPT®] or Healthcare Common Procedure Coding System [HCPCS]) are identified in the source PQRS measure.** ***Note:*** Unlike many BHC measures, this one begins by limiting the types of visits or encounters that qualify consumers for the eligible population. ***Step 2*** Identify consumers from step 1 who were aged 18 years and older on the date of the encounter.

D. MEDICAL RECORD SPECIFICATION

Denominator

The number of visits by consumers in the eligible population (Section C)

> **Exclusion:** Medical Reason: Consumer is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the consumer's health status. The clinical exclusion code is HCPCS G8430 (Current Medications not Documented, Patient not Eligible), whereby an eligible professional attests to documenting in the medical record the consumer is not eligible for a current list of medications being obtained, updated, or reviewed by the eligible professional.

Numerator

The number of consumers for whom an eligible professional attests to documenting, updating, or reviewing consumer´s current medications using all immediate resources available on the date of the encounter. This list must include ALL prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosages, frequency, and route.

Numerator Options: The options below indicate the coding possibilities related to the numerator. The first, where performance is met, indicates a situation where the data point is included in the numerator. The second, where performance is not met, means that the data point is excluded. If neither code is included in a record, the record should be retained in the denominator but treated as performance not met.

Performance Met: Eligible professional attests to documenting in the medical record they obtained, updated, or reviewed the consumer's current medications (G8427)

OR

Performance Not Met: Current list of medications not documented as obtained, updated, or reviewed by the eligible professional, reason not given (G8428).

Example Calculation

See Appendix DOC.

E. ADDITIONAL NOTES

Both this measure 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.

Interpretation of score: Better quality = Higher score

Preventive Care & Screening: Body Mass Index (BMI) Screening & Follow-Up (BMI-SF)

Based on a measure stewarded by the Centers for Medicare & Medicaid Services (NQF #0421, PQRS #128)

A. DESCRIPTION

Percentage of consumers aged 18 years and older with a BMI documented during the current encounter or during the previous six months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the current encounter

Normal Parameters:

- Age 65 years and older BMI > 23 and < 30 kg/m2
- Age 18 - 64 years BMI > 18.5 and < 25 kg/m2

Data Collection Method: Medical Records

Guidance for Reporting:

- This measure is stratified by whether the consumer is a Medicaid beneficiary, eligible for both Medicare and Medicaid, and other.
- There is no diagnosis associated with this measure. This measure is to be reported a minimum of once per measurement year for consumers seen during the reporting year. This measure may be reported by eligible professionals who perform the quality actions described in the measure based on the services provided at the time of the qualifying visit and the measure-specific denominator coding. The BMI may be documented in the medical record of the provider or in outside medical records obtained by the provider. If the most recent documented BMI is outside of normal parameters, then a follow-up plan must be documented during the encounter or during the previous six months of the current encounter. The documented follow-up plan must be based on the most recent documented BMI outside of normal parameters, example: "Consumer referred to nutrition counseling for BMI above normal parameters" (See Definitions for examples of a follow-up plan treatments). *If more than one BMI is reported during the measure period, the most recent BMI will be used to determine if the performance has been met.*
- Provider entities 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
- Please refer to the most recent source measure PQRS #128 at PQRS Measures for encounter codes needed to calculate this measure.
- Refer to the specific data-reporting template for the reporting requirements applicable to each measure and to the Appendices in Volume 2 of this manual.

Measurement Period: The measurement period for the denominator is the measurement year. The measurement period for the numerator is the measurement year and the previous 6 months.

B. DEFINITIONS

TERM	DEFINITION
Body Mass Index (BMI)	BMI is a number calculated using the Quetelet index—weight divided by height squared (W/H^2)—and is commonly used to classify weight categories. BMI can be calculated using: Metric Units: BMI = Weight (kg) / (Height [m] x Height [m]) **OR** English Units: BMI = (Weight [lbs] x 703) / (Height [in] × Height [in])
Follow-Up Plan	Proposed outline of treatment to be conducted as a result of a BMI out of normal parameters. A follow-up plan may include, but is not limited to: • Documentation of education • Referral (for example a registered dietician, nutritionist, occupational therapist, physical therapist, primary care provider, exercise physiologist, mental health professions, or surgeon) • Pharmacological interventions • Dietary supplements • Exercise counseling • Nutrition counseling

TERM	DEFINITION
Not eligible for BMI Calculation or Follow-Up Plan	A consumer is not eligible if one or more of the following reasons are documented: • Consumer is receiving palliative care • Consumer is pregnant • Consumer refuses BMI measurement (refuses height and/or weight) • Any other reason documented in the medical record by the provider why BMI measurement was not appropriate • Consumer is in an urgent or emergent medical situation where time is of the essence, and to delay treatment would jeopardize the consumer's health status
Provider Entity	The provider entity that is being measured (i.e., BHC)

C. ELIGIBLE POPULATION

CRITERIA	REQUIREMENTS
Age	Consumers aged 18 years and older on the date of service during the measurement year
Event/Diagnosis	Follow the steps below to identify the eligible population: ***Step 1*** Identify consumers flagged as having been seen at the provider entity at least once during the measurement year ***Step 2*** Identify consumers from step 1 who are aged 18 years or older on the date of service during the measurement year. **Relevant codes (Current Procedural Terminology [CPT®] or Healthcare Common Procedure Coding System [HCPCS]) are identified in the most recent source measure specification.** ***Note:*** The types of eligible encounters are limited to those listed.

D. MEDICAL RECORDS SPECIFICATION

Denominator

The number of consumers in the eligible population (Section C)

Note: The measurement period for the denominator is the measurement year.

Numerator

The number of consumers in the eligible population with a documented BMI during the encounter or during the previous six months AND, when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the current encounter.

Numerator Quality-Data Coding Options: The options below indicate the coding possibilities related to the numerator. The first three, where performance is met, indicate situations where the data point is included in the numerator. The fourth and fifth, where performance is not met, means that the data point is excluded from the numerator.

> **Performance Met:** BMI is documented within normal parameters and no follow up plan is required (G8420)
>
> **OR**
>
> **Performance Met:** BMI is documented above normal parameters and a follow-up plan is documented (G8417)
>
> **OR**
>
> **Performance Met:** BMI is documented below normal parameters and a follow-up plan is documented (G8418)
>
> **Performance Not Met:** BMI not documented and no reason is given (G8421)
>
> **OR**
>
> **Performance Not Met:** BMI documented outside normal parameters, no follow-up plan documented, no reason given (G8419)

Numerator Instructions:

- Height and Weight: An eligible professional or their staff is required to measure both height and weight. Both height and weight must be measured within six months of the current encounter and may be obtained from separate encounters. Self-reported values cannot be used.

- Follow-Up Plan: If the most recent documented BMI is outside of normal parameters, then a follow-up plan is documented during the encounter or during the previous six months of the current encounter. The documented follow-up plan must be based on the most recent documented BMI, outside of normal parameters, example: "Consumer referred to nutrition counseling for BMI above normal parameters." (See Definitions for examples of a follow-up plan treatments)
- Performance Met for G8417 and G8418
    - If the provider documents a BMI and a follow-up plan at the current visit **OR**
    - If the consumer has a documented BMI within the previous six months of the current encounter, the provider documents a follow-up plan at the current visit **OR**
    - If the consumer has a documented BMI within the previous six months of the current encounter **AND** the consumer has a documented follow-up plan for a BMI outside normal parameters within the previous six months of the current visit

Note: The measurement period for the numerator is the measurement year and the previous 6 months.

Exclusions: A consumer is not eligible for BMI calculation or development of a follow-up plan if one or more of the following reasons are documented:

- Consumer is receiving palliative care
- Consumer is pregnant
- Consumer refuses BMI measurement (refuses height and/or weight)
- Any other reason documented in the medical record by the provider why BMI measurement was not appropriate
- Consumer is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the consumer's health status

Relevant quality-data codes for non-eligibility include:

BMI Documented, Consumer not Eligible: BMI not documented, with documentation the consumer is not eligible for BMI calculation (G8422)

OR

BMI Documented Outside of Normal Limits, Follow-Up Plan not Documented, Consumer not Eligible: BMI is documented as being outside of normal limits, follow-up plan is not documented, documentation shows the consumer is not eligible (G8938)

Incomplete Reporting Exclusion: Failure to record quality-data codes necessary for computing the numerator means that the consumer is excluded from the denominator.

Example Calculation

See Appendix BMI-SF.

E. ADDITIONAL NOTES

The source measure is designed for the Medicare population and is not risk adjusted. The source measure was specified at both the provider and other levels. This measure is modified from the source measure to provide a specification consistent in format to other measures in this set of BHC measures.

Interpretation of score: Better quality = Higher score

Weight Assessment for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents (WCC-BH)

Based on a measure stewarded by the
National Committee for Quality Assurance (NQF #0024, HEDIS 2016)

A. DESCRIPTION

The percentage of children ages 3 to 17 who had an outpatient visit with a primary care practitioner (PCP) or obstetrical/gynecological (OB/GYN) practitioner and who had evidence of body mass index (BMI) percentile documentation during the measurement year

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

Data Collection Method: Administrative or Hybrid

Guidance for Reporting:

- This measure is stratified by whether the consumer is a Medicaid beneficiary, eligible for both Medicare and Medicaid, and other. This measure also is stratified by age. Report two age stratifications (3-11 years, 12-17 years) and a total. The total is the sum of the age stratifications. For purposes of determining whether a consumer is a Medicaid beneficiary or a dual Medicare and Medicaid enrollee, see Continuous Enrollment, Allowable Gap, and Anchor Date requirements below in section C.
- Only the BMI percentile component is included in this measure; the physical activity/nutrition counseling components are not included.
- The eligible population (denominator) for this measure includes children ages 3 to 17 who have an outpatient visit. Medicaid enrollees or those dually eligible for Medicare and Medicaid must meet the continuous enrollment criteria. The remainder are stratified as "Other."
- 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.
- For BHCs reporting a measure that is also an Electronic Health Record (EHR) Medicaid Incentive Program measure, indicate whether any information was

extracted from EHRs. Report this information in Section F (Additional Notes) of the data-reporting template.

- 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 or year prior to the measurement year.
- This measure may be calculated using sampling, but measure-specific guidelines on sampling are not available. Providers should review information in the introductory material to this manual related to sampling and hybrid measures and describe their sampling methodology in Section F (Additional Notes) of the data-reporting template.
- Referenced Value Sets may be found at NCQA HEDIS 2016.
- To the extent possible, include all paid, suspended, pending, and denied claims.
- Refer to Appendix D for definitions of a PCP and OB/GYN practitioner.
- Refer to the specific data-reporting template for the reporting requirements applicable to each measure and to the Appendices in Volume 2 of this manual.

Measurement Period: The measurement period is the measurement year. Hypertension diagnosis: Confirm anytime during the enrollee's history on or before the first six months of the measurement year

B. DEFINITIONS

TERM	DEFINITION
BMI	Body mass index: A statistical measure of the weight of a person scaled according to height
BMI percentile	The percentile ranking based on the CDC's BMI-for-age growth charts, which indicates the relative position of the consumer's BMI number among others of the same gender and age
Provider Entity	The provider entity that is being measured (i.e., BHC)

C. ELIGIBLE POPULATION

CRITERIA	REQUIREMENTS
Age	Consumers aged 3–17 years as of the end of the measurement year. Report two age stratifications and a total: • 3 to 11 • 12 to 17 • Total The total is the sum of the age stratifications.
Continuous Enrollment	The measurement year
Allowable Gap	No more than one gap in continuous enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a consumer for whom enrollment is verified monthly, the child may not have more than a 1-month gap in coverage (i.e., a child whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor Date	The last day of the measurement year
Benefits	Medical
Event/Diagnosis	Follow the steps below to identify the eligible population: ***Step 1*** Identify consumers flagged as having been seen at the provider entity at least once during the measurement year. ***Step 2*** Identify consumers from step 1 who were aged 3–17 years as of the end of the measurement year. ***Step 3*** Identify consumers from step 2 who had an outpatient visit (Outpatient Value Set) with a primary care practitioner (PCP) or obstetrical/gynecological (OB/GYN) practitioner during the measurement year.

D. ADMINISTRATIVE SPECIFICATION

Denominator

The number of consumers in the eligible population (Section C)

Numerator

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

Note: Records that do not include documentation of BMI percentile, or that include notation of BMI value only, or height and weight only do not count as numerator compliant.

Exclusions (optional)

Consumers who have a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year.

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 ages 3 to 11 and ages 12 to 17 and, separately, by whether the consumer is a Medicaid beneficiary, eligible for both Medicare and Medicaid, and other.

Use a sample size of 411, unless special circumstances apply or the eligible population is smaller. BHCs may reduce the sample size using information from the current year's administrative rate or the prior year audited, hybrid rate, if one exists. Regardless of the selected sample size, the National Committee for Quality Assurance (NCQA) recommends an oversample to allow for substitution in the event that cases in the original sample turn out to be ineligible for the measure. For additional information on using a reduced sample size, refer to Appendix C, Guidance for Selecting Sample Sizes for Hybrid Measures.

Numerator

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

- For those relying on **administrative data** rather than medical record review to calculate the numerator as part of the hybrid specification, refer to Administrative Specification to identify positive numerator hits from the administrative data.

- For those relying on **medical record review** rather than administrative data to calculate the numerator as part of the hybrid specification, 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 **OR**
  - BMI percentile plotted on an age-growth chart

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

  Note: Ranges and thresholds do not meet criteria. A distinct BMI percentile or value, if applicable, is required for numerator compliance. Documentation of >99 percent or <1 percent meet criteria because a distinct BMI percentile is evident (i.e., 100 percent or 0 percent).

Exclusions (optional)

Refer to the 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

Records that do not include documentation of BMI percentile, or that include notation of BMI value only, or height and weight only do not count as numerator compliant.

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.

The source measure is designed for the Medicaid population and is not risk adjusted. The source measure was specified and tested at the health plan level. This measure is modified to require clinic-level reporting, and to be consistent in format with other measures in this set of BHC measures, but is not tested at the clinic level.

Interpretation of score: Better quality = Higher score

Controlling High Blood Pressure (CBP-BH)

Based on a measure stewarded by the
National Committee for Quality Assurance (NQF #0018, HEDIS 2016)

A. DESCRIPTION

Percentage of consumers ages 18 to 85 who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled during the measurement year based on the following criteria:

- Consumers ages 18 to 59 whose BP was <140/90 mm Hg
- Consumers ages 60 to 85 with a diagnosis of diabetes whose BP was <140/90 mm Hg
- Consumers ages 60 to 85 without a diagnosis of diabetes whose BP was <150/90 mm Hg

A single rate is reported and is the sum of all three groups.

Data Collection Method: Hybrid

Guidance for Reporting:

- This measure is stratified by whether the consumer is a Medicaid beneficiary, eligible for both Medicare and Medicaid, and other. It also is stratified by age as discussed immediately below. For purposes of determining whether a consumer is a Medicaid beneficiary or a dual Medicare and Medicaid enrollee, see Continuous Enrollment, Allowable Gap, and Anchor Date requirements below in section C.
- This measure applies to consumers 18 to 85 years of age. BHCs should calculate and report this measure for two age groups (as applicable): ages 18 to 64 and ages 65 to 85. The numerator for consumers ages 18 to 64 will include consumers 18 to 59 years of age who meet the **first** criterion added to consumers 60 to 64 years of age who meet the **second or third** criteria. The rate for consumers 65 to 85 years of age will include all consumers in that age group who meet the **second or third** criteria: diagnosis of diabetes with BP < 140/90 mm Hg or no diagnosis of diabetes with BP of <150/90 mm Hg.
- To identify the eligible population for this measure, BHCs should use administrative data to select all consumers who had an outpatient visit with a diagnosis of hypertension during the first six months of the measurement year.

To identify the denominator, BHCs should then review the consumer's medical record to confirm the hypertension diagnosis, which can be recorded anytime during the consumer's history on or before the end of the sixth month of the measurement year. If the consumer's diagnosis cannot be confirmed then exclude the consumer.

- This measure requires use of the hybrid method.
- This measure may be calculated using sampling, but measure-specific guidelines on sampling are not available from the steward. Providers should review information in the introductory material to this manual related to sampling and hybrid measures and describe their sampling methodology in Section F (Additional Notes) of the data-reporting template.
- Referenced Value Sets may be found at NCQA HEDIS 2016.
- Table CBP-A corresponds to National Drug Code (NDC) Table CDC-A that is posted to NCQA HEDIS Final NDC Lists.
- Refer to the specific data-reporting template for the reporting requirements applicable to each measure and to the Appendices in Volume 2 of this manual.

Measurement Period: The measurement period for the denominator is the first 6 months of the measurement year. The measurement period for the numerator is the measurement year. For the hypertension diagnosis, confirm any time during the consumer's history during or before the first 6 months of the measurement year.

B. DEFINITIONS

TERM	DEFINITION
Adequate Control	Adequate control is defined as meeting any of the following criteria: • Consumers ages 18 to 59 whose BP was <140/90 mm Hg • Consumers ages 60 to 85 with a diagnosis of diabetes whose BP was <140/90 mm Hg • Consumers ages 60 to 85 without a diagnosis of diabetes whose BP was <150/90 mm Hg
BP	Blood pressure
HTN	Hypertension

TERM	DEFINITION
Representative BP	The most recent BP reading during the measurement year (as long as it occurred after the 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 consumer is "not controlled."
Provider Entity	The provider entity that is being measured (i.e., BHC)

C. ELIGIBLE POPULATION

CRITERIA	REQUIREMENTS
Age	Consumers aged 18 to 85 years as of the last day 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 consumer for whom enrollment is verified monthly, the consumer may not have more than a 1-month gap in coverage (i.e., a consumer whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor Date	The last day of the measurement year
Benefit	Medical

CRITERIA	REQUIREMENTS
Event/diagnosis	Follow the steps below to identify the eligible population: ***Step 1*** Identify consumers flagged as having been seen at the provider entity at least once during the measurement year. ***Step 2*** Identify consumers from step 1 who were 18 to 85 years of age as of the end of the measurement year. ***Step 3*** Identify consumers from step 2 who are hypertensive by identifying those with at least one outpatient visit (Outpatient Without UBREV Value Set) with a diagnosis of hypertension (Essential Hypertension Value Set) during the first six months of the measurement year.

CRITERIA	REQUIREMENTS
Diabetes flag for the numerator (cont'd)	After the Eligible Population is identified, assign each consumer a diabetic or not diabetic flag using only administrative data and the steps below. The flag is used to determine the appropriate BP threshold to use during numerator assessment (the threshold for consumers with diabetes is different than the threshold for consumers without diabetes). ***Step 1*** Assign a flag of diabetic to consumers who were identified as diabetic using claims/encounter data or pharmacy data. The BHC must use both methods to assign the diabetes flag, but a consumer only needs to be identified by one method. Consumers may be identified as having diabetes **during the measurement year or the year prior to the measurement year**. 1. **Claims/encounter data**. Consumers who met **any of the following criteria** during the measurement year or the year prior to the measurement year (count services that occur over both years): • At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), or nonacute inpatient encounters (Nonacute Inpatient Value Set) on different dates of service, **with** a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two visits. **OR** • At least one acute inpatient encounter (Acute Inpatient Value Set) **with** a diagnosis of diabetes (Diabetes Value Set). 2. **Pharmacy data**. Consumers who were dispensed insulin or hypoglycemics/antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year (refer to Table CBP-A in Appendix CBP-BH).

CRITERIA	REQUIREMENTS
Diabetes flag for the numerator (cont'd)	***Step 2*** From consumers identified in Step 1, assign a flag of "not diabetic" to consumers who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year. Note: Consumers classified as diabetic in step 1 based on pharmacy data alone and who had a diagnosis of gestational or steroid-induced diabetes as specified above are re-classified as not diabetic in this step. ***Step 3*** For consumers who were not assigned a flag in step 1 or step 2, assign a flag of "not diabetic."

D. HYBRID SPECIFICATION

Denominator

The number of consumers representing a systematic sample from the eligible population (Section C) whose diagnosis of hypertension is confirmed by chart review. Use a sample size of 411, unless special circumstances apply or the eligible population is smaller. BHCs may reduce the sample size using information from the current year's administrative rate or the prior year audited, hybrid rate, if one exists. Regardless of the selected sample size, the National Committee for Quality Assurance (NCQA) recommends **an oversample** to allow for substitution in the event that cases in the original sample turn out to be ineligible for the measure. For this measure, NCQA recommends that BHCs **use an oversample of 10 to 15 percent** to ensure enough confirmed cases of hypertension.

To **confirm the diagnosis of hypertension**, there must be a notation of **one of the following in the medical record** anytime during the consumer's history on or before the end of the sixth month of the measurement year:

- Hypertension
- HTN
- High BP (HBP)

- Elevated BP (↑BP)
- Borderline HTN
- Intermittent HTN
- History of HTN
- Hypertensive vascular disease (HVD)
- Hyperpiesia
- Hyperpiesis

It does not matter if hypertension was treated or is currently being treated. The notation indicating a **diagnosis of hypertension** may be recorded in **any of the following** documents:

- Problem list (this may include a diagnosis prior to the seventh month of the measurement year or an undated diagnosis that is not part of the office visit note; see Note at the end of this section)
- Office note
- Subjective, Objective, Assessment, Plan (SOAP) note
- Encounter form
- Diagnostic report
- Hospital discharge summary

Statements such as "rule out HTN," "possible HTN," "white-coat HTN," "questionable HTN," and "consistent with HTN" are not sufficient to confirm the diagnosis if such statements are the only notations of hypertension in the medical record.

If the diagnosis of **hypertension cannot be confirmed**, the **consumer is excluded** and replaced by the next consumer from the oversample.

Identifying the Medical Record

BHCs should **use one medical record** for both the confirmation of the diagnosis of hypertension and the representative BP. All eligible BP measurements recorded in the record must be considered. If a BHC cannot find the medical record, the consumer remains in the measure denominator and is considered noncompliant for the numerator.

BHCs should use the following steps to find the appropriate medical record to review.

Step 1

- Identify the consumer's PCP.
- If the consumer had more than one PCP for the time period, identify the PCP who most recently provided care to the consumer.

- If the consumer 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 consumer.
- If a practitioner other than the consumer's PCP manages the hypertension, the BHC may use the medical record of that practitioner.

Step 2

- Use one medical record to both confirm the diagnosis for the denominator and identify the representative BP level for the numerator. There are circumstances in which the BHC may need to go to a second medical record to either confirm the diagnosis or obtain the BP reading, as in the following two examples.

  Example 1: If a consumer sees one PCP during the denominator confirmation period (before the seventh month of the measurement year) and another PCP after June 30, the diagnosis of hypertension and the BP reading may be identified through two different medical records.

  Example 2: If a consumer has the same PCP for the entire measurement year, but it is clear from claims or medical record data that a specialist (e.g., cardiologist) manages the adult's hypertension after the sixth month of the measurement year, the BHC may use the PCP's chart to confirm the diagnosis and use the specialist's chart to obtain the BP reading. For example, if all recent claims coded with 401 came from the specialist, the BHC may use this chart for the most recent BP reading. If the consumer did not have any visit with the specialist prior to the seventh month of the measurement year, the BHC must go to another medical record to confirm the diagnosis.

Note: The measurement period for the denominator is the first six months of the measurement year.

Numerator

The number of consumers in the denominator whose most recent BP (both systolic and diastolic) is adequately controlled during the measurement year based on the following criteria:

- Consumers ages 18 to 59 as of December 31 of the measurement year whose BP was <140/90 mm Hg
- Consumers ages 60 to 85 as of December 31 of the measurement year and flagged with a diagnosis of diabetes whose BP was <140/90 mm Hg
- Consumers ages 60 to 85 as of December 31 of the measurement year and flagged as not having a diagnosis of diabetes whose BP was <150/90 mm Hg

To determine if a consumer's BP is adequately controlled, the representative BP must be identified.

Note: The measurement period for the numerator is the measurement year using the medical records specification below. The blood pressure reading indicating adequate control must occur after the diagnosis of hypertension was made.

E. MEDICAL RECORDS SPECIFICATION

Follow the steps below to determine representative BP.

Step 1

Identify the most recent BP reading noted during the measurement year. The reading must occur after the date when the diagnosis of hypertension was confirmed. **Do not include** BP readings:

- Taken during an acute inpatient stay or an ED visit
- Taken during an outpatient visit which was for the sole purpose of having a diagnostic test or surgical procedure performed (e.g., sigmoidoscopy, removal of a mole)
- Obtained the same day as a major diagnostic or surgical procedure (e.g., stress test, administration of IV contrast for a radiology procedure, endoscopy)
- Reported by or taken by the consumer

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.

Step 2

Determine numerator compliance based on the following criteria:

- Consumers ages 18 to 59 as of December 31 of the measurement year whose BP was <140/90 mm Hg
- Consumers ages 60 to 85 as of December 31 of the measurement year and flagged with a diagnosis of diabetes whose BP was <140/90 mm Hg
- Consumers ages 60 to 85 as of December 31 of the measurement year and flagged as not having a diagnosis of diabetes whose BP was <150/90 mm Hg

The consumer is not compliant if the BP reading does not meet the specified threshold or is missing, or 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).

Step 3

A single rate is reported for all three groups for each stratification (ages 18 to 64, ages 65 to 85, and total). Sum the numerator events from Step 2 to obtain a rate.

Note: The measurement period for the numerator is the measurement year.

Exclusions (optional)

- Exclude from the eligible population all consumers with evidence of end-stage renal disease (ESRD) (ESRD Value Set; ESRD Obsolete Value Set) or kidney transplant (Kidney Transplant Value Set) on or prior to the last day of the measurement year.

  Note: Documentation in the medical record must include a dated note indicating evidence of ESRD, kidney transplant, or dialysis.

- Exclude from the eligible population all consumers with a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year.
- Exclude from the eligible population all consumers who had a non-acute inpatient admission during the measurement year. To identify non-acute inpatient admissions:
  - Identify all acute and non-acute inpatient stays (Inpatient Stay Value Set).
  - Confirm the stay was for non-acute care based on the presence of a non-acute code (Non-acute Inpatient Stay Value Set) on the claim.
  - Identify the admission date for the stay.

F. ADDITIONAL NOTES

Problem lists generally indicate established conditions; excluding undated entries might hinder confirmation of the denominator. If a problem list is found in an office visit note then it would be considered a dated problem list and the date of the visit must be used.

Only administrative data should be used to assign the diabetes flag. The intent of the flag is to determine the appropriate BP threshold to use for the consumer during numerator assessment. The only exception is if the consumer is flagged as a diabetic but medical record evidence contains information that classifies the consumer as a valid data error. To meet criteria as a valid data error, the medical record must contain no evidence of diabetes and include a notation that refutes the diagnosis. In this case, the diabetes flag may be changed to "not diabetic," but the consumer may not be removed from the sample.

The source measure is designed for the Medicaid population and is not risk adjusted. The source measure was specified and tested at the health plan level. This measure is modified to require clinic-level reporting, and to be consistent in format with other measures in this set of BHC measures, but is not tested at the clinic level.

Interpretation of score: Better quality = Higher score

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

Based on a measure stewarded by the American Medical Association (AMA) and CPI® Foundation (PCPI®) **(**NQF #0028, PQRS # 226)

A. DESCRIPTION

Percentage of consumers aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user

Data Collection Method: Medical Records

Guidance for Reporting:

- This measure is stratified by whether the consumer is a Medicaid beneficiary, eligible for both Medicare and Medicaid, and other.
- This measure is to be reported once per measurement year for consumers seen during the measurement year.
- This measure is intended to reflect the quality of services provided for preventive screening for tobacco use.
- Provider entities 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
- Please refer to the most recent source measure PQRS #226 at PQRS Measures for codes needed to calculate this measure.
- Refer to the specific data-reporting template for the reporting requirements applicable to each measure and to the Appendices in Volume 2 of this manual.

Measurement Period: The measurement period for the denominator is the measurement year and, for the numerator, is the measurement year and the prior year.

B. DEFINITIONS

TERM	DEFINITION
Provider Entity	The provider entity that is being measured (i.e., BHC)
Tobacco Cessation Intervention	Includes brief counseling (3 minutes or less) and/or pharmacotherapy
Tobacco Use	Includes use of any type of tobacco

C. ELIGIBLE POPULATION

CRITERIA	REQUIREMENTS
Age	Consumers aged 18 years or older on the date of service during the measurement year
Event/Diagnosis	Follow the steps below to identify the eligible population: ***Step 1*** Identify consumers seen at the provider entity during the measurement year. ***Step 2*** Identify consumers from step 1 who were aged 18 years and older on the date of service during the measurement year. ***Step 3*** Identify consumers from step 2 who had an eligible encounter at the provider entity during the measurement year. **Relevant codes (Current Procedural Terminology [CPT®] or Healthcare Common Procedure Coding System [HCPCS]) may be found in the most recent source measure.**

D. MEDICAL RECORD SPECIFICATION

Denominator

The number of consumers in the eligible population (Section C)

Note: The measurement period for the denominator is the measurement year.

Incomplete Reporting Exclusion: Failure to record quality-data codes necessary for computing the numerator means that the consumer is excluded from the denominator.

Numerator

The number of consumers who were screened for tobacco use at least once within 24 months **AND** who received tobacco cessation intervention if identified as a tobacco user

Numerator Options: The options below indicate the coding possibilities related to the numerator. The first two, where performance is met, indicate situations where the data point is included in the numerator. The third, where performance is not met, means that the data point represents a quality failure and is not counted in the numerator.

Performance Met: Consumer screened for tobacco use AND received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user (see most recent source measure for codes)

OR

Performance Met: Consumer screened for tobacco use and identified as a non-user of tobacco (see most recent source measure for codes)

Performance Not Met: Tobacco screening OR tobacco cessation intervention not performed, reason not otherwise specified (see most recent source measure for codes)

Exception:[2] Documentation of medical reason(s) for not screening for tobacco use (e.g., limited life expectancy, other medical reasons) (see most recent source measure for codes)

Note: The measurement period for the numerator is the measurement year and the prior year. For CCBHCs that do not have access to this information for the year prior to Demonstration Year 1 (DY1), screening should occur during DY1.

Example Calculation: See Appendix TSC.

E. ADDITIONAL NOTES

Both this measure 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 score: Better quality = Higher score

[2] The AMA PCPI specifications refer to "exceptions" in circumstances where many specifications would reference "exclusions." We retain the AMA PCPI language for consistency with the original measure. The AMA PCPI measures also place exceptions in numerator calculations.

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

Based on a measure stewarded by the American Medical Association (AMA) and PCPI® Foundation (PCPI®) (NQF #2152, PQRS #431)

A. DESCRIPTION

Percentage of consumers aged 18 years and older who were screened at least once within the last 24 months for unhealthy alcohol use using a systematic screening method AND who received brief counseling if identified as an unhealthy alcohol user

Data Collection Method: Medical Records

Guidance for Reporting:

- This measure is stratified by whether the consumer is a Medicaid beneficiary, eligible for both Medicare and Medicaid, and other.
- This measure is to be reported once per measurement year for consumers seen during the measurement year. This measure is intended to reflect the quality of services provided for preventive screening for unhealthy alcohol use. There is no diagnosis associated with this measure. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.
- Provider entities 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
- Please refer to the most recent source measure PQRS #431 at PQRS Measures for codes needed to calculate this measure.
- Refer to the specific data-reporting template for the reporting requirements applicable to each measure and to the Appendices in Volume 2 of this manual.

Measurement Period: The measurement period for the denominator is the measurement year and, for the numerator, is the measurement year and the prior year.

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.
Provider Entity	The provider entity that is being measured (i.e., BHC)
Systematic Screening Method	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 ≥2)

C. ELIGIBLE POPULATION

CRITERIA	REQUIREMENTS
Age	Consumers aged 18 years or older on the date of service during the measurement year

CRITERIA	REQUIREMENTS
Event/Diagnosis	Follow the steps below to identify the eligible population: ***Step 1*** Identify consumers seen at the provider entity during the measurement year. ***Step 2*** Identify consumers from step 1 who were aged 18 years and older on the date of service during the measurement year. ***Step 3*** 1. Identify consumers from step 2 who met either of the following criteria during the measurement year: Had at least two encounters at the provider entity during the measurement year. **Relevant codes (Current Procedural Terminology [CPT®] or Healthcare Common Procedure Coding System [HCPCS]) may be found in the most recent source measure.** **OR** 2. Had one preventive care visit. Relevant codes (Current Procedural Terminology [CPT®] or Healthcare Common Procedure Coding System [HCPCS]) may be found in the most recent source measure.

D. MEDICAL RECORD SPECIFICATION

Denominator

The number of consumers in the eligible population (Section C)

Note: The measurement period for the denominator is the measurement year.

Incomplete Reporting Exclusion: Failure to record quality-data codes necessary for computing the numerator means that the consumer is excluded from the denominator.

Numerator

The number of consumers who were screened at least once within the last 24 months for unhealthy alcohol use using a systematic screening method **AND** who received brief counseling if identified as an unhealthy alcohol user.

Numerator Options: The options below indicate the coding possibilities related to the numerator. The first two, where performance is met, indicate situations where the data point is included in the numerator. The third, where performance is not met, means that the data point represents a quality failure and is not counted in the numerator.

Performance Met: Consumer identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method and received brief counseling (G9621)

OR

Performance Met: Consumer not identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method (G9622)

Performance Not Met: Consumer not screened for unhealthy alcohol screening using a systematic screening method OR consumer did not receive brief counseling, reason not given (G9624)

Exception:[3] Documentation of medical reason(s) for not screening for unhealthy alcohol use in the measurement year or the year prior (e.g., limited life expectancy, other medical reasons) (G9623)

Note: The measurement period for the numerator is the measurement year and the prior year. For CCBHCs who do not have access to this information for the year prior to Demonstration Year 1 (DY1), screening should occur during DY1.

Example Calculation: See Appendix ASC.

[3] The AMA PCPI specifications refer to "exceptions" in circumstances where many specifications would reference "exclusions." We retain the AMA PCPI language for consistency with the original measure. The AMA PCPI measures also place exceptions in numerator calculations.

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 score: Better quality = Higher score

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

Based on a measure stewarded by the
American Medical Association (AMA) and PCPI® Foundation (PCPI®) (NQF #1365, PQRS #382)

A. DESCRIPTION

Percentage of consumer visits for those consumers aged 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk

Data Collection Method: Electronic Health Records

Guidance for Reporting:

- This measure is stratified by whether the consumer is a Medicaid beneficiary, eligible for both Medicare and Medicaid, other, and by total population. For purposes of determining whether a consumer is a Medicaid beneficiary or a dual Medicare and Medicaid enrollee, use their insurance status on the date of the measured visit.
- This measure is specified for calculation using electronic health records.
- This measure is based on the percentage of consumer visits rather than consumers.
- More information about this measure is available in the eCQM Library (CMS 177v3), available at eCQM Library, Annual Updates, eCQM Electronic Specifications page on CMS.gov.
- More information about CMS177v3 is available in the Electronic Clinical Quality Improvement Resource Center (eCQI Resource Center)
- Value sets for this measure are available from the U.S. National Library of Medicine Value Set Authority Center (VSAC).
- Access to the VSAC requires a Unified Medical Language System (UMLS) license; states may apply for a UMLS license at UMLS Metathesaurus License webpage.
- When searching for value sets for this measure, states should use the measure's associated e-Measure number (CMS177v3) or NQF number (1365).
- The measure steward periodically releases updated value sets. Always use the value set that corresponds with the specification release date. This specification and associated value sets are part of the 07-01-2014 release.
- Refer to Appendix SRA-BH-C for e-Measure flows for this measure.

- Refer to the specific data-reporting template for the reporting requirements applicable to each measure and to the Appendices in Volume 2 of this manual.

Measurement Period: The measurement period for both the denominator and the numerator is the measurement year (e.g., for CCBHCs, DY1 or DY2).

B. DEFINITIONS

TERM	DEFINITION
Provider Entity	The provider entity that is being measured (i.e., BHC)

C. ELIGIBLE POPULATION

CRITERIA	REQUIREMENTS
Age	Consumers 6–17 years of age as of the start of the measurement year
Event/Diagnosis	Follow the steps below to identify the eligible population: ***Step 1*** Identify consumers seen at the provider entity who were 6–17 years of age as of the start of the measurement year. ***Step 2*** Identify consumers from step 1 who had at least two qualifying visits during the measurement year. ***Step 3*** Identify consumers from step 2 who had an active diagnosis of Major Depressive Disorder at the time of the encounter. ***Note:*** One consumer may have multiple encounters with an active diagnosis of Major Depressive Disorder and each encounter counts separately. ***Note:*** See Electronic Health Record Specification (section D) for the logic in calculating the denominator.

D. ELECTRONIC HEALTH RECORD SPECIFICATION

Denominator

All consumer visits for those consumers 6–17 years of age with a diagnosis of major depressive disorder

Denominator Logic

- **Initial Consumer Population =**
    - AND: "Consumer Characteristic Birthdate: birth date" >= 6 year(s) starts before start of "Measurement Period"
    - AND: "Consumer Characteristic Birthdate: birth date" < 17 year(s) starts before start of "Measurement Period"
    - AND: Count >= 2 of:
        - OR: "Encounter, Performed: Office Visit"
        - OR: "Encounter, Performed: Outpatient Consultation"
        - OR: "Encounter, Performed: Patient Provider Interaction"
        - OR: "Encounter, Performed: Psych Visit - Diagnostic Evaluation"
        - OR: "Encounter, Performed: Psych Visit - Family Psychotherapy"
        - OR: "Encounter, Performed: Psychoanalysis"
        - OR: "Encounter, Performed: Group Psychotherapy"
        - OR: "Encounter, Performed: Psych Visit - Psychotherapy"
        - during "Measurement Period"
    - AND:
        - OR:
            - AND: "Occurrence A of Diagnosis, Active: Major Depressive Disorder-Active" starts before or during "Occurrence A of Encounter, Performed: Psych Visit - Diagnostic Evaluation"
            - AND: "Occurrence A of Encounter, Performed: Psych Visit - Diagnostic Evaluation" during "Measurement Period"
            - AND NOT: "Occurrence A of Diagnosis, Active: Major Depressive Disorder-Active" ends before start of "Occurrence A of Encounter, Performed: Psych Visit - Diagnostic Evaluation"
        - OR:
            - AND: "Occurrence A of Diagnosis, Active: Major Depressive Disorder-Active" starts before or during "Occurrence A of Encounter, Performed: Psych Visit - Family Psychotherapy"
            - AND: "Occurrence A of Encounter, Performed: Psych Visit - Family Psychotherapy" during "Measurement Period"
            - AND NOT: "Occurrence A of Diagnosis, Active: Major Depressive Disorder-Active" ends before start of "Occurrence

A of Encounter, Performed: Psych Visit - Family Psychotherapy"

- OR:
  - AND: "Occurrence A of Diagnosis, Active: Major Depressive Disorder-Active" starts before or during "Occurrence A of Encounter, Performed: Face-to-Face Interaction"
  - AND: "Occurrence A of Encounter, Performed: Face-to-Face Interaction" during "Measurement Period"
  - AND NOT: "Occurrence A of Diagnosis, Active: Major Depressive Disorder-Active" ends before start of "Occurrence A of Encounter, Performed: Face-to-Face Interaction"
- OR:
  - AND: "Occurrence A of Diagnosis, Active: Major Depressive Disorder-Active" starts before or during "Occurrence A of Encounter, Performed: Group Psychotherapy"
  - AND: "Occurrence A of Encounter, Performed: Group Psychotherapy" during "Measurement Period"
  - AND NOT: "Occurrence A of Diagnosis, Active: Major Depressive Disorder-Active" ends before start of "Occurrence A of Encounter, Performed: Group Psychotherapy"
- OR:
  - AND: "Occurrence A of Diagnosis, Active: Major Depressive Disorder-Active" starts before or during "Occurrence A of Encounter, Performed: Outpatient Consultation"
  - AND: "Occurrence A of Encounter, Performed: Outpatient Consultation" during "Measurement Period"
  - AND NOT: "Occurrence A of Diagnosis, Active: Major Depressive Disorder-Active" ends before start of "Occurrence A of Encounter, Performed: Outpatient Consultation"
- OR:
  - AND: "Occurrence A of Diagnosis, Active: Major Depressive Disorder-Active" starts before or during "Occurrence A of Encounter, Performed: Office Visit"
  - AND: "Occurrence A of Encounter, Performed: Office Visit" during "Measurement Period"

- AND NOT: "Occurrence A of Diagnosis, Active: Major Depressive Disorder-Active" ends before start of "Occurrence A of Encounter, Performed: Office Visit"

▪ OR:

- AND: "Occurrence A of Diagnosis, Active: Major Depressive Disorder-Active" starts before or during "Occurrence A of Encounter, Performed: Psychoanalysis"
- AND: "Occurrence A of Encounter, Performed: Psychoanalysis" during "Measurement Period"
- AND NOT: "Occurrence A of Diagnosis, Active: Major Depressive Disorder-Active" ends before start of "Occurrence A of Encounter, Performed: Psychoanalysis"

▪ OR:

- AND: "Occurrence A of Diagnosis, Active: Major Depressive Disorder-Active" starts before or during "Occurrence A of Encounter, Performed: Psych Visit - Psychotherapy"
- AND: "Occurrence A of Encounter, Performed: Psych Visit - Psychotherapy" during "Measurement Period"
- AND NOT: "Occurrence A of Diagnosis, Active: Major Depressive Disorder-Active" ends before start of "Occurrence A of Encounter, Performed: Psych Visit - Psychotherapy"

- **Denominator** =
  - AND: "Initial Consumer Population"

Numerator

The number of consumer visits with an assessment for suicide risk

Numerator Definition

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 consumer.

Suicide risk assessment can include:

- specific inquiry about suicidal thoughts, intent, plans, means, and behaviors
- identification of specific psychiatric symptoms (e.g., psychosis, severe anxiety, substance use) or general medical conditions that may increase the likelihood of acting on suicidal ideas
- assessment of past and, particularly, recent suicidal behavior

- delineation of current stressors and potential protective factors (e.g., positive reasons for living, strong social support)
- identification of any family history of suicide or mental illness

Low burden tools to track suicidal ideation and behavior such as the Columbia-Suicide Severity Rating Scale can also be used.

Numerator Guidance

A suicide risk assessment should be performed at every visit for Major Depressive Disorder during the measurement period.

This measure is an episode-of-care measure; the level of analysis for this measure is every visit for Major Depressive Disorder during the measurement period. A minimum of two encounters are required during the measurement period for a consumer to be included in this measure to establish that the eligible professional has an existing relationship with the consumer; if the consumer is only seen once by the eligible professional, the consumer is not included in the measure. Once it has been established that the consumer has been seen at least twice by the eligible professional, every visit for Major Depressive Disorder should be counted as a measurable episode for the measure calculation. For example, at every visit for MDD, the consumer should have a suicide risk assessment.

Use of a standardized tool or instrument to assess suicide risk will meet numerator performance. Standardized tools can be mapped to the concept “Intervention, Performed: Suicide Risk Assessment” included in the numerator logic below.

Numerator Logic

- AND: "Intervention, Performed: Suicide Risk Assessment" during
  - OR: "Occurrence A of Encounter, Performed: Office Visit"
  - OR: "Occurrence A of Encounter, Performed: Outpatient Consultation"
  - OR: "Occurrence A of Encounter, Performed: Face-to-Face Interaction"
  - OR: "Occurrence A of Encounter, Performed: Psych Visit - Diagnostic Evaluation"
  - OR: "Occurrence A of Encounter, Performed: Psych Visit - Psychotherapy"
  - OR: "Occurrence A of Encounter, Performed: Psych Visit - Family Psychotherapy"
  - OR: "Occurrence A of Encounter, Performed: Psychoanalysis"
  - OR: "Occurrence A of Encounter, Performed: Group Psychotherapy"

Exclusions

None.

E. ADDITIONAL NOTES

Both this measure 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 score: Better quality = Higher score

Data Criteria - Quality Data Model (QDM) Data Elements

Available in the **SRA Value Set**

"Diagnosis, Active: Major Depressive Disorder-Active" using "Major Depressive Disorder-Active Grouping Value Set (2.16.840.1.113883.3.526.3.1491)"

"Encounter, Performed: Face-to-Face Interaction" using "Face-to-Face Interaction Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1048)"

"Encounter, Performed: Group Psychotherapy" using "Group Psychotherapy Grouping Value Set (2.16.840.1.113883.3.526.3.1187)"

"Encounter, Performed: Office Visit" using "Office Visit Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1001)"

"Encounter, Performed: Outpatient Consultation" using "Outpatient Consultation Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1008)"

"Encounter, Performed: Patient Provider Interaction" using "Patient Provider Interaction Grouping Value Set (2.16.840.1.113883.3.526.3.1012)"

"Encounter, Performed: Psych Visit - Diagnostic Evaluation" using "Psych Visit - Diagnostic Evaluation Grouping Value Set (2.16.840.1.113883.3.526.3.1492)"

"Encounter, Performed: Psych Visit - Family Psychotherapy" using "Psych Visit - Family Psychotherapy Grouping Value Set (2.16.840.1.113883.3.526.3.1018)"

"Encounter, Performed: Psych Visit - Psychotherapy" using "Psych Visit - Psychotherapy Grouping Value Set (2.16.840.1.113883.3.526.3.1496)"

"Encounter, Performed: Psychoanalysis" using "Psychoanalysis Grouping Value Set (2.16.840.1.113883.3.526.3.1141)"

"Intervention, Performed: Suicide Risk Assessment" using "Suicide Risk Assessment Grouping Value Set (2.16.840.1.113883.3.526.3.1484)"

"Patient Characteristic Birthdate: birth date" using "birth date LOINC Value Set (2.16.840.1.113883.3.560.100.4)"

Reporting Stratification

"Patient Characteristic Payer: Payer" using "Payer SOP Value Set (2.16.840.1.114222.4.11.3591)"

Supplemental Data Elements

"Patient Characteristic Ethnicity: Ethnicity" using "Ethnicity CDC Value Set (2.16.840.1.114222.4.11.837)"

"Patient Characteristic Race: Race" using "Race CDC Value Set (2.16.840.1.114222.4.11.836)"

"Patient Characteristic Sex: ONC Administrative Sex" using "ONC Administrative Sex Administrative Sex Value Set (2.16.840.1.113762.1.4.1)"

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

Based on a measure stewarded by the American Medical Association (AMA) and PCPI® Foundation (PCPI®) (NQF #0104, PQRS #107 (electronic version only))

A. DESCRIPTION

Percentage of consumers aged 18 years and older with a diagnosis of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified

Data Collection Method: Electronic Health Records or Medical Records

Guidance for Reporting:

- This measure is stratified by whether the consumer is a Medicaid beneficiary, eligible for both Medicare and Medicaid, and other. For purposes of determining whether a consumer is a Medicaid beneficiary or a dual Medicare and Medicaid enrollee, use their insurance status on the date of the measured visit.
- This measure is specified two ways, for calculation either using electronic health records or using medical records.
- This measure is based on the percentage of consumer visits rather than consumers.
- For those using the Electronic Health Records Specification:
    - More information about this measure is available in the eCQM Library (CMS 161v3), available at eCQM Library, Annual Updates, eCQM Electronic Specifications page on CMS.gov.
    - More information about CMS161v3 is available at the Electronic Clinical Quality Improvement Resource Center (eCQI Resource Center)
    - Value sets for this measure are available from the U.S. National Library of Medicine Value Set Authority Center (VSAC) are available from the U.S. National Library of Medicine Value Set Authority Center (VSAC)
    - Access to the VSAC requires a Unified Medical Language System (UMLS) license; states may apply for a UMLS license at the UMLS Metathesaraus License webpage.
    - When searching for value sets for this measure, states should use the measure's associated e-Measure number (CMS161v4) or NQF number (0104).

  - The measure steward periodically releases updated value sets. Always use the value set that corresponds with the specification release date. This specification and associated value sets are part of the 07-01-2014 release.
  - Refer to Appendix SRA-A.A for e-Measure flows for this measure.
- For those using the Medical Records Specification:
  - For provider entities who 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
- Refer to the specific data-reporting template for the reporting requirements applicable to each measure and to the Appendices in Volume 2 of this manual.

Measurement Period: The measurement period for both the denominator and the numerator is the measurement year (e.g., for CCBHCs, DY1 or DY2).

B. DEFINITIONS

TERM	DEFINITION
Initial Consumer Population	All consumers aged 18 years and older with a diagnosis of major depressive disorder (MDD)
Provider Entity	The provider entity that is being measured (i.e., BHC)
Suicide Risk Assessment	A suicide risk assessment must include questions about the following: 1. Suicidal ideation 2. Consumer's intent of initiating a suicide attempt AND, if either is present: 3. Consumer plans for a suicide attempt 4. Whether the consumer has means for completing suicide

C. ELIGIBLE POPULATION

CRITERIA	REQUIREMENTS
Age	Consumers aged 18 years and older

CRITERIA	REQUIREMENTS
Event/Diagnosis for Those Using the Electronic Health Records Specification	Follow the steps below to identify the eligible population: ***Step 1*** Identify consumers seen at the provider entity who were aged 18 and older at the start of the measurement year. ***Step 2*** Identify consumers from step 1 who had at least one qualifying visit during the measurement year. ***Step 3*** Identify consumers from step 2 who had an active diagnosis of Major Depressive Disorder at the time of the encounter. ***Note:*** One consumer may have multiple encounters with an active diagnosis of Major Depressive Disorder and each encounter counts separately. ***Note:*** See Electronic Health Record Specification (section D) for the logic in calculating the denominator.

CRITERIA	REQUIREMENTS
Event/Diagnosis for Those Using the Medical Records Specification	Follow the steps below to identify the eligible population: ***Step 1*** Identify consumers seen at the provider entity at least once during the measurement year. ***Step 2*** Identify consumers from step 1 aged 18 and older at the time of the first encounter identified in step 3. ***Step 3*** Identify consumers from step 2 with a new diagnosis or recurrent episode of MDD identified by the provider entity during the measurement year. Relevant codes (International Classification of Diseases, Tenth Revision, Clinical Modification ([CD-10-CM] and Current Procedural Terminology [CPT®]) may be found in the original measure specification at AMA PCPI Major Depressive Disorder Adult Specifications. ***Step 4*** Identify the number of times, for the consumers in step 3, there was a new diagnosis or recurrent episode of MDD identified by the clinic during the measurement year. ***Note:*** 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. This is an episode-of-care measure and should be reported for each instance of a new or recurrent episode of MDD; every new or recurrent episode will count separately in the Eligible Population.

D. ELECTRONIC HEALTH RECORDS SPECIFICATION

Denominator

All consumer visits for those consumers aged 18 years and older with a diagnosis of major depressive disorder

Denominator Logic

- **Initial Consumer Population =**
    - AND: “Patient Characteristic Birthdate: birth date” >= 17 year(s) starts before start of “Measurement Period”
    - AND: “Diagnosis, Active: Major Depressive Disorder-Active” starts during
        - OR: “Occurrence A of Encounter, Performed: Psych Visit – Diagnostic Evaluation”
        - OR: "Occurrence A of Encounter, Performed: Psych Visit - Psychotherapy"
        - OR: "Occurrence A of Encounter, Performed: Emergency Department Visit"
        - OR: "Occurrence A of Encounter, Performed: Office Visit"”
        - OR: “Occurrence A of Encounter, Performed: Outpatient Consultation”
        - OR: “Occurrence A of Encounter, Performed: Psychoanalysis”
        - OR: “Occurrence A of Encounter, Performed: Face-to-Face Interaction”
        - during “Measurement Period”
    - AND:
        - OR:
            - AND: “Occurrence A of Diagnosis, Active: Major Depressive Disorder-Active” starts before or during “Occurrence A of Encounter, Performed: Psych Visit – Diagnostic Evaluation”
            - AND: “Occurrence A of Encounter, Performed: Psych Visit – Diagnostic Evaluation” during “Measurement Period”
            - AND NOT: “Occurrence A of Diagnosis, Active: Major Depressive Disorder-Active” ends before start of “Occurrence A of Encounter, Performed: Psych Visit – Diagnostic Evaluation”
        - OR:
            - AND: “Occurrence A of Diagnosis, Active: Major Depressive Disorder-Active” starts before or during “Occurrence A of Encounter, Performed: Psych Visit – Psychotherapy”
            - AND: “Occurrence A of Encounter, Performed: Psych Visit – Psychotherapy” during “Measurement Period”

- AND NOT: “Occurrence A of Diagnosis, Active: Major Depressive Disorder-Active” ends before start of “Occurrence A of Encounter, Performed: Psych Visit – Psychotherapy”

- OR:
  - AND: “Occurrence A of Diagnosis, Active: Major Depressive Disorder-Active” starts before or during “Occurrence A of Encounter, Performed: Emergency Department Visit “
  - AND: “Occurrence A of Encounter, Performed: Emergency Department Visit “ during “Measurement Period”
  - AND NOT: “Occurrence A of Diagnosis, Active: Major Depressive Disorder-Active” ends before start of “Occurrence A of Encounter, Performed: Emergency Department Visit “
- OR:
  - AND: “Occurrence A of Diagnosis, Active: Major Depressive Disorder-Active” starts before or during “Occurrence A of Encounter, Performed: Office Visit”
  - AND: “Occurrence A of Encounter, Performed: Office Visit” during “Measurement Period”
  - AND NOT: “Occurrence A of Diagnosis, Active: Major Depressive Disorder-Active” ends before start of “Occurrence A of Encounter, Performed: Office Visit”
- OR:
  - AND: “Occurrence A of Diagnosis, Active: Major Depressive Disorder-Active” starts before or during “Occurrence A of Encounter, Performed: Outpatient Consultation”
  - AND: “Occurrence A of Encounter, Performed: Outpatient Consultation” during “Measurement Period”
  - AND NOT: “Occurrence A of Diagnosis, Active: Major Depressive Disorder-Active” ends before start of “Occurrence A of Encounter, Performed: Outpatient Consultation”
- OR:
  - AND: “Occurrence A of Diagnosis, Active: Major Depressive Disorder-Active” starts before or during “Occurrence A of Encounter, Performed: Psychoanalysis”
  - AND: “Occurrence A of Encounter, Performed: Psychoanalysis” during “Measurement Period”

- AND NOT: “Occurrence A of Diagnosis, Active: Major Depressive Disorder-Active” ends before start of “Occurrence A of Encounter, Performed: Psychoanalysis”

▪ OR:

- AND: Occurrence A of Diagnosis, Active: Major Depressive Disorder-Active" starts before or during "Occurrence A of Encounter, Performed: Face-to-Face Interaction"
- AND: "Occurrence A of Encounter, Performed: Face-to-Face Interaction" during "Measurement Period"
- AND NOT: "Occurrence A of Diagnosis, Active: Major Depressive Disorder-Active" ends before start of "Occurrence A of Encounter, Performed: Face-to-Face Interaction"

- **Denominator =**
  - AND: “Initial Consumer Population”

Numerator

The number of consumer visits with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified.

Numerator Guidance

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). This measure is an episode-of-care measure and should be reported for each instance of a new or recurrent episode of MDD; every new or recurrent episode will count separately in the Initial Consumer Population.

Use of a standardized tool or instrument to assess suicide risk will meet numerator performance. Standardized tools can be mapped to the concept "Intervention, Performed: Suicide Risk Assessment” included in the numerator logic below.

The measure description outlined in the header for this measure states, ‘consumers aged 18 years and older’ while the logic statement states, ‘>= 17 year(s) starts before start of “Measurement Period.”’ The logic statement, as written, captures consumers who turn 18 years old during the measurement period so that these patients are included in the measure. To ensure all consumers with major depressive disorder (MDD) are assessed for suicide risk, there are two clinical quality measures addressing suicide risk assessment; CMS 177 covers children and adolescents aged 6 through 17, and CMS 161 covers the adult population aged 18 years and older.

Numerator Logic

- AND: “Intervention, Performed: Suicide Risk Assessment” during
  - OR: “Occurrence A of Encounter, Performed: Psych Visit Diagnostic Evaluation"
  - OR: "Occurrence A of Encounter, Performed: Psych Visit - Psychotherapy"
  - OR: "Occurrence A of Encounter, Performed: Emergency Department Visit "
  - OR: "Occurrence A of Encounter, Performed: Office Visit"
  - OR: "Occurrence A of Encounter, Performed: Outpatient Consultation"
  - OR: "Occurrence A of Encounter, Performed: Psychoanalysis"
  - OR: "Occurrence A of Encounter, Performed: Face-to-Face Interaction"

Exclusions

None

E. MEDICAL RECORDS SPECIFICATION

Denominator

The number of consumers in the eligible population (Section C)

Numerator

The number of consumers with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified.

Exclusions

None

Example Calculation: See Appendix SRA-A.B.

F. ADDITIONAL NOTES

Both this measure 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 score: Better quality = Higher score

Data Criteria – Quality Data Model (QDM) Data Elements for the Electronic Measure

- "Diagnosis, Active: Major Depressive Disorder-Active" using "Major Depressive Disorder-Active Grouping Value Set (2.16.840.1.113883.3.526.3.1491)"
- "Encounter, Performed: Emergency Department Visit" using "Emergency Department Visit Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1010)"
- "Encounter, Performed: Face-to-Face Interaction" using "Face-to-Face Interaction Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1048)"
- "Encounter, Performed: Office Visit" using "Office Visit Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1001)"
- "Encounter, Performed: Outpatient Consultation" using "Outpatient Consultation Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1008)"
- "Encounter, Performed: Psych Visit - Diagnostic Evaluation" using "Psych Visit - Diagnostic Evaluation Grouping Value Set (2.16.840.1.113883.3.526.3.1492)"
- "Encounter, Performed: Psych Visit - Psychotherapy" using "Psych Visit - Psychotherapy Grouping Value Set (2.16.840.1.113883.3.526.3.1496)"
- "Encounter, Performed: Psychoanalysis" using "Psychoanalysis Grouping Value Set (2.16.840.1.113883.3.526.3.1141)"
- "Intervention, Performed: Suicide Risk Assessment" using "Suicide Risk Assessment Grouping Value Set (2.16.840.1.113883.3.526.3.1484)"
- "Patient Characteristic Birthdate: birth date" using "birth date LOINC Value Set (2.16.840.1.113883.3.560.100.4)"

Reporting Stratification

- "Patient Characteristic Payer: Payer" using "Payer SOP Value Set (2.16.840.1.114222.4.11.3591)"

Supplemental Data Elements

- "Patient Characteristic Ethnicity: Ethnicity" using "Ethnicity CDCREC Value Set (2.16.840.1.114222.4.11.837)"
- "Patient Characteristic Race: Race" using "Race CDCREC Value Set (2.16.840.1.114222.4.11.836)"
- "Patient Characteristic Sex: ONC Administrative Sex" using "ONC Administrative Sex Administrative Gender Value Set (2.16.840.1.113762.1.4.1)

Screening for Clinical Depression and Follow-Up Plan (CDF-BH)

Based on a measure stewarded by the
Centers for Medicare & Medicaid Services (NQF #0418; PQRS #134)

A. DESCRIPTION

Percentage of consumers aged 12 and older screened for clinical depression on the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen

Data Collection Method: Hybrid

Guidance for Reporting:

- This measure is stratified by whether the consumer is a Medicaid beneficiary, eligible for both Medicare and Medicaid, and other. It also is stratified by age group (ages 12 to 17, ages 18 to 64, and age 65 and older). For purposes of determining whether a consumer is a Medicaid beneficiary or a dual Medicare and Medicaid enrollee, use their insurance status on the date of the measured visit.
- This measure uses administrative data and medical record review to calculate the denominator exclusions for the measure. Providers may also choose to use medical record review to identify numerator cases. Providers should indicate in section E or F (Adherence to Measure Specifications or Additional Notes, respectively) of the data-reporting template, deviations from the measure specifications if they use the hybrid method to identify numerator cases.
- This measure may be calculated using sampling, but measure-specific guidelines on sampling are not available from the steward. Providers should review information in the introductory material to this manual related to sampling and hybrid measures and describe their sampling methodology in Section F (Additional Notes) of the data-reporting template.
- The original specification for this measure included six G codes intended to capture, for the numerator, whether individual providers reported on this measure. For the purpose of BHC reporting, there are two G codes included in the numerator to capture whether clinical depression screening was done and if the screen was positive, whether a follow-up plan was documented.
- The date of encounter and screening must occur on the same date of service; if a consumer has more than one encounter during the measurement year, the consumer should be counted in the numerator and denominator only once based on the most recent encounter.

- Please refer to the most recent source measure PQRS #134 at PQRS Measures for codes needed to calculate this measure.
- To the extent possible, include all paid, suspended, pending, and denied claims.
- Refer to the specific data-reporting template for the reporting requirements applicable to each measure and to the Appendices in Volume 2 of this manual.

Measurement Period: The measurement period for both the denominator and the numerator is the measurement year (e.g., for CCBHCs, DY1 or DY2).

B. DEFINITIONS

TERM	DEFINITION
Follow-up Plan	Proposed outline of treatment to be conducted as a result of clinical depression screening. Follow-up for a positive depression screening must include one (1) or more of the following: • Additional evaluation • Suicide risk assessment • Referral to a practitioner who is qualified to diagnose and treat depression • Pharmacological interventions • Other interventions or follow-up for the diagnosis or treatment of depression The documented follow-up plan must be related to positive depression screening, for example: "Patient referred for psychiatric evaluation due to positive depression screening."
Provider Entity	The provider entity that is being measured (i.e., BHC)
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. Screening tests can predict the likelihood of someone having or developing a particular disease or condition. This measure looks for the screening being conducted in the practitioner's office that is filing the code.

TERM	DEFINITION
Standardized Tool	An 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. Some depression screening tools are: 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); Hopkins Symptom Checklist (HSCL); The Zung Self-Rating Depression Scale (SDS), and Cornell Scale Screening (this screening tool is used in situations where the consumer has cognitive impairment and is administered through the caregiver), and PRIME MD-PHQ2.

C. ELIGIBLE POPULATION

CRITERIA	REQUIREMENTS
Age	Consumers aged 12 years and older on date of encounter. Report three age stratifications: • 12–17 years • 18–64 years • 65 years and older
Event/Diagnosis	Follow the steps below to identify the eligible population: ***Step 1*** Identify consumers flagged as having been an outpatient visit at the provider entity at least once during the measurement year according to the codes **(Current Procedural Terminology [CPT®] and Healthcare Common Procedure Coding System [HCPCS])** identifying outpatient visits in accordance with the source measure. ***Step 2*** Identify consumers from step 1 who were aged 12 years and older on the date of the encounter.

D. HYBRID SPECIFICATION

Denominator

The number of consumers in the eligible population (Section C) with an outpatient visit during the measurement year (refer to codes in source measure).

Numerator

The number of consumers who were screened for clinical depression using a standardized tool **AND**, **if positive**, a follow-up plan is documented on the date of the positive screen using one of the codes in Table CDF-A in Appendix CDF-BH.B.

Note: Providers should indicate deviations from the measure specifications if they choose to use the hybrid method to identify numerator cases.

Exclusions

Exclude consumers if **one or more** of the following conditions are documented in the patient medical record:

- Consumer has an active diagnosis of Depression or Bipolar Disorder (see Table CDF-B in Appendix CDF-BH.B)
- Consumer refuses to participate
- Consumer is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the consumer's health status
- Situations where the consumer's functional capacity or motivation to improve may impact the accuracy of results of nationally recognized standardized depression assessment tools (for example, certain court-appointed cases or cases of delirium).

In addition, use the codes in Table CDF-B in Appendix CDF-BH.B to identify G codes indicating rationales for not screening or not providing follow-up.

Example Calculation: See Appendix CDF-BH.A.

E. ADDITIONAL NOTES

The source measure is designed for the Medicaid population and is not risk adjusted. The source measure was specified and tested at the health plan level. This measure is modified to require clinic-level reporting, and to be consistent in format with other measures in this set of BHC measures, but is not tested at the clinic level.

Interpretation of score: Better quality = Higher score

Depression Remission at Twelve Months (DEP-REM-12)

Based on a measure stewarded by Minnesota Community Measurement (NQF #0710, PQRS #370)

A. DESCRIPTION

Adult consumers 18 years of age or older with Major Depression or Dysthymia who reached remission 12 months (± 30 days) after an index visit. This measure applies to consumers with both newly diagnosed and existing Depression whose current PHQ-9 score indicates a need for treatment.

Data Collection Method: Medical Records

Guidance for Reporting:

- This measure is stratified by whether the consumer is a Medicaid beneficiary, eligible for both Medicare and Medicaid, and other.
- This measure is to be reported once per reporting period for consumers seen during the denominator identification measurement period with a diagnosis of Depression and an initial PHQ-9 greater than nine.
- These measures apply to consumers who are diagnosed with Major Depression or Dysthymia; either newly diagnosed or existing.
- Provider entities 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
- Referenced Value Sets are available from the source measure steward's website at the Cycle A DDS Guides page on the MN Community Measurement.
- Refer to the specific data-reporting template for the reporting requirements applicable to each measure and to the Appendices in Volume 2 of this manual.

Measurement Period: The measurement period for the denominator is the measurement year (e.g., for CCBHCs, DY1 or DY2), but it starts for each person at their individual index date. The measurement period for the numerator runs from the index date for the individual during the measurement year to the point 12 months after (± 30 days).

B. DEFINITIONS

TERM	DEFINITION
Index Date	An index visit occurs when ALL of the following criteria are met: • A PHQ-9 result greater than nine • An active diagnosis of Major Depression or Dysthymia** (Major Depression or Dysthymia Value Set) • The patient is NOT in a prior index period An index period begins with an index visit and is 13 months in duration. **For behavioral health providers only: The diagnosis of Major Depression or Dysthymia must be the primary diagnosis. ***Note:*** This distinction between behavioral health providers and other providers is only meaningful for BHCs that include non-behavioral health healthcare providers who may screen for depression as a part of providing general health care.
Provider Entity	The provider entity that is being measured (i.e., BHC)
PHQ-9	The Patient Health Questionnaire (PHQ-9) tool is a widely accepted, standardized tool that is completed by the consumer, 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 available at Patient Health Questionnaire (PHQ-9).
Remission	A PHQ-9 score of less than five
Twelve Months	The point in time from the index date in the measurement period that a patient meets the inclusion criteria (diagnosis and elevated PHQ-9 > 9) extending out twelve months and then allowing a grace period of thirty days prior to and thirty days after this date. Any PHQ-9 less than five obtained during this 60 day period is deemed remission at 12 months; values obtained prior to or after this period are not counted as numerator compliant (remission).

C. ELIGIBLE POPULATION

CRITERIA	REQUIREMENTS
Age	Consumers 18 years of age or older at the index visit
Event/Diagnosis	Follow the steps below to identify the eligible population: ***Step 1*** Identify consumers seen at the provider entity at least once during the measurement year. ***Step 2*** Identify consumers from step 1 who have a diagnosis of Major Depression or Dysthymia during an outpatient encounter during the measurement year (Major Depression or Dysthymia Value Set). ***Note:*** For behavioral health providers, the Depression or dysthymia diagnosis codes must be listed as the primary diagnosis. This excludes patients with other psychiatric diagnoses with a secondary component of Depression. If the provider is primary care, the diagnosis codes can be in any position (this might occur if the patient was diagnosed by a primary care provider and subsequently seen by the BHC). This distinction between behavioral health providers and other providers is only meaningful for BHCs that include non-behavioral health healthcare providers who may screen for depression as a part of providing general health care. ***Step 3*** Identify consumers from step 2 who have an index date PHQ-9 score greater than 9 documented during the twelve-month denominator identification period (code G9511). ***Step 4*** Identify consumers from step 3 who are aged 18 years and older at the index date. ***Note:*** To be considered denominator eligible for this measure, the consumer must have both the diagnosis of Major Depression or Dysthymia and an index date PHQ-9 score greater than 9 documented at the same encounter during the dates of denominator identification measurement period.

D. MEDICAL RECORD SPECIFICATION

Denominator

The number of consumers in the eligible population (Section C)

Note: The measurement period for the denominator is the measurement year, but it starts for each person at their individual index date.

Numerator

The number of consumers in the eligible population who achieved remission with a PHQ-9 result less than 5, 12 months (± 30 days) after an index visit

Numerator Options: The options below indicate the coding possibilities related to the numerator. The first, where performance is met, indicate situations where the data point is included in the numerator. The second, where performance is not met, means that the data point is excluded from the numerator.

Performance Met: Remission at twelve months as demonstrated by a twelve month (+/-30 days) PHQ-9 score of less than 5 **(G9509 or equivalent record of score)**

OR

Performance Not Met: Remission at twelve months not demonstrated by a twelve month (+/-30 days) PHQ-9 score of less than five. Either PHQ-9 score was not assessed during the allowed time period or is greater than or equal to 5 **(G9510 or equivalent record of score)**

Note: The measurement period for the numerator runs from the index date for the individual during the measurement year to the point 12 months after (± 30 days).

Required Exclusions

The following exclusions must be applied to the eligible population:

- Consumer had an active diagnosis of Bipolar Disorder (Bipolar Disorder Value Set)
- Consumer had an active diagnosis of Personality Disorder (Personality Disorder Value Set)

For consumers with bipolar disorder or personality disorder diagnoses, those diagnoses can be in any position (primary, secondary, etc.).

Optional Exclusions: The following exclusions are allowed to be applied to the eligible population:

- Consumer was a permanent nursing home resident at any time during the measurement year
- Consumer was in hospice or receiving palliative care at any time during the measurement year
- Consumer died prior to the end of the measurement year

Example Calculation

See Appendix DEP-REM-12.

E. ADDITIONAL NOTES

Both this measure 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 score: Better quality = Higher score

V. TECHNICAL SPECIFICATIONS -- STATE-REPORTED MEASURES

Housing Status (HOU)

SAMHSA-Developed Metric

A. DESCRIPTION

Percentage of consumers in 10 categories of living situation

Data Collection Method: Uniform Reporting System (URS) data

Guidance for Reporting:

- These data are reported in aggregate by the states as part of the URS and are broken into 10 categories of living situations. As part of the URS, they are reported in Table 15 of the URS Tables; for the Mental Health Block Grants, they are reported in Table 19 of the MHBG Report Tables on the URS & CLD Forms and Information page on NRI website. For purposes of this measure, the state will report by provider entity.
- For the purposes of this metric, the data should be collected at least twice during the measurement year, including at admission (intake) and/or discharge where relevant. When collected at a point other than admission or discharge, the living situation should be the one reported at the last assessment of housing status during the measurement period.
- Refer to the specific data-reporting template for the reporting requirements applicable to each measure and to the Appendices in Volume 2 of this manual.

Measurement Period: The measurement period is the measurement year, divided into two equal parts.

B. DEFINITIONS

TERM	DEFINITION
Living Situation	As used in the URS, living situation describes the type of residence in which the consumer resided. The specific living situations include: • Private Residence: Consumer lives in a house, apartment, trailer, hotel, dorm, barrack, or Single Room Occupancy (SRO). • Foster Home: Consumer resides in a Foster Home. A Foster Home is a home that is licensed by a County or State Department to provide foster care to children, adolescents, and/or adults. This includes Therapeutic Foster Care Facilities. Therapeutic Foster Care is a service that provides treatment for troubled children within private homes of trained families. • Residential Care: Consumer resides in a residential care facility. This level of care may include a Group Home, Therapeutic Group Home, Board and Care, Residential Treatment, or Rehabilitation Center, or Agency-operated residential care facilities. • Crisis Residence: Consumer resides in a residential (24 hours/day) stabilization program that delivers services for acute symptom reduction and restores consumers to a pre-crisis level of functioning. These programs are time limited for consumers until they achieve stabilization. Crisis residences serve persons experiencing rapid or sudden deterioration of social and personal conditions such that they are clinically at risk of hospitalization but may be treated in this alternative setting.

TERM	DEFINITION
Living Situation (cont'd)	• Children's Residential Treatment Facility: Consumer resides in a Children and Youth Residential Treatment Facility (RTF). RTFs provide fully integrated mental health treatment services to seriously emotionally disturbed children and youth. RTFs are an organization, not licensed as a psychiatric hospital, whose primary purpose is the provision of individually planned programs of mental health treatment services in conjunction with residential care for children and youth. The services are provided in facilities which are certified by state or federal agencies or through a national accrediting agency. • Institutional Setting: Consumer resides in an institutional care facility with care provided on a 24-hour 7 day a week basis. This level of care may include a Skilled Nursing/Intermediate Care Facility, Nursing Homes, Institutes of Mental Disease (IMD), Inpatient Psychiatric Hospital, Psychiatric Health Facility (PHF), Veterans Affairs Hospital, or State Hospital. • Jail/ Correctional Facility: Consumer resides in a Jail and/or Correctional facility with care provided on a 24-hour, 7 day a week basis. This level of care may include a Jail, Correctional Facility, Detention Centers, Prison, Youth Authority Facility, Juvenile Hall, Boot Camp, or Boys Ranch.

TERM	DEFINITION
Living Situation (cont'd)	• Homeless: A person should be counted in the "Homeless" category if he/she was reported homeless at their most recent (last) assessment during the reporting period (or at discharge for patients discharged during the year). The "last" Assessment could occur at Admission, Discharge, or at some point during treatment. A person is considered homeless if he/she lacks a fixed, regular, and adequate nighttime residence and/or his/her primary nighttime residency is: A) A supervised, publicly or privately operated shelter designed to provide temporary living accommodations, B) An institution that provides a temporary residence for consumers intended to be institutionalized, or C) A public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings (e.g., on the street). • Other: Consumer resides in any other living situation not expressly included above. • Unavailable: Information on a consumer's residence is not available.
Provider Entity	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	Consumers of all ages

D. SPECIFICATION

The following specification details how the state should ask to receive the data on measure of living situation from the provider entity:

Denominator

The number of consumers seen during each measurement period (Section C)

Numerator

The number of consumers in each living situation based on their most recent assessment or on the most recent available information on record during the measurement period. For people with two or more living situations during the measurement period (one half year), report only the **last known living situation.** The last assessment could occur at admission, discharge, or at some point during treatment.second measurement period.

Note: The intention here is to continue reporting on the URS or MHBG tables as has been done in the past. Hence, if a person is only seen in the first measurement period, they will be excluded from the count in the second measurement period.

Example Calculation

See Appendix HOU to this metric for an example of how the state should require the data be reported by the provider entity.

E. ADDITIONAL NOTES

For these data to be meaningful, the provider entity must actually assess the living situation of each consumer at least twice a year.

Suicide Attempts (SU-A)

SAMHSA-Developed Metric

A. DESCRIPTION

The percentage of consumers aged 12 years and older who attempted suicide during the measurement year, where the suicide attempt resulted in injury requiring medical services

Data Collection Method: Administrative

Guidance for Reporting:

- This metric is stratified by age (12–17 years, 18–64 years, 65 years and older) and by whether the consumer is a Medicaid beneficiary, eligible for both Medicare and Medicaid, and other.
- Suicide attempts are defined here as those that are either fatal ones or non-fatal ones that resulted in the use of medical services.
- To the extent possible, include all paid, suspended, pending, and denied claims.
- Refer to the specific data-reporting template for the reporting requirements applicable to each measure and to the Appendices in Volume 2 of this manual.

Measurement Period: The measurement period for the denominator is the first 11 months of the measurement year. The measurement period for the numerator is the measurement year.

B. DEFINITIONS

TERM	DEFINITION
Injury Requiring Medical Services	Physical injury related to the suicide attempt for which medical services were obtained
Provider Entity	The provider entity that is being measured (i.e., BHC)
Suicide Attempt	A self-directed, potentially injurious behavior with any intent to die as a result of the behavior, whether the person dies as a result or not

C. ELIGIBLE POPULATION

CRITERIA	REQUIREMENTS
Age	Consumers aged 12 years and older as of the first encounter at the provider entity during the measurement year Report three age stratifications and a total rate: • 12–17 years • 18–64 years • 65 years and older • Total (all age groups)
Benefits	Medical
Event/Diagnosis	Follow the steps below to identify the eligible population: ***Step 1*** Identify consumers flagged as having been seen at the provider entity at least once during the first 11 months of the measurement year. ***Step 2*** Identify consumers from step 1 aged 12 years and older as of the first encounter at the provider entity during the measurement year.

D. ADMINISTRATIVE SPECIFICATION

Denominator

The number of consumers in the eligible population (Section C)

Note: The measurement period for the denominator is the first 11 months of the measurement year.

Numerator

The number of consumers in the eligible population who attempted suicide at least once during the measurement year, where the suicide attempt resulted in injury requiring medical services during the measurement year

An eligible suicide attempt must be evidenced by consumer receipt of medical services in an outpatient, intensive outpatient, partial hospitalization, emergency

department (ED), nonacute inpatient, or acute inpatient setting, **with** one of more of the following:

- International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) ICD-10-CM Codes from Tables 1–3 of Appendix SU-A
- ICD-10-CM Suicidal Ideation Code R45851 **and** any ICD-10-CM Indicating Physical Injury
- ICD-10-CM Suicide Attempt Code T1491

Application of the ICD-10-CM codes referred to above should be taken as evidence of injury requiring medical services.

Note: Only one suicide attempt per consumer should be counted towards the numerator.

Note: The measurement period for the numerator is the measurement year.

Exclusions

None.

E. ADDITIONAL NOTES

This measure is designed to require provider-level reporting but is not tested at the provider level.

This measure has limitations. Complete accuracy depends on knowledge of consumer intent and accurate coding that reflects suicidality. This measure also only captures suicide attempts that result in billing for services and does not include some individuals who die before receiving any medical services.

Interpretation of score: Better quality = Lower score. The goal is zero.

Patient Experience of Care Survey (PEC)

SAMHSA-Developed Metric

A. DESCRIPTION

Annual completion and submission of 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

Guidance for Reporting:

- Results of the MHSIP generally are not reported unless the survey is statewide and the sample size is sufficient to be statistically meaningful, and 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 in order to generate sufficient sample size, specifically reaching out to 300 consumers 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 11 and 11a of the URS reporting template that is current at time of the survey and that may be found at URS & CLD Forms and Information page on NRI website (Table 22A 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 and to the Appendices in Volume 2 of this manual.

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 consumer experience of care. The official version and instructions are found at URS & CLD Forms and Information page on NRI website. Some states have customized this survey, and instructions on the site address that circumstance.
Mental Health Statistics Improvement Program (MHSIP)	The MHSIP Consumer Surveys measure concerns that are important to consumers of publicly funded mental health services in the areas of Access, Quality/Appropriateness, Outcomes, Overall Satisfaction, and Participation in Treatment Planning
Provider Entity	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	Consumers 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.

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

SAMHSA-Developed Metric

A. DESCRIPTION

Annual completion and submission of 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

Guidance for Reporting:

- 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 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 in order to generate sufficient sample size, specifically reaching out to 300 consumers 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 11 and 11a of the URS reporting template that is current at time of the survey and which may be found at http://www.nri-inc.org/#!urs-forms--info/c1xvm (Table 22B 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 and to the Appendices in Volume 2 of this manual.

Measurement Period: The measurement period for both the denominator and numerator is the measurement year.

B. DEFINITIONS

TERM	DEFINITION
YSS-F Experience of Care Survey	The YSS-F Experience of Care Survey is used to collect data on youth and family behavioral health consumer experience of care. The official version and instructions are found at URS & CLD Forms and Information page on NRI website.. Some states have customized this survey, and the instructions on this site also address that circumstance.
Provider Entity	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	Consumers aged 17 years or younger at the time of survey

D. SPECIFICATION

For purposes of the 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.

Follow-up After Emergency Department Visit for Mental Illness (FUM)

Based on measure stewarded by the
National Committee for Quality Assurance **(**Draft HEDIS 2017)

A. DESCRIPTION

The percentage of emergency department (ED) visits for consumers 6 years of age and older with a primary diagnosis of mental illness, who had an outpatient visit, an intensive outpatient encounter or a partial hospitalization for mental illness. Two rates are reported:

1. The percentage of ED visits for which the consumer received follow-up within 30 days of the ED visit.

2. The percentage of ED visits for which the consumer received follow-up within 7 days of the ED visit.

Data Collection Method: Administrative

Guidance for Reporting:

- When initially required of the CCBHCs, the Follow-Up After Discharge from the Emergency Department for Mental Health or Alcohol or Other Dependence (NQF # 2605) was intended. Because that measure (which included two rates (30 and 7 day follow-up) for each of mental illness and AOD dependence) has not been maintained and is being replaced with two measures for HEDIS 2017 use which separate mental illness and AOD dependence with two rates each, the specifications in this manual rely on the separate draft 2017 HEDIS measures.
- This measure is stratified by whether the consumer is a Medicaid beneficiary, eligible for both Medicare and Medicaid, and other. For purposes of determining whether a consumer is a Medicaid beneficiary or a dual Medicare and Medicaid enrollee, see Continuous Enrollment, Allowable Gap, and Anchor Date requirements below in section C.
- Referenced Value Sets may be found in the Healthcare Effectiveness Data and Information Set (HEDIS) specifications Volume 2. Value Sets are available at NCQA HEDIS 2017.

- Refer to the specific data-reporting template for the reporting requirements applicable to each measure and to the Appendices in Volume 2 of this manual.

Measurement Period: The measurement period for the denominator is the measurement year (e.g., for CCBHCs, DY1 or DY2) absent the last 30 days of the measurement year. The measurement period for the numerator is the measurement year.

B. DEFINITIONS

TERM	DEFINITION
Provider Entity	The provider entity that is being measured (i.e., BHC)

C. ELIGIBLE POPULATION

CRITERIA	REQUIREMENTS
Age	Consumers aged 6 years and older as of the date of the ED visit
Continuous Enrollment	Date of ED visit through 30 days after the ED visit
Allowable Gap	No gaps in enrollment
Anchor Date	None
Benefits	Medical and mental health

CRITERIA	REQUIREMENTS
Event/Diagnosis	Follow the steps below to identify the eligible population: ***Step 1*** Identify consumers flagged as having been seen at the provider entity during the measurement year. ***Step 2*** Identify consumers from step 1 who were aged 6 years and older as of the date of the ED visit. ***Step 3*** Identify consumers from step 2 who had an ED visit (ED Value Set) with a primary diagnosis of mental illness (Mental Illness Value Set) on or between the first day of the measurement year and the last day of the measurement year (less 30 days). ***Note:*** The denominator for this measure is based on ED visits, not on consumers. If a consumer has more than one ED visit, include all ED visits between the first day of the measurement year and the last day of the measurement year (less 30 days). ***Note:*** If a consumer has more than one ED visit in a 30-day period, include only the last ED visit in each 30-day period.

D. ADMINISTRATIVE SPECIFICATION

Denominator

The number of ED visits by consumers in the eligible population (Section C)

Note: The measurement period for the denominator is the measurement year less the last 30 days of the measurement year.

Numerator

30-Day Follow-Up

An outpatient visit, intensive outpatient encounter or partial hospitalization, with any practitioner, with a primary diagnosis of a mental health disorder within 30 days after the

ED visit. Include outpatient visits, intensive outpatient visits or partial hospitalizations that occur on the date of the ED visit.

7-Day Follow-Up

An outpatient visit, intensive outpatient encounter or partial hospitalization, with any practitioner, with a primary diagnosis of a mental health disorder within 7 days after the ED visit. Include outpatient visits, intensive outpatient visits or partial hospitalizations that occur on the date of the ED visit.

For both indicators, **any of the following meet criteria** for a follow-up visit:

- A visit (FUH Stand Alone Visits Value Set) **with** a primary diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- A visit (FUH Visits Group 1 Value Set **and** FUH POS Group 1 Value Set) **with** a primary diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- A visit (FUH Visits Group 2 Value Set **and** FUH POS Group 2 Value Set) **with** a primary diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- A visit to a behavioral healthcare facility (FUH RevCodes Group 1 Value Set)
- A visit to a non-behavioral healthcare facility (FUH RevCodes Group 2 Value Set) **with** a primary diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)

Note: Organizations may have 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. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the required period for the rate (i.e., within 30 days after the ED visit or within 7 days after the ED visit).

Exclusions

ED visits followed by admission or direct transfer to an acute or nonacute inpatient care setting within the 30-day follow-up period, regardless of primary 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.

Note: These events are excluded from the measure because admission to the hospital or transfer may prevent an outpatient follow-up visit from taking place.

Note: Organizations identify "transfers" using their own methods and confirm the acute or nonacute inpatient care setting using the steps above.

E. ADDITIONAL NOTES

The source measure is designed for the Commercial, Medicaid, and Medicare population and does not require risk adjustment. The source measure was specified and tested at the health plan level. This measure is modified to require clinic-level reporting, and to be consistent in format with other measures in this set of BHC measures, but is not tested at the clinic level.

Interpretation of score: Better quality = Higher score

Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)

Based on measure stewarded by the
National Committee for Quality Assurance **(**Draft HEDIS 2017)

A. DESCRIPTION

The percentage of emergency department (ED) visits for consumers 13 years of age and older with a primary diagnosis of alcohol or other drug (AOD) dependence, who had an outpatient visit, an intensive outpatient encounter or a partial hospitalization for AOD. Two rates are reported:

1. The percentage of ED visits for which the consumer received follow-up within 30 days of the ED visit.

2. The percentage of ED visits for which the consumer received follow-up within 7 days of the ED visit.

Data Collection Method: Administrative

Guidance for Reporting:

- When initially required of the CCBHCs, the Follow-Up After Discharge from the Emergency Department for Mental Health or Alcohol or Other Dependence (NQF # 2605) was intended. Because that measure (which included two rates (30 and 7 day follow-up) for each of mental illness and AOD dependence) has not been maintained and is being replaced with two measures for HEDIS 2017 use which separate mental illness (FUM) and AOD dependence (FUA) with two rates each, the specifications in this manual rely on the separate draft 2017 HEDIS measures.
- This measure is stratified by whether the consumer is a Medicaid beneficiary, eligible for both Medicare and Medicaid, and other. For purposes of determining whether a consumer is a Medicaid beneficiary or a dual Medicare and Medicaid enrollee, see Continuous Enrollment, Allowable Gap, and Anchor Date requirements below in section C.
- Referenced Value Sets may be found in the Healthcare Effectiveness Data and Information Set (HEDIS) specifications Volume 2. Value Sets are available at NCQA HEDIS 2017.

- Refer to the specific data-reporting template for the reporting requirements applicable to each measure and to the Appendices in Volume 2 of this manual.

Measurement Period: The measurement period for the denominator is the measurement year (e.g., for CCBHCs, DY1 or DY2) absent the last 30 days of the measurement year. The measurement period for the numerator is the measurement year.

B. DEFINITIONS

TERM	DEFINITION
Provider Entity	The provider entity that is being measured (i.e., BHC)

C. ELIGIBLE POPULATION

CRITERIA	REQUIREMENTS
Age	Consumers aged 13 years and older as of the date of the ED visit
Continuous Enrollment	Date of ED visit through 30 days after the ED visit
Allowable Gap	No gaps in enrollment
Anchor Date	None
Benefits	Medical and chemical dependency ***Note:*** Consumers with detoxification-only chemical dependency benefits do not meet these criteria.

CRITERIA	REQUIREMENTS
Event/Diagnosis	Follow the steps below to identify the eligible population: ***Step 1*** Identify consumers flagged as having been seen at the provider entity during the measurement year. ***Step 2*** Identify consumers from step 1 who were aged 13 years and older as of the date of the ED visit. ***Step 3*** Identify consumers from step 2 who had an ED visit (ED Value Set) with a primary diagnosis of AOD (AOD Dependence Value Set) on or between the first day of the measurement year and the last day of the measurement year (less 30 days). ***Note:*** The denominator for this measure is based on ED visits, not on consumers. If a consumer has more than one ED visit, include all ED visits between the first day of the measurement year and the last day of the measurement year (less 30 days). ***Note:*** If a consumer has more than one ED visit in a 30-day period, include only the last ED visit in each 30-day period.

D. ADMINISTRATIVE SPECIFICATION

Denominator

The number of ED visits by consumers in the eligible population (Section C)

Note: The measurement period for the denominator is the measurement year less the last 30 days of the measurement year.

Numerator

30-Day Follow-Up

An outpatient visit, intensive outpatient encounter or partial hospitalization, with any practitioner, with a primary diagnosis of AOD within 30 days after the ED visit. Include outpatient visits, intensive outpatient visits or partial hospitalizations that occur on the date of the ED visit.

7-Day Follow-Up

An outpatient visit, intensive outpatient encounter or partial hospitalization, with any practitioner, with a primary diagnosis of AOD within 7 days after the ED visit. Include outpatient visits, intensive outpatient visits or partial hospitalizations that occur on the date of the ED visit.

For both indicators, **any of the following meet criteria** for a follow-up visit:

- IET Stand Alone Visits Value Set **with** a primary diagnosis of AOD (AOD Dependence Value Set)
- IET Visits Group 1 Value Set **with** IET POS Group 1 Value Set **and** a primary diagnosis of AOD (AOD Dependence Value Set)
- IET Visits Group 2 Value Set **with** IET POS Group 2 Value Set **and** a primary diagnosis of AOD (AOD Dependence Value Set)

Note: Organizations may have 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. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the required period for the rate (i.e., within 30 days after the ED visit or within 7 days after the ED visit).

Exclusions

ED visits followed by admission or direct transfer to an acute or nonacute inpatient care setting within the 30-day follow-up period, regardless of primary 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.

Note: These events are excluded from the measure because admission to the hospital or transfer may prevent an outpatient follow-up visit from taking place.

Note: Organizations identify "transfers" using their own methods and confirm the acute or nonacute inpatient care setting using the steps above.

E. ADDITIONAL NOTES

The source measure is designed for the Commercial, Medicaid, and Medicare population and does not require risk adjustment. The source measure was specified and tested at the health plan level. This measure is modified to require clinic-level reporting, and to be

consistent in format with other measures in this set of BHC measures, but is not tested at the clinic level.

Interpretation of score: Better quality = Higher score

Plan All-Cause Readmissions Rate (PCR-BH)

Based on a measure stewarded by the
National Committee for Quality Assurance (NQF #1768, HEDIS 2016)

A. DESCRIPTION

For consumers age 18 and older, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days. Data are reported in the following three categories:

- Count of Index Hospital Stays (IHS) (denominator)
- Count of 30-Day Readmissions (numerator)
- Readmission Rate

Data Collection Method: Administrative

Guidance for Reporting:

- This measure is stratified by age (aged 18 to 64 years, aged 65 years and older) and by whether the consumer is a Medicaid beneficiary, eligible for both Medicare and Medicaid, and other. For purposes of determining whether a consumer is a Medicaid beneficiary or a dual Medicare and Medicaid enrollee, see Continuous Enrollment, Allowable Gap, and Anchor Date requirements below in section C.
- This measure requires risk adjustment. However, there are no standardized risk adjustment tables for Medicaid. Therefore, it is suggested that states report unadjusted rates for this measure (Appendix PCR-BH, Columns 1, 2, and 3 in Tables PCR-A and PCR-B) until a standardized risk adjustor is made available.
- Referenced Value Sets may be found at NCQA 2016
- Include paid claims only.
- Refer to the specific data-reporting template for the reporting requirements applicable to each measure and to the Appendices in Volume 2 of this manual.

Measurement Period: The measurement period for the denominator is measured from the discharge date and encompasses the measurement year (e.g., for CCBHCs, DY1 or DY2) less the last 30 days. The measurement period for the numerator is the measurement year.

B. DEFINITIONS

TERM	DEFINITION
Classification Period	365 days prior to and including an Index Discharge Date
Index Admission Date	The IHS admission date
Index Discharge Date	The IHS discharge date. The index discharge date must occur during the measurement year less the last 30 days.
Index Hospital Stay (IHS)	An acute inpatient stay with a discharge occur during the measurement year less the last 30 days. Exclude stays that meet the exclusion criteria in the denominator section
Index Readmission Date	The admission date associated with the Index Readmission Stay
Index Readmission Stay	An acute inpatient stay for any diagnosis with an admission date within 30 days of a previous Index Discharge Date
Planned Hospital Stay	A hospital stay is considered planned if it meets criteria as described in step 6 (required exclusions) of the Eligible Population
Provider Entity	The provider entity that is being measured (i.e., BHC)

C. ELIGIBLE POPULATION

CRITERIA	REQUIREMENTS
Age	Consumers aged 18 and older as of Index Discharge Date. Report two age stratifications: • Aged 18 to 64 years • Aged 65 years and older
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
Benefits	Medical

CRITERIA	REQUIREMENTS
Event/Diagnosis	Follow the steps below to identify the eligible population: ***Step 1*** Identify consumers flagged as having been seen at the provider entity at least once during the measurement year. ***Step 2*** Identify consumers from step 1 who were aged 18 years and older as of the Index Discharge Date. ***Step 3*** Identify consumers from step 2 who experience an acute inpatient discharge during the measurement year less the last 30 days. 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 ***Note:*** The measure includes acute discharges from any type of facility (including behavioral healthcare facilities). ***Note: Acute-to-Acute Transfers:*** Keep the original admission date as the Index Admission Date, but use the transfer's discharge date as the Index Discharge Date. States must identify "direct transfers" using their own methods and then confirm the acute inpatient care setting using the process in step 3. ***Step 4*** From consumers identified in step 3, **exclude** hospital stays where the Index Admission Date is the same as the Index Discharge Date. ***Step 5*** From consumers identified in step 4, **exclude** other hospital stays for the following reasons: • The consumer died during the stay • A principal diagnosis of pregnancy (Pregnancy Value Set) • A principal diagnosis of a condition originating in the perinatal period (Perinatal Conditions Value Set)

CRITERIA	REQUIREMENTS
Event/Diagnosis	***Note:*** For hospital stays where there was an acute-to-acute transfer (identified in step 3 (Note)), use both the original stay and the transfer stay to identify exclusions in this step. ***Step 6*** For consumers identified in step 5, **exclude** planned readmissions as identified below: For all acute inpatient discharges identified using steps 1–5, determine if there was a planned hospital stay within 30 days. To identify planned hospital stays, identify all acute inpatient discharges during the measurement year: 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. 4. Exclude any hospital stay as an Index Hospital Stay if the admission date of the first stay within 30 days meets any of the following criteria: • A principal diagnosis of maintenance chemotherapy (Chemotherapy 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) • A potentially planned procedure (Potentially Planned Procedure Value Set) without a principal acute diagnosis (Acute Condition Value Set) Note: For hospital stays where there was an acute-to-acute transfer (identified in step 3 (Note)), use only the original stay to identify planned hospital stays in this step (i.e., do not use diagnoses and procedures from the transfer stay). Example 1: For a consumer with the following acute inpatient stays, exclude stay 1 as an Index Hospital Stay.

CRITERIA	REQUIREMENTS
Event/Diagnosis	• Stay 1 (January 30–February 1 of the measurement year): Acute inpatient discharge with a principal diagnosis of COPD • Stay 2 (February 5–7 of the measurement year): Acute inpatient discharge with a principal diagnosis of maintenance chemotherapy Example 2: For a consumer with the following acute inpatient stays, exclude stays 2 and 3 as Index Hospital Stays in the following scenario. • Stay 1 (January 15–17 of the measurement year): Acute inpatient discharge with a principal diagnosis of diabetes • Stay 2 (January 30–February 1 of the measurement year): Acute inpatient discharge with a principal diagnosis of COPD • Stay 3 (February 5–7 of the measurement year): Acute inpatient discharge with an organ transplant • Stay 4 (February 10–15 of the measurement year): Acute inpatient discharge with a principal diagnosis of rehabilitation ***Step 7*** For consumers identified in step 6, calculate continuous enrollment. ***Step 8*** Assign each acute inpatient stay to an age category. Refer to Table PCR-A and Table PCR-B in Appendix PCR-BH. ***Note:*** The denominator for this measure is based on discharges, not consumers. Include all acute inpatient discharges for consumers who had one or more discharges on or between the first day of the measurement year and the first day of the twelfth month of the measurement year. The state should follow the steps above to identify acute inpatient stays.

D. ADMINISTRATIVE SPECIFICATION

Denominator

The number of eligible discharges (Section C)

Numerator

At least one acute readmission for any diagnosis within 30 days of the Index Discharge Date.

Step 1

Identify all acute inpatient stays with an admission date on or between the second day and the last day of the measurement year. To identify acute inpatient admissions:

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.

Step 2

***Acute-to-acute transfers*:** Keep the original admission date as the Index Admission Date, but use the transfer's discharge date as the Index Discharge Date. States must identify "direct transfers" using their own methods and then confirm the acute inpatient care setting using the steps above.

Step 3

Exclude acute inpatient hospital discharges with a principal diagnosis of pregnancy (Pregnancy Value Set) or a principal diagnosis for a condition originating in the perinatal period (Perinatal Conditions Value Set).

Step 4

For each IHS, determine if any of the acute inpatient stays had an admission date within 30 days after the Index Discharge Date.

Reporting

Reporting: Denominator

Count the number of IHS and enter these values into the table in Appendix PCR-BH.

Reporting: Numerator

Count the number of IHS with a readmission within 30 days and enter these values into the table in Appendix PCR-BH.

Reporting: Readmission Rate

This measure requires risk adjustment. However, there are no standardized risk adjustment tables for Medicaid. Therefore, it is suggested that states report unadjusted rates for this measure (Appendix PCR-BH, Columns 1, 2, and 3 in Tables PCR-A and PCR-B) until a standardized risk adjustor is made available.

Note: Medicaid-specific risk adjustment tables are required to calculate columns 4, 5, and 6 in Tables PCR-A and PCR-B in Appendix PCR-BH.

E. ADDITIONAL NOTES

The source measure is designed for the Medicaid population and is not risk adjusted. The source measure was specified and tested at the health plan level. This measure is modified to require clinic-level reporting, and to be consistent in format with other measures in this set of BHC measures, but is not tested at the clinic level.

Interpretation of score: Better quality = Higher score

Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

Based on a measure stewarded by the
National Committee for Quality Assurance (NQF #1932, HEDIS 2016)

A. DESCRIPTION

The percentage of consumers 18-64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year

Data Collection Method: Administrative

Guidance for Reporting:

- This measure is stratified by whether the consumer is a Medicaid beneficiary, eligible for both Medicare and Medicaid, and other. For purposes of determining whether a consumer is a Medicaid beneficiary or a dual Medicare and Medicaid enrollee, see Continuous Enrollment, Allowable Gap, and Anchor Date requirements below in section C.
- Referenced Value Sets may be found in the Healthcare Effectiveness Data and Information Set (HEDIS) specifications Volume 2. Value Sets are available at NCQA HEDIS 2016
- Refer to the specific data-reporting template for the reporting requirements applicable to each measure and to the Appendices in Volume 2 of this manual.

Measurement Period: The measurement period for the denominator is the measurement year and the year prior to the measurement year. The measurement period for the numerator is the measurement year (e.g., for CCBHCs, DY1 or DY2).

B. DEFINITIONS

TERM	DEFINITION
Antipsychotic Medication Dispensing Events	A dispensed antipsychotic, as identified by claim/encounter data. Antipsychotics are those identified on the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) 2016 Final National Drug Code (NDC) Lists webpage at HEDIS 2016 Final NDC Lists
Glucose Test	A glucose test (Glucose Tests Value Set) performed during the measurement year, as identified by claim/encounter or automated laboratory data
HbA1c Test	An Hemoglobin A1c (HbA1c) test (HbA1c Tests Value Set) performed during the measurement year, as identified by claim/encounter or automated laboratory data
Provider Entity	The provider entity that is being measured (i.e., BHC)

C. ELIGIBLE POPULATION

CRITERIA	REQUIREMENTS
Age	Consumers aged 18–64 years as of the end 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 consumer for whom enrollment is verified monthly, the consumer may not have more than a 1-month gap in coverage (i.e., a consumer whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor Date	The last day of the measurement year
Benefits	Medical and pharmacy

CRITERIA	REQUIREMENTS
Event/Diagnosis	Follow the steps below to identify the eligible population: ***Step 1*** Identify consumers flagged as having been seen at the provider entity at least once during the measurement year. ***Step 2*** Identify consumers from step 1 who were aged 18–64 years as of the end of the measurement year. ***Step 3*** Identify consumers from step 2 with schizophrenia or bipolar disorder as those who met **at least one** of the following criteria during the measurement year: 1. **At least one** acute inpatient encounter, with any diagnosis of schizophrenia or bipolar disorder. **Any of the following code combinations meet criteria:** • BH Stand Alone Acute Inpatient Value Set **with** Schizophrenia Value Set • BH Stand Alone Acute Inpatient Value Set **with** Bipolar Disorder Value Set • BH Stand Alone Acute Inpatient Value Set **with** Other Bipolar Disorder Value Set • BH Acute Inpatient Value Set **with** BH Acute Inpatient POS Value Set **and** Schizophrenia Value Set • BH Acute Inpatient Value Set **with** BH Acute Inpatient POS Value Set **and** Bipolar Disorder Value Set • BH Acute Inpatient Value Set **with** BH Acute Inpatient POS Value Set **and** Other Bipolar Disorder Value Set **OR**

CRITERIA	REQUIREMENTS
Event/Diagnosis (cont'd)	2. **At least two** visits in an outpatient, intensive outpatient (IOP), partial hospitalization (PH), emergency department (ED), or nonacute inpatient setting, on different dates of service, with any diagnosis of schizophrenia. **Any two of the following code combinations meet criteria:** • BH Stand Alone Outpatient/PH/IOP Value Set **with** Schizophrenia Value Set • BH Outpatient/PH/IOP Value Set **with** BH Outpatient/PH/IOP POS Value Set **and** Schizophrenia Value Set • ED Value Set **with** Schizophrenia Value Set • BH ED Value Set **with** BH ED POS Value Set **and** Schizophrenia Value Set • BH Stand Alone Nonacute Inpatient Value Set **with** Schizophrenia Value Set • BH Nonacute Inpatient Value Set **with** BH Nonacute Inpatient POS Value Set **and** Schizophrenia Value Set **OR** 3. **At least two** visits in an outpatient, intensive outpatient (IOP), partial hospitalization (PH), ED, or nonacute inpatient setting, on different dates of service, with any diagnosis of bipolar disorder. **Any two of the following code combinations meet criteria:** • BH Stand Alone Outpatient/PH/IOP Value Set **with** Bipolar Disorder Value Set • BH Stand Alone Outpatient/PH/IOP Value Set **with** Other Bipolar Disorder Value Set • BH Outpatient/PH/IOP Value Set **with** BH Outpatient/PH/IOP POS Value Set **and** Bipolar Disorder Value Set • BH Outpatient/PH/IOP Value Set **with** BH Outpatient/PH/IOP POS Value Set **and** Other Bipolar Disorder Value Set

CRITERIA	REQUIREMENTS
Event/Diagnosis (cont'd)	• ED Value Set with Bipolar Disorder Value Set • ED Value Set with Other Bipolar Disorder Value Set • BH ED Value Set with BH ED POS Value Set and Bipolar Disorder Value Set • BH ED Value Set with BH ED POS Value Set and Other Bipolar Disorder Value Set • BH Stand Alone Nonacute Inpatient Value Set with Bipolar Disorder Value Set • BH Stand Alone Nonacute Inpatient Value Set with Other Bipolar Disorder Value Set • BH Nonacute Inpatient Value Set with BH Nonacute Inpatient POS Value Set and Bipolar Disorder Value Set • BH Nonacute Inpatient Value Set with BH Nonacute Inpatient POS Value Set and Other Bipolar Disorder Value Set ***Step 4*** Identify and exclude consumers from step 3 who met **any of the following criteria:** 1. Exclude consumers with diabetes. There are two ways to identify consumers with diabetes: by claim/encounter data and by pharmacy data. The reporting entity must use both methods to identify consumers with diabetes, but a consumer need only be identified by one method to be excluded from the measure. Consumers may be identified as having diabetes during the measurement year or the year prior to the measurement year. - Claim/encounter data. Consumers who met any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years)

CRITERIA	REQUIREMENTS
Event/Diagnosis (cont'd)	• **At least two** outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), **or** nonacute inpatient encounters (Nonacute Inpatient Value Set) on different dates of service, **with** a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two visits. • **At least one** acute inpatient encounter (Acute Inpatient Value Set) **with** a diagnosis of diabetes (Diabetes Value Set) **OR** 2. Pharmacy data. Consumers who were dispensed insulin or oral hypoglycemics/ antihyperglycemics during the measurement year or year prior to the measurement year on an ambulatory basis (See Table CDC-A on the NCQA HEDIS 2015 Final National Drug Code (NDC) Lists webpage at: HEDIS 2016 Final NDC Lists). 3. Consumers who had no antipsychotic medications dispensed during the measurement year. There are two ways to identify dispensing events: by claim/encounter data and by pharmacy data. The reporting entity must use both methods to identify dispensing events, but an event need only be identified by one method to be counted. - *Claim/encounter data.* An antipsychotic medication (Long-Acting Injections Value Set) - *Pharmacy data.* Dispensed an antipsychotic medication on an ambulatory basis. (See Table SSD-D on the NCQA website at HEDIS 2016 Final NDC Lists for a current list of antipsychotic medications).

D. ADMINISTRATIVE SPECIFICATION

Denominator

The number of consumers in the eligible population (Section C)

Note: The measurement period for the denominator is the measurement year and the year prior to the measurement year.

Numerator

The number of consumers who had one or more diabetes screenings (a glucose test [Glucose Tests Value Set] or an HbA1c [HbA1c Tests Value Set]) performed during the measurement year, as identified by claim/encounter or automated laboratory data

Note: The measurement period for the numerator is the measurement year.

Exclusions

See ***Step 4*** in Section C above.

E. ADDITIONAL NOTES

The source measure is designed for the Medicaid population and is not risk adjusted. The source measure was specified and tested at the health plan level. This measure is modified to require clinic-level reporting, and to be consistent in format with other measures in this set of BHC measures, but is not tested at the clinic level.

Interpretation of score: Better quality = Higher score

Diabetes Care For People With Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (SMI-PC)

Based on a measure stewarded by the
National Committee for Quality Assurance (NQF #2607)

A. DESCRIPTION

The percentage of consumers 18–75 years of age with a serious mental illness and diabetes (type 1 and type 2) whose most recent Hemoglobin A1c (HbA1c) level during the measurement year is >9.0%

Data Collection Method: Administrative

Guidance for Reporting:

- The source measure is adapted from an existing health plan measure used in a variety of reporting programs for the general population (NQF #0059: Comprehensive Diabetes Care: Hemoglobin A1c [HbA1c] Control >9.0%). NQF #0059 is derived in turn from the Healthcare Effectiveness Data and Information Set (HEDIS) Comprehensive Diabetes Care (CDC) measure.
- This measure is stratified by whether the consumer is a Medicaid beneficiary, eligible for both Medicare and Medicaid, and other. For purposes of determining whether a consumer is a Medicaid beneficiary or a dual Medicare and Medicaid enrollee, see Continuous Enrollment, Allowable Gap, and Anchor Date requirements below in section C.
- Referenced Value Sets are currently outdated. If value sets are updated to reflect ICD-10 codes and made publically available, this measure is ready for use at the BHC level.
- Refer to the specific data-reporting template for the reporting requirements applicable to each measure and to the Appendices in Volume 2 of this manual.

Measurement Period: The measurement period for the denominator is the measurement year and the year prior to the measurement year. The measurement period for the numerator is the measurement year.

B. DEFINITIONS

TERM	DEFINITION
Diabetes	Diabetes includes both type 1 and type 2 diabetes.
HbA1c	Hemoglobin A1c
Provider Entity	The provider entity that is being measured (i.e., BHC)
Serious Mental Illness	For purposes of this measure, Serious Mental Illness includes schizophrenia, bipolar I disorder, or major depression.

C. ELIGIBLE POPULATION

CRITERIA	REQUIREMENTS
Age	Consumers aged 18–75 years as of the end of the measurement year
Continuous Enrollment	The measurement year and the year prior to 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 consumer for whom enrollment is verified monthly, the consumer may not have more than a 1-month gap in coverage (i.e., a consumer whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor Date	The last day of the measurement year
Benefits	Medical

CRITERIA	REQUIREMENTS
Event/Diagnosis	Follow the steps below to identify the eligible population: ***Step 1*** Identify consumers flagged as having been seen at the provider entity at least once during the measurement year. ***Step 2*** Identify consumers from step 1 who were aged 18–75 years as of the end of the measurement year. ***Step 3*** Identify consumers from step 2 with a diagnosis of serious mental illness. Consumers are identified as having serious mental illness if they met **at least one of the following criteria** during the measurement year: 1. **At least one** acute inpatient claim/encounter **with** any diagnosis of schizophrenia, bipolar I disorder, or major depression **using any of the following code combinations:** • BH Stand Alone Acute Inpatient Value Set **with** Schizophrenia Value Set • BH Stand Alone Acute Inpatient Value Set **with** Bipolar Disorder Value Set • BH Stand Alone Acute Inpatient Value Set **with** Major Depression Value Set • BH Acute Inpatient Value Set **with** BH Acute Inpatient POS Value Set **and** Schizophrenia Value Set • BH Acute Inpatient Value Set **with** BH Acute Inpatient POS Value Set **and** Bipolar Disorder Value Set • BH Acute Inpatient Value Set **with** BH Acute Inpatient POS Value Set **and** Major Depression Value Set **OR**

CRITERIA	REQUIREMENTS
Event/Diagnosis (con't)	2. **At least two** visits in an outpatient, intensive outpatient (IOP), partial hospitalization (PH), emergency department (ED), or nonacute inpatient setting, on different dates of service, with any diagnosis of schizophrenia. **Any two of the following code combinations meet criteria:** • BH Stand Alone Outpatient/PH/IOP Value Set **with** Schizophrenia Value Set • BH Outpatient/PH/IOP Value Set **with** BH Outpatient/PH/IOP POS Value Set **and** Schizophrenia Value Set • ED Value Set **with** Schizophrenia Value Set • BH ED Value Set **with** BH ED POS Value Set **and** Schizophrenia Value Set • BH Stand Alone Nonacute Inpatient Value Set **with** Schizophrenia Value Set • BH Nonacute Inpatient Value Set **with** BH Nonacute Inpatient POS Value Set **and** Schizophrenia Value Set **OR** 3. **At least two** visits in an outpatient, IOP, PH, ED, or nonacute inpatient setting on different dates of service **with** a diagnosis of bipolar I disorder. **Any two of the following code combinations meet criteria:** • BH Stand Alone Outpatient/PH/IOP Value Set **with** Bipolar Disorder Value Set • BH Outpatient/PH/IOP Value Set **with** BH Outpatient/PH/IOP POS Value Set **and** Bipolar Disorder Value Set • ED Value Set **with** Bipolar Disorder Value Set • BH ED Value Set **with** BH ED POS Value Set **and** Bipolar Disorder Value Set

CRITERIA	REQUIREMENTS
Event/Diagnosis (cont'd)	• BH Stand Alone Nonacute Inpatient Value Set **with** Bipolar Disorder Value Set • BH Nonacute Inpatient Value Set **with** BH Nonacute Inpatient POS Value Set **and** Bipolar Disorder Value Set ***Step 4*** Identify consumers from step 3 with diabetes (Diabetes Value Set) during the measurement year or the year prior to the measurement year, using the following data: 1. *Claim/encounter data:* Had a diagnosis of diabetes during the measurement year or the year prior to the measurement year on claims for either of the following types of encounters: • **At least two** outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), emergency department (ED) visits (ED Value Set), or nonacute inpatient encounters (Nonacute Inpatient Value Set) on different dates of service **with** a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two visits. **OR** • **At least one** acute inpatient encounter (Acute Inpatient Value Set) **with** a diagnosis of diabetes (Diabetes Value Set) **OR** 2. *Pharmacy data:* Were dispensed insulin or hypoglycemics/ antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year. For prescriptions that can be used to identify consumers with diabetes, refer to Table CDC-A on the NCQA HEDIS 2016 Final National Drug Code (NDC) Lists webpage at: HEDIS 2016 Final NDC Lists). ***Note:*** The reporter must use both methods to identify the eligible population, but a consumer only needs to be identified by one method to be included in the measure.

D. ADMINISTRATIVE SPECIFICATION

Denominator

The number of consumers in the eligible population (Section C)

Note: The measurement period for the denominator is the measurement year and the year prior to the measurement year.

Numerator

The number of consumers whose most recent HbA1c level is greater than 9.0% (poor control) during the measurement year

Numerator Options: Either an Administrative or Medical Records data source may be used.

Administrative:

Use codes (HbA1c Tests Value Set) to identify the most recent HbA1c test during the measurement year. The patient 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 patient is not numerator compliant if the result for the most recent HbA1c test during the measurement year is ≤9.0%.

Organizations that use Current Procedural Terminology (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 patient is numerator compliant.

Value Set	Numerator Compliance
HbA1c Level Less Than 7.0 Value Set	Not compliant
HbA1c Level 7.0–9.0 Value Set	Not compliant
HbA1c Level Greater Than 9.0 Value Set	Compliant

Medical Records:

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 patient 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 patient is not numerator compliant if the most recent HbA1c level during the measurement year is ≤9.0%.

Ranges and thresholds do not meet criteria for this indicator. A distinct numeric result is required for numerator compliance.

Note: This numerator represents a reversal of the pattern for most measures, where compliance would be a positive outcome and better quality would be associated with a higher score. In this measure, HbA1c levels >9.0% (poor control) and failure to perform the test or report the score are considered numerator compliant because they reflect a failure to control, test, or report this outcome.

Note: The measurement period for the numerator is the measurement year.

Exclusions: Consumers who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or year prior to the measurement year and who meet **either** of the following criteria:

- A diagnosis of polycystic ovaries (Polycystic Ovaries Value Set), in any setting, any time during the consumer's history through the end of the measurement year

  OR

- A diagnosis of gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year.

E. ADDITIONAL NOTES

The source measure is designed for the Medicaid population and is not risk adjusted. The source measure was specified and tested at the health plan level. This measure is modified to require clinic-level reporting, and to be consistent in format with other measures in this set of BHC measures, but is not tested at the clinic level.

Interpretation of score: Better quality = Lower score

Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)

Based on a measure stewarded by the
National Committee for Quality Assurance (HEDIS 2016)

A. DESCRIPTION

The percentage of children and adolescents aged 1–17 years who had two or more antipsychotic prescriptions and had metabolic testing

Data Collection Method: Administrative

Guidance for Reporting:

- This measure is stratified by whether the consumer is a Medicaid beneficiary, eligible for both Medicare and Medicaid, and other. The total denominator also is stratified by age (1-5, 6-11, 12-17, and total). For purposes of determining whether a consumer is a Medicaid beneficiary or a dual Medicare and Medicaid enrollee, see Continuous Enrollment, Allowable Gap, and Anchor Date requirements below in section C.
- Referenced Value Sets may be found in the Healthcare Effectiveness Data and Information Set (HEDIS) specifications Volume 2. Value Sets are available at NCQA HEDIS 2016.
- Refer to the specific data-reporting template for the reporting requirements applicable to each measure and to the Appendices in Volume 2 of this manual.

Measurement Period: The measurement period is the measurement year for both the denominator and numerator.

B. DEFINITIONS

TERM	DEFINITION
Antipsychotic Medication Dispensing Events	A dispensed antipsychotic, as identified by claim/encounter data. Antipsychotics are those identified on the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) 2016 Final National Drug Code (NDC) Lists webpage at HEDIS 2016 Final NDC Lists.
Cholesterol Test Other Than LDL	A cholesterol test other than LDL (Cholesterol Tests Other Than LDL Value Set) performed during the measurement year, as identified by claim/encounter or automated laboratory data

TERM	DEFINITION
Glucose Test	A glucose test (Glucose Tests Value Set) performed during the measurement year, as identified by claim/encounter or automated laboratory data
HbA1c Test	An Hemoglobin A1c (HbA1c) test (HbA1c Tests Value Set) performed during the measurement year, as identified by claim/encounter or automated laboratory data
LDL-C Test	A low-density lipoprotein cholesterol (LDL-C) test (LDL-C Tests Value Set) performed during the measurement year, as identified by claim/encounter or automated laboratory data
Provider Entity	The provider entity that is being measured (i.e., BHC)

C. ELIGIBLE POPULATION

CRITERIA	REQUIREMENTS
Age	Consumers aged 1–17 years as of the end of the measurement year. Report three age stratifications and a total rate: • 1–5 years • 6–11 years • 12–17 years • Total (the sum of the age stratifications)
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	The last day of the measurement year
Benefits	Medical and pharmacy

CRITERIA	REQUIREMENTS
Event/Diagnosis	Follow the steps below to identify the eligible population: ***Step 1*** Identify consumers flagged as having been seen at the provider entity at least once during the measurement year. ***Step 2*** Identify consumers from step 1 aged 1–17 years as of the end of the measurement year. ***Step 3*** Identify consumers from step 2 who had at least two antipsychotic medication dispensing events of the same or different medications, on different dates of service during the measurement year (See Table APM-A on the NCQA website for the current list of antipsychotic medications (HEDIS 2016 Final NDC Lists)).

D. ADMINISTRATIVE SPECIFICATION

Denominator

The number of consumers in the eligible population (Section C)

Numerator

The number of consumers in the eligible population who met both of the following during the measurement year:

- At least one test for blood glucose (Glucose Tests Value Set) or HbA1c (HbA1c Tests Value Set)
- At least one test for LDL-C (LDL-C Tests Value Set) or cholesterol (Cholesterol Tests Other Than LDL Value Set)

Exclusions

None

E. ADDITIONAL NOTES

The source measure is designed for the Medicaid and Commercial populations and is not risk adjusted. The source measure was specified and tested at the health plan level. This measure is modified to require clinic-level reporting, and to be consistent in format with other measures in this set of BHC measures, but is not tested at the clinic level.

Interpretation of score: Better quality = Higher score

Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)

Based on measure stewarded by the
National Committee for Quality Assurance (NQF #1933, HEDIS 2016)

A. DESCRIPTION

The percentage of consumers 18–64 years of age with schizophrenia and cardiovascular disease, who had an LDL-C test during the measurement year

Data Collection Method: Administrative

Guidance for Reporting:

- This measure is stratified by whether the consumer is a Medicaid beneficiary, eligible for both Medicare and Medicaid, and other. For purposes of determining whether a consumer is a Medicaid beneficiary or a dual Medicare and Medicaid enrollee, see Continuous Enrollment, Allowable Gap, and Anchor Date requirements below in section C.
- See 2016 Healthcare Effectiveness Data and Information Set (HEDIS) Value Sets referred to in the specification for relevant codes. Referenced Value Sets may be found in the National Committee for Quality Assurance (NCQA) HEDIS specifications Volume 2. Value Sets are available at NCQA HEDIS 2016.
- Refer to the specific data-reporting template for the reporting requirements applicable to each measure and to the Appendices in Volume 2 of this manual.

Measurement Period: For the denominator, the measurement period is the measurement year and the prior year. The measurement period for the numerator is the measurement year.

B. DEFINITIONS

TERM	DEFINITION
AMI	Acute Myocardial Infarction
CABG	Coronary Artery Bypass Graft
IVD	Ischemic Vascular Disease

TERM	DEFINITION
LDL-C Test	An LDL-C test (LDL-C Tests Value Set) performed during the measurement year, as identified by claim/encounter or automated laboratory data The reporting entity may use a calculated or direct LDL.
PCI	Percutaneous Coronary Intervention
Provider Entity	The provider entity that is being measured (i.e., BHC)

C. ELIGIBLE POPULATION

CRITERIA	REQUIREMENTS
Age	Consumers aged 18–64 years as of the end of the measurement year
Continuous Enrollment	The measurement year and the year prior to the measurement year
Allowable Gap	No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a consumer for whom enrollment is verified monthly, the consumer may not have more than a 1-month gap in coverage (i.e., a consumer whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor Date	The last day of the measurement year
Benefits	Medical

CRITERIA	REQUIREMENTS
Event/Diagnosis	Follow the steps below to identify the eligible population: ***Step 1*** Identify consumers flagged as having been seen at the provider entity at least once during the measurement year. ***Step 2*** Identify consumers from step 1 aged 18–64 years as of the end of the measurement year. ***Step 3*** Identify consumers from step 2 with schizophrenia as those who met **at least one of the following criteria** during the measurement year: 1. At least one acute inpatient encounter with any diagnosis of schizophrenia. **Either of the following code combinations meets criteria:** – BH Stand Alone Acute Inpatient Value Set **with** Schizophrenia Value Set – BH Acute Inpatient Value Set **with** BH Acute Inpatient POS Value Set **and** Schizophrenia Value Set **OR** 2. At least two visits in an outpatient, intensive outpatient (IOP), partial hospitalization (PH), emergency department (ED), or nonacute inpatient setting, on different dates of service, with any diagnosis of schizophrenia. **Any two of the following code combinations meet criteria:** – BH Stand Alone Outpatient/PH/IOP Value Set with Schizophrenia Value Set – BH Outpatient/PH/IOP Value Set **with** BH Outpatient/PH/IOP POS Value Set **and** Schizophrenia Value Set – ED Value Set **with** Schizophrenia Value Set – BH ED Value Set **with** BH ED POS Value Set **and** Schizophrenia Value Set

CRITERIA	REQUIREMENTS
Event/Diagnosis (cont'd)	– BH Stand Alone Nonacute Inpatient Value Set **with** Schizophrenia Value Set – BH Nonacute Inpatient Value Set **with** BH Nonacute Inpatient POS Value Set **and** Schizophrenia Value Set ***Step 4*** Identify consumers from step 3 who also have cardiovascular disease. Consumers are identified as having cardiovascular disease in two ways: by event (AMI, CABG, or PCI) or by diagnosis (AMI). The reporting entity must use both methods to identify the eligible population, but a consumer need only be identified by one to be included in the measure. 1. *Event:* **Any of the following during the year prior to the measurement year meet criteria:** - *AMI*. Discharged from an inpatient setting with an AMI (AMI Value Set). To identify discharges: a. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). b. Identify the discharge date for the stay. - *CABG*. Discharged from an inpatient setting with a CABG (CABG Value Set). To identify discharges: a. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). b. Identify the discharge date for the stay. - *PCI*. Consumers who had PCI (PCI Value Set) in any setting (e.g., inpatient, outpatient, ED). **OR** 2. *Diagnosis:* Identify consumers with IVD as those who met at least either of the following criteria during **both** the measurement year **and** the year prior to the measurement year. The criteria need not be the same across both years. - At least one outpatient visit (Outpatient Value Set) with a diagnosis of IVD (IVD Value Set) - At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of IVD (IVD Value Set).

D. ADMINISTRATIVE SPECIFICATION

Denominator

The number of consumers in the eligible population (Section C)

Note: For the denominator, the measurement period is the measurement year and the prior year.

Numerator

The number of consumers with an LDL-C test (LDL-C Tests Value Set) performed during the measurement year, as identified by claim/encounter or automated laboratory data.

Note: The measurement period for the numerator is the measurement year.

Exclusions

None

E. ADDITIONAL NOTES

The source measure is designed for the Medicaid population and is not risk adjusted. The source measure was specified and tested at the health plan level. This measure is modified to require clinic-level reporting, and to be consistent in format with other measures in this set of BHC measures, but is not tested at the clinic level.

Interpretation of score: Better quality = Higher score

Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder (AMS-BD)

Based on a measure stewarded by the
Centers for Medicare & Medicaid Services (NQF #1880)

A. DESCRIPTION

The percentage of consumers at least 18 years of age as of the beginning of the measurement period with Bipolar I Disorder who had at least two prescription drug claims for mood stabilizer medications and had a Proportion of Days Covered (PDC) of at least 0.8 for mood stabilizer medications during the measurement period (12 consecutive months)

Data Collection Method: Administrative

Guidance for Reporting:

- This measure is stratified by whether the consumer is a Medicaid beneficiary, eligible for both Medicare and Medicaid, and other. For purposes of determining whether a consumer is a Medicaid beneficiary or a dual Medicare and Medicaid enrollee, see Continuous Enrollment, Allowable Gap, and Anchor Date requirements below in section C.
- Please refer to the most recent Code Tables in the source measure (NQF 1880) at CMS Quality Measures for the diagnostic codes, mood stabilizer medications and encounter codes referenced in this specification.
- To the extent possible, include all paid, suspended, pending, and denied claims.
- Refer to the specific data-reporting template for the reporting requirements applicable to each measure and to the Appendices in Volume 2 of this manual.

Measurement Period: The measurement period for the denominator and the numerator is the measurement year.

B. DEFINITIONS

TERM	DEFINITION
Bipolar I Disorder	A diagnosis of Bipolar I Disorder is indicated by the presence of any of the ICD-10 bipolar diagnostic codes listed in the source measure Code Tables.

TERM	DEFINITION
Mood Stabilizer Medication	A list of medications that may be treated as mood stabilizers for purposes of this specification are listed in the source measure Code Tables.

TERM	DEFINITION
Proportion of Days Covered (PDC)	The PDC is a measure of adherence to prescribed medications. Calculate the PDC for each individual in the eligible population (i.e., the measure's denominator) according to the following methods: 1. Determine the individual's medication therapy period, defined as the index prescription date through the end of the measurement period, or death, whichever comes first. The index date is the service date (fill date) of the first prescription drug claim for a mood stabilizer medication in the measurement period. 2. Within the medication therapy period, count the days the individual was covered by at least one drug in the mood stabilizer medication class based on the prescription drug claim service date and days of supply. a. Sort and de-duplicate claims for mood stabilizers by beneficiary ID, service date, generic name, and descending days' supply. If prescriptions for the same drug (generic name) are dispensed on the same date of service for an individual, keep the dispensing with the largest days' supply. b. Calculate the number of days covered by mood stabilizer therapy per individual: i. For prescription drug claims with a days' supply that extends beyond the end of the measurement period, count only the days for which the drug was available to the individual during the measurement period. ii. If claims for the same drug (generic name) overlap, then adjust the last prescription start date to be the day after the previous fill has ended. iii. If claims for different drugs (different generic names) overlap, do not adjust the prescription start date.

TERM	DEFINITION
Proportion of Days Covered (PDC)	3. Calculate the PDC for each individual. Divide the number of covered days found in step 2 by the number of days in the individual's medication therapy period found in step 1. ***Note:*** An example of SAS code for steps 1-3 was adapted from Pharmacy Quality Alliance (PQA) and is also available at SAS Global Forum 2007.
Provider Entity	The provider entity that is being measured (i.e., BHC)

C. ELIGIBLE POPULATION

CRITERIA	REQUIREMENTS
Age	Consumers aged 18 years or older at the beginning of the measurement year
Continuous Enrollment	The measurement year
Allowable Gap	No more than one gap in enrollment of up to 31 days during the measurement year. To determine continuous enrollment for a consumer for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage. To determine continuous enrollment for a consumer, the consumer must be: 1. Continuously enrolled in Part D with no more than a 1-month gap in enrollment during the measurement year, 2. Continuously enrolled in Part A and Part B with no more than a 1-month gap in Part A enrollment and no more than a 1-month gap in Part B enrollment during the measurement year, **AND** 3. No more than 1 month of HMO (Health Maintenance Organization) enrollment during the measurement year.
Anchor Date	The last day of the measurement year
Benefits	Medical and pharmacy

CRITERIA	REQUIREMENTS
Event/Diagnosis	Follow the steps below to identify the eligible population: ***Step 1*** Identify consumers flagged as having been seen at the provider entity at least once during the measurement year. ***Step 2*** Identify consumers from step 1 who were aged 18 years or older at the beginning of the measurement year. ***Step 3*** Identify consumers from step 2 who are identified by having a diagnosis of Bipolar I Disorder (see the source measure Code Tables for bipolar diagnoses) within the inpatient or outpatient claims data during the measurement year. Individuals must have: 1. At least two encounters with a diagnosis of Bipolar I Disorder with different dates of service in an outpatient setting, emergency department (ED) setting, or nonacute inpatient setting (see the source measure Code Tables for encounter codes) during the measurement period. **OR** 2. At least one encounter with a diagnosis of Bipolar I Disorder in an acute inpatient setting (see the source measure Code Tables for encounter codes) during the measurement period. ***Step 4*** Identify consumers from step 3 who had at least two prescription drug claims for mood stabilizer medications (see the source measure Code Tables for mood stabilizers) on different dates of service during the measurement period.

D. ADMINISTRATIVE SPECIFICATION

Denominator

The number of consumers in the eligible population (Section C)

Numerator

The number of consumers with Bipolar I Disorder who had at least two prescription drug claims for mood stabilizer medications and a PDC of at least 0.8 for mood stabilizer medications. To calculate the numerator, first calculate the PDC for each individual in the

denominator and then determine the number of those individuals who have a PDC of at least 0.8.

Exclusions

None

E. ADDITIONAL NOTES

The source measure is designed for the Medicare population and is not risk adjusted. The source measure was specified and tested at the state and other levels, including specifications at the provider group level from which this measure is drawn. This measure is modified from the source measure, however, to provide a specification consistent in format to other measures in this set of BHC measures.

Interpretation of score: Better quality = Higher score

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

Based on a measure stewarded by the
Centers for Medicare and Medicaid Services (HEDIS 2016)

A. DESCRIPTION

Percentage of consumers ages 19 to 64 during the measurement year with schizophrenia 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:

- This measure is stratified by whether the consumer is a Medicaid beneficiary, eligible for both Medicare and Medicaid, and other. For purposes of determining whether a consumer is a Medicaid beneficiary or a dual Medicare and Medicaid enrollee, see Continuous Enrollment, Allowable Gap, and Anchor Date requirements below in section C.
- Referenced Value Sets may be found at NCQA HEDIS 2016.
- Table SAA-A (Appendix SAA-BH) provides a list of antipsychotics. The National Committee for Quality Assurance's (NCQA) National Drug Code (NDC) current list of antipsychotic medications can be found at: NCQA HEDIS 2016.
- To the extent possible, include all paid, suspended, pending, and denied claims.
- Refer to the specific data-reporting template for the reporting requirements applicable to each measure and to the Appendices in Volume 2 of this manual.

Measurement Period: For both the denominator and the numerator, the measurement period is the measurement year.

B. DEFINITIONS

TERM	DEFINITION
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 Table SAA-A (Appendix SAA-BH). For multiple J Codes or NDCs for the same or different medications on the same day, use the medication with the longest days' supply. For multiple J Codes or NDCs 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.
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 drug ID provided on the NDC list to determine if the prescriptions are the same or different.
Intake Period	The 12-month window starting 7 months prior to the measurement year and ending at the end of the fourth month after the beginning of the measurement year
IPSD	Index Prescription Start Date: The earliest prescription dispensing date for an antipsychotic medication during the measurement year
Long-Acting Injections Dispensing Event	Injections count as one dispensing event. Multiple J codes or NDCs for the same or different medication on the same day are counted as a single dispensing event.

TERM	DEFINITION
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.
PDC	Proportion of Days Covered: The number of days a consumer is covered by at least one antipsychotic medication prescription, divided by the number of days in the treatment period
Provider Entity	The provider entity that is being measured (i.e., BHC)
Treatment Period	The period of time beginning on the IPSD through the last day of the measurement year

C. ELIGIBLE POPULATION

CRITERIA	REQUIREMENTS
Age	Consumers aged 19 to 64 years as of the last day 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 consumer for whom enrollment is verified monthly, the consumer may not have more than a 1-month gap in coverage (i.e., a consumer whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor Date	The last day of the measurement year
Benefits	Medical and pharmacy

CRITERIA	REQUIREMENTS
Event/Diagnosis	Follow the steps below to identify the eligible population: ***Step 1*** Identify consumers flagged as having been seen at the provider entity at least once during the measurement year. ***Step 2*** Identify consumers from step 1 who were aged 19 to 64 years as of the last day of the measurement year. ***Step 3*** Identify consumers from step 2 with schizophrenia if they met **at least one** of the following criteria during the measurement year: 1. At least one acute inpatient encounter with any diagnosis of schizophrenia. **Either of the following code combinations meets criteria:** 2. BH Stand Alone Acute Inpatient Value Set with Schizophrenia Value Set 3. BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set and Schizophrenia Value Set **OR** 4. 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. **Any two of the following code combinations meet criteria:** • BH Stand Alone Outpatient/PH/IOP Value Set with Schizophrenia Value Set • BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set and Schizophrenia Value Set • ED Value Set with Schizophrenia Value Set • BH ED Value Set with BH ED POS Value Set and Schizophrenia Value Set

CRITERIA	REQUIREMENTS
Event/Diagnosis	• BH Stand Alone Nonacute Inpatient Value Set with Schizophrenia Value Set • BH Nonacute Inpatient Value Set with BH Nonacute Inpatient POS Value Set and Schizophrenia Value Set ***Step 4*** Required exclusions. From consumers in step 3, **exclude** those who met **at least one** of the following during the measurement year: 1. A diagnosis of dementia (Dementia Value Set) 2. 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. 3. Claims/encounter data. An antipsychotic medication (Long-Acting Injections 14 Days Supply Value Set or Long-Acting Injections 28 Days Supply Value Set) 4. Pharmacy data. Dispensed an antipsychotic medication (Table SAA-A (Appendix SAA-BH)) on an ambulatory basis

D. ADMINISTRATIVE SPECIFICATION

Denominator

The number of consumers in the eligible population (Section C)

Numerator

The number of consumers who achieved a PDC of at least 80 percent for their antipsychotic medications (Table SAA-A (Appendix SAA-BH); Long-Acting Injections 14 Days Supply Value Set; Long-Acting Injections 28 Days Supply Value Set) during the measurement year.

Follow the steps below to identify numerator compliance:

Step 1

Identify the IPSD. The IPSD is the earliest dispensing event for any antipsychotic medication (Table SAA-A (Appendix SAA-BH); Long-Acting Injections 14 Days Supply Value Set; Long-Acting Injections 28 Days Supply Value Set) 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 (Table SAA-A (Appendix SAA-BH); Long-Acting Injections 14 Days Supply Value Set; Long-Acting Injections 28 Days Supply Value Set) during the treatment period. To ensure that the day's supply does not exceed the treatment period, subtract any day's supply that extends beyond the last day of the measurement year.

Step 4

Calculate the consumer's PDC using the following equation:

Total Days Covered by an Antipsychotic Medication in the Treatment Period (step 3)
divided by Total Days in Treatment Period (step 2)

Round to two decimal places, using the .5 rule (if the decimal is 0.5 or above round up to the nearest whole number. If the decimal is 0.499999 or below round down to the nearest whole number).

Step 5

Sum the number of consumers whose PDC is ≥80 percent for their treatment period.

Exclusions

Exclude those who met **at least one** 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.
    - Claims/encounter data. An antipsychotic medication (Long-Acting Injections 14 Days Supply Value Set or Long-Acting Injections 28 Days Supply Value Set)
    - Pharmacy data. Dispensed an antipsychotic medication (Table SAA-A (Appendix SAA-BH)) on an ambulatory basis

E. ADDITIONAL NOTES

The source measure is designed for the Medicaid population and is not risk adjusted. The source measure was specified and tested at the health plan level. This measure is

modified to require clinic-level reporting, and to be consistent in format with other measures in this set of BHC measures, but is not tested at the clinic level.

Interpretation of score: Better quality = Higher score

Follow-Up After Hospitalization for Mental Illness (FUH-BH-A)

Based on a measure stewarded by the
National Committee for Quality Assurance (NQF #0576, HEDIS 2016)

A. DESCRIPTION

The percentage of discharges for consumers age 21 and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner

Two rates are reported:

- Percentage of discharges for which the consumer received follow-up within 30 days of discharge
- Percentage of discharges for which the consumer received follow-up within 7 days of discharge

Data Collection Method: Administrative

Guidance for Reporting:

- This measure is stratified by age (aged 21 to 64 years, aged 65 years and older) and by whether the consumer is a Medicaid beneficiary, eligible for both Medicare and Medicaid, and other. For purposes of determining whether a consumer is a Medicaid beneficiary or a dual Medicare and Medicaid enrollee, see Continuous Enrollment, Allowable Gap, and Anchor Date requirements below in section C.
- 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
- Referenced Value Sets may be found at NCQA HEDIS 2016.
- To the extent possible, include all paid, suspended, pending, and denied claims.
- Refer to Appendix D for the definition of a mental health practitioner.
- Refer to the specific data-reporting template for the reporting requirements applicable to each measure and to the Appendices in Volume 2 of this manual.

Measurement Period: For both rates, the measurement period for the denominator is measured from the discharge date and encompasses the measurement year (e.g., for CCBHCs, DY1 or DY2) less the last 30 days. The measurement period for the numerator for rate 1 is the discharge date through 7 days after the discharge date. The measurement period for the numerator for rate 2 is the measurement year.

B. DEFINITIONS

TERM	DEFINITION
Provider Entity	The provider entity that is being measured (i.e., BHC)

C. ELIGIBLE POPULATION

CRITERIA	REQUIREMENTS
Age	Consumers aged 21 and older as of the date of discharge. Report two age stratifications (as applicable): • 21–64 years • 65 years and older
Continuous Enrollment	The date of discharge through 30 days after discharge
Allowable Gap	No gaps in enrollment
Anchor Date	None
Benefits	Medical and mental health (inpatient and outpatient)

CRITERIA	REQUIREMENTS
Event/Diagnosis	Follow the steps below to identify the eligible population: ***Step 1*** Identify consumers flagged as having been seen at the provider entity at least once during the measurement year. ***Step 2*** Identify consumers from step 1 who were aged 21 years and older as of the date of discharge. ***Step 3*** Identify consumers from step 2 who experience an acute inpatient discharge with a principal diagnosis of mental illness (Mental Illness Value Set) during the measurement year less the last 30 days. 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. ***Note:*** Use only facility claims to identify discharges and diagnoses for denominator events (including readmissions or direct transfers). Do not use professional claims. ***Note:*** The denominator for this measure is based on discharges, not consumers. If consumers had more than one discharge, include all discharges during the measurement year less the last 30 days.

CRITERIA	REQUIREMENTS
Acute Facility Readmission or Direct Transfer	If the discharge is followed by readmission or direct transfer to an acute inpatient care setting for a principal mental health diagnosis (Mental Health Diagnosis Value Set) within the 30-day follow-up period, **count only the last discharge**. Exclude **both** the initial discharge and the readmission/direct transfer discharge if the last discharge occurs during the last 30 days of the measurement year. To identify readmissions to an acute inpatient care setting: 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. States must identify "direct transfers" using their own methods and then confirm the acute inpatient care setting using the steps above.

CRITERIA	REQUIREMENTS
Exclusions	**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 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. **Exclude** discharges followed by readmission or direct transfer to an acute inpatient care setting within the 30-day follow-up period if the principal diagnosis was for non-mental health (any principal diagnosis code other than those included in the Mental Health Diagnosis Value Set). To identify readmissions to an acute inpatient care setting: 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. ***Note:*** States must identify "direct transfers" using their own methods and then confirm the acute inpatient care setting using the steps above. ***Note:*** These discharges are excluded from the measure because rehospitalization or transfer may prevent an outpatient follow-up visit from taking place.

D. ADMINISTRATIVE SPECIFICATION

Denominator

The number of eligible discharges for the eligible population (Section C)

Note: For the denominator, the measurement period is measured from the discharge date and encompasses the measurement year less the last 30 days.

Numerators

Rate 1: 30-Day Follow-Up

An outpatient visit, intensive outpatient visit, or partial hospitalization with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient visits, or partial hospitalizations that occur on the date of discharge.

Rate 2: 7-Day Follow-Up

An outpatient visit, intensive outpatient visit, or partial hospitalization with a mental health practitioner within 7 days after discharge include outpatient visits, intensive outpatient visits, or partial hospitalizations that occur on the date of discharge.

For both indicators, any of the following meet criteria for a follow-up visit:

- A visit (FUH Stand Alone Visits Value Set) with a mental health practitioner
- A visit (FUH Visits Group 1 Value Set and FUH POS Group 1 Value Set) with a mental health practitioner
- A visit (FUH Visits Group 2 Value Set and FUH POS Group 2 Value Set) with a mental health practitioner
- A visit in a behavioral healthcare facility (FUH RevCodes Group 1 Value Set)
- A visit in a non-behavioral healthcare facility (FUH RevCodes Group 2 Value Set) with a mental health practitioner
- A visit in a non-behavioral healthcare facility (FUH RevCodes Group 2 Value Set) with a diagnosis of mental illness (Mental Illness Value Set)
- Transitional care management services (TCM 7 Day Value Set) where the date of service on the claim is 29 days after the date the eligible population event/diagnosis date of discharge

The following meets criteria for only the 30-Day Follow-Up indicator:

- Transitional care management services (TCM 14 Day Value Set) where the date of service on the claim is 29 days after the event/diagnosis date of discharge

Note: Transitional care management is a 30-day period that begins on the date of discharge and continues for the next 29 days. The date of service on the claim is within 29 days after discharge and not the date of the face-to-face visit.

Note: The measurement period for the numerator for rate 1 is the discharge date through 7 days after the discharge date. The measurement period for the numerator for rate 2 is the measurement year.

E. ADDITIONAL NOTES

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

The source measure is designed for the Medicaid population and is not risk adjusted. The source measure was specified and tested at the health plan level. This measure is modified to require clinic-level reporting, and to be consistent in format with other measures in this set of BHC measures, but is not tested at the clinic level.

Interpretation of score: Better quality = Higher score

Follow-Up after Hospitalization for Mental Illness (FUH-BH-C)

Based on a measure stewarded by the
National Committee for Quality Assurance (NQF #0576, HEDIS 2016

A. DESCRIPTION

Percentage of discharges for children and adolescents ages 6-20 who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner.

Two rates are reported:

- Percentage of discharges for which children received follow-up within 30 days of discharge
- Percentage of discharges for which children received follow-up within 7 days of discharge

Data Collection Method: Administrative

Guidance for Reporting:

- This measure is stratified by whether the consumer is a Medicaid beneficiary, eligible for both Medicare and Medicaid, and other. For purposes of determining whether a consumer is a Medicaid beneficiary or a dual Medicare and Medicaid enrollee, see Continuous Enrollment, Allowable Gap, and Anchor Date requirements below in section C.
- Follow the detailed specifications to (1) include the appropriate discharge when the patient 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 patient 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.
- Referenced Value Sets may be found at NCQA HEDIS 2016.
- To the extent possible, include all paid, suspended, pending, and denied claims.
- Refer to Appendix D for the definition of a mental health practitioner.

- Refer to the specific data-reporting template for the reporting requirements applicable to each measure and to the Appendices in Volume 2 of this manual.

Measurement Period: For both rates, the measurement period for the denominator is measured from the discharge date and encompasses the measurement year (e.g., for CCBHCs, DY1 or DY2) less the last 30 days. The measurement period for the numerator for rate 1 is the discharge date through 7 days after the discharge date. The measurement period for the numerator for rate 2 is the measurement year.

B. DEFINITIONS

TERM	DEFINITION
Provider Entity	The provider entity that is being measured (i.e., BHC)

C. ELIGIBLE POPULATION

CRITERIA	REQUIREMENTS
Age	Consumers aged 6–20 years as of the date of discharge
Continuous Enrollment	The date of discharge through 30 days after discharge
Allowable Gap	No gaps in enrollment
Anchor Date	None
Benefits	Medical and mental health (inpatient and outpatient)

CRITERIA	REQUIREMENTS
Event/Diagnosis	Follow the steps below to identify the eligible population: ***Step 1*** Identify consumers flagged as having been seen at the provider entity at least once during the measurement year. ***Step 2*** Identify consumers from step 1 who were aged 6–20 years as of the date of discharge. ***Step 3*** Identify consumers from step 2 who experience an acute inpatient discharge with a principal diagnosis of mental illness (Mental Illness Value Set) during the measurement year less the last 30 days. 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. ***Note:*** Use only facility claims to identify discharges and diagnoses for denominator events (including readmissions or direct transfers). Do not use professional claims. ***Note:*** The denominator for this measure is based on discharges, not children. If children have more than one discharge, include all discharges during the measurement year less the last 30 days.

CRITERIA	REQUIREMENTS
Acute Facility Readmission or Direct Transfer	If the discharge is followed by readmission or direct transfer to an acute inpatient care setting for a principal mental health diagnosis (Mental Health Diagnosis Value Set) within the 30-day follow-up period, **count only the last discharge**. Exclude **both** the initial discharge and the readmission/direct transfer discharge if the last discharge occurs during the last 30 days of the measurement year. To identify readmissions to an acute inpatient care setting: 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. States must identify "direct transfers" using their own methods and then confirm the acute inpatient care setting using the steps above.

CRITERIA	REQUIREMENTS
Exclusions	**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 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. **Exclude** discharges followed by readmission or direct transfer to an acute inpatient care setting within the 30-day follow-up period if the principal diagnosis was for non-mental health (any principal diagnosis code other than those included in the Mental Health Diagnosis Value Set). To identify readmissions to an acute inpatient care setting: 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. ***Note:*** States must identify "direct transfers" using their own methods and then confirm the acute inpatient care setting using the steps above. ***Note:*** These discharges are excluded from the measure because rehospitalization or transfer may prevent an outpatient follow-up visit from taking place.

D. ADMINISTRATIVE SPECIFICATION

Denominator

The number of eligible discharges for the eligible population (Section C)

Note: For the denominator, the measurement period is measured from the discharge date and encompasses the measurement year less the last 30 days.

Numerators

Rate 1: 30-Day Follow-Up

An outpatient visit, intensive outpatient visit, or partial hospitalization with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient visits, or partial hospitalizations that occur on the date of discharge.

Rate 2: 7-Day Follow-Up

An outpatient visit, intensive outpatient visit, or partial hospitalization with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient visits, or partial hospitalizations that occur on the date of discharge.

For both indicators, any of the following meet criteria:

- A visit (FUH Stand Alone Visits Value Set) with a mental health practitioner
- A visit (FUH Visits Group 1 Value Set and FUH POS Group 1 Value Set) with a mental health practitioner
- A visit (FUH Visits Group 2 Value Set and FUH POS Group 2 Value Set) with a mental health practitioner
- A visit in a behavioral healthcare facility (FUH RevCodes Group 1 Value Set)
- A visit in a non-behavioral healthcare facility (FUH RevCodes Group 2 Value Set) with a mental health practitioner
- A visit in a non-behavioral healthcare facility (FUH RevCodes Group 2 Value Set) with a diagnosis of mental illness (Mental Illness Value Set)
- Transitional care management services (TCM 7 Day Value Set) where the date of service on the claim is 29 days after the date the eligible population event/diagnosis date of discharge

The following meets criteria for only the 30-Day Follow-Up indicator:

- Transitional care management services (TCM 14 Day Value Set) where the date of service on the claim is 29 days after the event/diagnosis date of discharge

Note: Transitional care management is a 30-day period that begins on the date of discharge and continues for the next 29 days. The date of service on the claim is within 29 days after discharge and not the date of the face-to-face visit.

Note: The measurement period for the numerator for rate 1 is the discharge date through 7 days after the discharge date. The measurement period for the numerator for rate 2 is the measurement year.

E. ADDITIONAL NOTES

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

The source measure is designed for the Medicaid population and is not risk adjusted. The source measure was specified and tested at the health plan level. This measure is modified to require clinic-level reporting, and to be consistent in format with other measures in this set of BHC measures, but is not tested at the clinic level.

Interpretation of score: Better quality = Higher score

Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder (ADHD) Medication (ADD-BH)

Based on a measure stewarded by the
National Committee for Quality Assurance (NQF #0108; HEDIS 2016)

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 as of the Index Prescription Start Date (IPSD) with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase.

Continuation and Maintenance (C&M) Phase: Percentage of children ages 6 to 12 as of the IPSD with an ambulatory 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

Guidance for Reporting:

- This measure is stratified by whether the consumer is a Medicaid beneficiary, eligible for both Medicare and Medicaid, and other. For purposes of determining whether a consumer is a Medicaid beneficiary or a dual Medicare and Medicaid enrollee, see Continuous Enrollment, Allowable Gap, and Anchor Date requirements below in section C.
- 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 should be removed from the denominator of both indicators.
- Referenced Value Sets may be found at NCQA HEDIS 2016.
- Table ADD.A (Appendix ADD-BH) provides a list of ADHD medications. NCQA's National Drug Code (NDC) current list of ADHD medications can be found at: NCQA HEDIS 2016.
- To the extent possible, include all paid, suspended, pending, and denied claims.
- Refer to Appendix D for the definition of a prescribing practitioner.
- Refer to the specific data-reporting template for the reporting requirements applicable to each measure and to the Appendices in Volume 2 of this manual.

Measurement Period:

For the denominator, two measurement periods are used:

- Index prescription start date (IPSD): 10 months before the measurement year begins to 2 months after the measurement year begins
- Negative medication history review: The time period between 120 days before the IPSD measurement period begins and 120 days before the IPSD measurement period ends

For the numerator, two measurement periods are used:

- Initiation Phase: The time period between 30 days after the IPSD measurement period begins and 30 days after the IPSD measurement period ends
- Continuation and Maintenance Phase: The time period between 300 days after the IPSD measurement period begins and 300 days after the IPSD measurement period ends

B. DEFINITIONS

TERM	DEFINITION
Continuous Medication Treatment	The number of medication treatment days during the 10-month follow-up period must be ≥210 days (i.e., 300 treatment days – 90 gap days)
C&M Phase	The 300 days following the IPSD (10 months)
Initiation Phase	The 30 days following the IPSD

TERM	DEFINITION
Intake Period	The 12-month window starting 10 months before the measurement year begins to 2 months after the measurement year begins
IPSD	Index Prescription Start Date. 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	A period of 120 days (4 months) prior to the IPSD when the child had no ADHD medications dispensed for either new or refill prescriptions
New Episode	The child must have a 120-day (4-month) Negative Medication History on or before the IPSD.
Provider Entity	The provider entity that is being measured (i.e., BHC)
Treatment Days (Covered Days)	The actual number of calendar days covered with prescriptions within the specified 300-day measurement interval (e.g., a prescription of a 90 days' supply dispensed on the 220th day will have 80 days counted in the 300-day interval)

C. ELIGIBLE POPULATION

Eligible Population: Rate 1 - Initiation Phase

CRITERIA	REQUIREMENTS
Age	Consumers aged 6 years as of 10 months before the measurement year begins to age 12 as of 2 months after the measurement year begins
Continuous Enrollment	Initiation Phase: Children must be continuously enrolled for 120 days (4 months) prior to the IPSD through 30 days (1 month) after the IPSD.
Allowable Gap	None
Anchor Date	None
Benefits	Medical and pharmacy

CRITERIA	REQUIREMENTS
Event/Diagnosis	Follow the steps below to identify the eligible population: ***Step 1*** Identify all children in the specified age range who were dispensed an ADHD medication (Table ADD.A (Appendix ADD-BH)) 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. For children in step 2, identify those who are continuously enrolled for 120 days (4 months) prior to the IPSD through 30 days after the IPSD. ***Step 4*** For children in step 3, **exclude** those who had an acute inpatient encounter for mental health or chemical dependency during the 30 days after the IPSD. **Any of the following meet criteria:** 1. An acute inpatient encounter (Acute Inpatient Value Set) **with** a principal mental health diagnosis (Mental Health Diagnosis Value Set) **OR** 2. An acute inpatient encounter (Acute Inpatient Value Set) **with** a principal diagnosis of chemical dependency (Chemical Dependency Value Set)

Eligible Population: Rate 2 - Continuation and Maintenance Phase

CRITERIA	REQUIREMENTS
Age	Consumers aged 6 years as of 10 months before the measurement year begins to age 12 years as of 2 months after the measurement year begins
Continuous Enrollment	Children must be continuously enrolled for 120 days (4 months) prior to the IPSD and 300 days (10 months) after the IPSD. 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.
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 consumer for whom enrollment is verified monthly, the child may not have more than a 1-month gap in coverage (i.e., a child whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor Date	None.
Benefits	Medical and pharmacy

CRITERIA	REQUIREMENTS
Event/Diagnosis	Follow the steps below to identify the eligible population: ***Step 1*** Identify all children that meet the eligible population criteria for Rate 1—Initiation Phase. ***Step 2*** Calculate continuous enrollment. For children in step 1, identify those who are continuously enrolled from 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 filled a sufficient number of prescriptions to provide continuous treatment for at least 210 days out of the 300-day period after the IPSD. The definition of "continuous medication treatment" allows gaps in medication treatment, up to a total of 90 days during the 300-day (10-month) period. (This period spans the Initiation Phase [1 month] and the C&M Phase [9 months].) ***Note:*** Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication. ***Note:*** Regardless of the number of gaps, the total gap days may be no more than 90. Count any combination of gaps (e.g., one washout gap of 14 days and numerous weekend drug holidays). ***Step 4*** Of the children in step 3, **exclude** those who had an acute inpatient encounter for mental health or chemical dependency during the 300 days (10 months) after the IPSD. **Any of the following meet criteria:** A. An acute inpatient encounter (Acute Inpatient Value Set) **with** a principal mental health diagnosis (Mental Health Diagnosis Value Set) **OR** B. An acute inpatient encounter (Acute Inpatient Value Set) **with** a principal diagnosis of chemical dependency (Chemical Dependency Value Set)

D. ADMINISTRATIVE SPECIFICATION

Denominator

The number of consumers in the eligible population (Section C) for Rate 1 and Rate 2, respectively

Note: The measurement period for the IPSD is the time period 10 months before the measurement year begins to 2 months after the measurement year begins. The measurement period for the negative medication history review is the time period between 120 days before the IPSD measurement period begins and 120 days before the IPSD measurement period ends.

Numerator

Rate 1 - Initiation Phase

An outpatient, intensive outpatient, or partial hospitalization 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 the criteria:**

- ADD Stand Alone Visits Value Set
- ADD Visits Group 1 Value Set **with** ADD POS Group 1 Value Set
- ADD Visits Group 2 Value Set **with** ADD POS Group 2 Value Set

Note: Do not count a visit on the IPSD as the Initiation Phase visit.

Note: For the Initiation Phase numerator, the measurement period is the time period between 30 days after the IPSD measurement period begins and 30 days after the IPSD measurement period ends.

Rate 2 - Continuation and Maintenance

Identify all children that meet the following criteria:

- Numerator compliant for Rate 1 Initiation Phase, and
- At least two follow-up visits with any practitioner, from 31–300 days (9 months) after the IPSD.

One of the two visits (during days 31–300) may be a telephone visit (Telephone Visits Value Set) with any practitioner. **Any of the following code combinations identify follow-up visits:**

- ADD Stand Alone Visits Value Set
- ADD Visits Group 1 Value Set with ADD POS Group 1 Value Set
- ADD Visits Group 2 Value Set with ADD POS Group 2 Value Set
- Telephone Visits Value Set

Note: For the Continuation and Maintenance Phase numerator, the measurement period is the time period between 300 days after the IPSD measurement period begins and 300 days after the IPSD measurement period ends.

Exclusions (optional)

Exclude from the denominator for both rates, children with a diagnosis of narcolepsy (Narcolepsy Value Set) any time during their history through the last day of the measurement year.

Note: For the denominator, two measurement periods are used:

- Index prescription start date (IPSD): 10 months before the measurement year begins to 2 months after the measurement year begins
- Negative medication history review: The time period covering 120 days prior to the IPSD measurement period (beginning 120 days before the IPSD measurement period begins and ending 120 days before the IPSD measurement period ends)

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 time frame required for the rate (e.g., within 30 days after or from 31–300 days after the IPSD).

The source measure is designed for the Medicaid population and is not risk adjusted. The source measure was specified and tested at the health plan level. This measure is modified to require clinic-level reporting, and to be consistent in format with other measures in this set of BHC measures, but is not tested at the clinic level.

Interpretation of score: Better quality = Higher score

Antidepressant Medication Management (AMM-BH)

Based on a measure stewarded by the
National Committee for Quality Assurance (NQF #0105, HEDIS 2016)

A. DESCRIPTION

The percentage of consumers 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 consumers who remained on an antidepressant medication for at least 84 days (12 weeks)
- Effective Continuation Phase Treatment. Percentage of consumers who remained on an antidepressant medication for at least 180 days (6 months)

Data Collection Method: Administrative

Guidance for Reporting:

- This measure is stratified by whether the consumer is a Medicaid beneficiary, eligible for both Medicare and Medicaid, and other. It also is stratified by age. States should calculate and report the two rates listed above for ages 18 to 64 and age 65 and older. For purposes of determining whether a consumer is a Medicaid beneficiary or a dual Medicare and Medicaid enrollee, see Continuous Enrollment, Allowable Gap, and Anchor Date requirements below in section C.
- Referenced Value Sets may be found at NCQA HEDIS 2016.
- Table AMM-C (Appendix AMM-BH) provides a list of antidepressant medications. The National Committee for Quality Assurance's (NCQA) National Drug Code (NDC) current list of ADHD medications can be found at: NCQA HEDIS 2016
- To the extent possible, include all paid, suspended, pending, and denied claims.
- Refer to the specific data-reporting template for the reporting requirements applicable to each measure and to the Appendices in Volume 2 of this manual.

Measurement Period:

For the denominator, two measurement periods are used:

Index prescription start date (IPSD): The time period between 7 months before the measurement year begins and 4 months after the measurement year begins

Negative medication history review: The time period between 105 days before the IPSD measurement period begins and 105 days before the IPSD measurement period ends

For the numerator, two measurement periods are used:

Acute Phase: The time period between 114 days after the IPSD measurement period begins and 114 days after the IPSD measurement period ends

Continuation Phase: The time period between 231 days after the IPSD measurement period begins and 231 days after the IPSD measurement period ends

B. DEFINITIONS

TERM	DEFINITION
Intake Period	The 12-month window starting 7 months prior to the measurement year and ending at the end of the fourth months after the beginning of the measurement year
IPSD	Index Prescription Start Date: The earliest prescription dispensing date for an antidepressant medication during the Intake Period
Negative Medication History	A period of 105 days prior to the IPSD when the consumer had no pharmacy claims for either new or refill prescriptions for an antidepressant medication.
Provider Entity	The provider entity that is being measured (i.e., BHC)
Treatment Days	The actual number of calendar days covered with prescriptions within the specified 180-day (6-month) measurement interval. For Effective Continuation Phase Treatment, a prescription of 90 days (3 months) supply dispensed on the 151st day will have 80 days counted in the 231-day interval.

C. ELIGIBLE POPULATION

CRITERIA	REQUIREMENTS
Age	Consumers aged 18 and older as of the end of the fourth month of the measurement year. Report two age stratifications: • Ages 18 - 64 • Ages 65+
Continuous Enrollment	105 days (3 months) prior to the IPSD through 231 days after the IPSD
Allowable Gap	No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a consumer for whom enrollment is verified monthly, the consumer may not have more than a 1-month gap in coverage (i.e., a consumer whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor Date	IPSD
Benefits	Medical and pharmacy

CRITERIA	REQUIREMENTS
Event/Diagnosis	Follow the steps below to identify the eligible population: ***Step 1*** Identify consumers flagged as having been seen at the provider entity at least once during the measurement year. ***Step 2*** Identify consumers from step 1 who were aged 18 years and older as of the end of the fourth month of the measurement year. ***Step 3*** Determine the IPSD. For consumers identified in step 2, identify the date of the earliest dispensing event for an antidepressant medication (Table AMM-C (Appendix AMM-BH)) during the Intake Period. ***Step 4*** Required exclusion. For consumers identified in step 3, **exclude** those who did not have a diagnosis of major depression in an inpatient, outpatient, ED, intensive outpatient, or partial hospitalization setting during the 121 day period from 60 days prior to the IPSD, through the IPSD and the 60 days after the IPSD. Consumers who meet **any of the following criteria** remain in the eligible population: • An outpatient visit, intensive outpatient encounter or partial hospitalization with any diagnosis of major depression. **Either of the following code combinations meets criteria:** o AMM Stand Alone Visits Value Set with Major Depression Value Set o AMM Visits Value Set with AMM POS Value Set and Major Depression Value Set • An ED visit (ED Value Set) with any diagnosis of Major Depression (Major Depression Value Set)

CRITERIA	REQUIREMENTS
Event/Diagnosis (cont'd)	• An acute or nonacute inpatient discharge with any diagnosis of Major Depression (Major Depression Value Set). To identify acute and nonacute inpatient discharges: o Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set) o Identify the discharge date for the stay. ***Note:*** For a direct transfer, use the discharge date from the last discharge. ***Step 5*** Test for Negative Medication History. For consumers identified in step 4, exclude those who filled a prescription for an antidepressant medication 105 days prior to the IPSD. ***Step 6*** Calculate continuous enrollment. For consumers identified in step 5, identify those that are continuously enrolled for 105 days prior to the IPSD to 231 days after the IPSD.

D. ADMINISTRATIVE SPECIFICATION

Denominator

The number of consumers in the eligible population (Section C)

Note: For the denominator, two measurement periods are used:

a. Index prescription start date (IPSD): The time period between 7 months before the measurement year begins and 4 months after the measurement year begins

b. Negative medication history review: The time period between 105 days before the IPSD measurement period begins and 105 days before the IPSD measurement period ends

Numerator

Rate 1 - Effective Acute Phase Treatment

At least 84 days (12 weeks) of continuous treatment with antidepressant medication (Table AMM-C (Appendix AMM-BH)) beginning on the IPSD through 114 days after the IPSD (115 total days) Continuous treatment allows gaps in medication treatment up to a total of 30 days during the 115-day 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, there may be no more than 30 gap days. Count any combination of gaps (e.g., two washout gaps of 15 days each, or two washout gaps of 10 days each and one treatment gap of 10 days).

Note: For the Acute Phase Treatment rate, the measurement period is the time period between 114 days after the IPSD measurement period begins and 114 days after the IPSD measurement period ends.

Rate 2 - Effective Continuation Phase Treatment

At least 180 days (6 months) of continuous treatment with antidepressant medication (Table AMM-C (Appendix AMM-BH)) beginning on the IPSD through 231 days after the IPSD (232 total days). Continuous treatment allows gaps in medication treatment up to a total of 51 days during the 232-day 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, there may be no more than 51 gap days. Count any combination of gaps (e.g., two washout gaps, each of 25 days, or two washout gaps of 10 days each and one treatment gap of 10 days).

Note: For the Continuation Phase Treatment rate, the measurement period is the time period between 231 days after the IPSD measurement period begins and 231 days after the IPSD measurement period ends.

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.

The source measure is designed for the Medicaid population and is not risk adjusted. The source measure was specified and tested at the health plan level. This measure is modified to require clinic-level reporting, and to be consistent in format with other measures in this set of BHC measures, but is not tested at the clinic level.

Interpretation of score: Better quality = Higher score

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-BH)

Based on a measure stewarded by the
National Committee for Quality Assurance (NQF #0004, HEDIS 2016)

A. DESCRIPTION

Percentage of consumers age 13 and older with a new episode of alcohol or other drug (AOD) dependence who received the following:

- Initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis
- Initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit

Data Collection Method: Administrative

Guidance for Reporting:

- Two rates are reported: initiation of AOD treatment and engagement of AOD treatment.
- This measure is stratified by age (aged 13 to 17 years, aged 18 to 64 years, aged 65 years and older) and by whether the consumer is a Medicaid beneficiary, eligible for both Medicare and Medicaid, and other. For purposes of determining whether a consumer is a Medicaid beneficiary or a dual Medicare and Medicaid enrollee, see Continuous Enrollment, Allowable Gap, and Anchor Date requirements below in section C.
- Referenced Value Sets may be found at NCQA HEDIS 2016.
- To the extent possible, include all paid, suspended, pending, and denied claims.
- Refer to the specific data-reporting template for the reporting requirements applicable to each measure and to the Appendices in Volume 2 of this manual.

Measurement Period:

For the denominator, two measurement periods are used:

- The Index Episode Start Date (IESD) measurement period is the first 10 months and 15 days of the measurement year.

- The Negative Diagnosis History Review measurement period looks back 60 days prior to the IESD. It begins 60 days prior to the measurement year and ends 60 days prior to the last possible date of the IESD during the measurement year.

For the numerator, two measurement periods are used:

- The measurement period for Initiation of AOD Treatment covers the 13 days following the IESD. It begins on the 1st day of the first month and ends 13 days after the measurement period for the IESD ends.
- The measurement period for Engagement of AOD Treatment covers the 29 days following Initiation of AOD Treatment. It begins on the 2nd day of the first month and ends 29 days after the measurement period for Initiation of AOD Treatment ends.

B. DEFINITIONS

TERM	DEFINITION
Intake Period	The first 10 months and 15 days of the measurement year. The Intake Period is used to capture new episodes of AOD.
Index Episode	The earliest inpatient, intensive outpatient, partial hospitalization, outpatient, detoxification, or emergency department (ED) visit during the Intake Period with a diagnosis of AOD. For ED visits that result in an inpatient stay, the inpatient stay is the Index Episode.
IESD	Index Episode Start Date (IESD). The earliest date of service for an inpatient, intensive outpatient, partial hospitalization, outpatient, detoxification, or ED encounter during the Intake Period with a diagnosis of AOD. For an outpatient, intensive outpatient, partial hospitalization, detoxification, or ED visit (not resulting in an inpatient stay), the IESD is the date of service. For an inpatient (acute or nonacute) event, the IESD is the date of discharge. For an ED visit that results in an inpatient event, the IESD is the date of the inpatient discharge. For direct transfers, the IESD is the discharge date from the last admission.

TERM	DEFINITION
Negative Diagnosis History	A period of 60 days (2 months) before the IESD when the consumer had no claims/encounters with a diagnosis of AOD dependence. For an inpatient event, use the admission date to determine the Negative Diagnosis History. For ED visits that result in an inpatient stay, use the ED date of service to determine the Negative Diagnosis History. For direct transfers, use the first admission to determine the Negative Diagnosis History.
Provider Entity	The provider entity that is being measured (i.e., BHC)

C. ELIGIBLE POPULATION

CRITERIA	REQUIREMENTS
Age	Consumers ages 13 years and older as of the last day of the measurement year. Report three age stratifications: • Ages 13 to 17 • Ages 18 to 64 • Ages 65+
Continuous Enrollment	60 days (2 months) prior to the IESD through 44 days after the IESD (105 total days)
Allowable Gap	None
Anchor Date	None
Benefits	Medical and chemical dependency (inpatient and outpatient) Note: Medicaid enrollees with detoxification-only chemical dependency benefits do not meet these criteria.

CRITERIA	REQUIREMENTS
Event/Diagnosis	Follow the steps below to identify the eligible population: ***Step 1*** Identify the Index Episode. Identify all consumers in the specified age range who during the Intake Period had **one of the following**: 1. An outpatient visit, intensive outpatient visit, or partial hospitalization with a diagnosis of AOD. **Any of the following code combinations meet criteria:** • IET Stand Alone Visits Value Set **with** AOD Dependence Value Set • IET Visits Group 1 Value Set **with** IET Place of Services (POS) Group 1 Value Set **and** AOD Dependence Value Set • IET Visits Group 2 Value Set **with** IET POS Group 2 Value Set **and** AOD Dependence Value Set 2. A detoxification visit (Detoxification Value Set) 3. An ED visit (ED Value Set) **with** a diagnosis of AOD (AOD Dependence Value Set) **OR** 4. An acute or nonacute inpatient discharge **with either** an AOD diagnosis (AOD Dependence Value Set) **or** an AOD procedure code (AOD Procedures Value Set). To identify acute and nonacute inpatient discharges: • Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). • Identify the discharge date for the stay. ***Note:*** For consumers with more than one episode of AOD, use the first episode.

CRITERIA	REQUIREMENTS
Event/Diagnosis (cont'd)	***Note:*** For consumers whose first episode was an ED visit that resulted in an inpatient stay, use the inpatient discharge. Select the IESD. ***Step 2*** For consumers from step 1, test for Negative Diagnosis History. Exclude consumers who had a claim/encounter with a diagnosis of AOD (AOD Dependence Value Set) during the 60 days (2 months) before the IESD. ***Note:*** For an inpatient IESD, use the admission date to determine the 60-day Negative Diagnosis History period. ***Note:*** For an ED visit that results in an inpatient stay, use the ED date of service to determine the 60-day Negative Diagnosis History period. ***Step 3*** For consumers from step 2, calculate continuous enrollment. Consumers must be continuously enrolled for 60 days (2 months) before the IESD through 44 days after the IESD (105 total days), with no gaps.

D. ADMINISTRATIVE SPECIFICATION

Denominator

The number of consumers in the eligible population (Section C)

Note: For the denominator, two measurement periods are used:

- The Index Episode Start Date (IESD) is the first 10 months and 15 days of the measurement year.
- The Negative Diagnosis History Review measurement period looks back 60 days prior to the IESD. It begins 60 days prior to the measurement year and ends 60 days prior to the last possible date of the IESD during the measurement year.

Numerator

Rate 1: Initiation of AOD Treatment

Initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of diagnosis.

If the Index Episode was an inpatient discharge, the inpatient stay is considered initiation of treatment and the consumer is compliant.

If the Index Episode was an outpatient, intensive outpatient, partial hospitalization, detoxification, or ED visit, the consumer must have an inpatient admission, outpatient visit, intensive outpatient encounter, or partial hospitalization, with a diagnosis of AOD, on the IESD or in the 13 days after the IESD (14 total days). If the IESD and the initiation visit occur on the same day, they must be with different providers in order to count. **Any of the following code combinations meet criteria:**

1. An acute or nonacute inpatient admission **with** a diagnosis of AOD (AOD Dependence Value Set). To identify acute and nonacute inpatient admissions:
    a. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
    b. Identify the admission date for the stay.
2. IET Stand Alone Visits Value Set **with** AOD Dependence Value Set
3. IET Visits Group 1 Value Set **with** IET POS Group 1 Value Set **and** AOD Dependence Value Set

    OR

4. IET Visits Group 2 Value Set **with** IET POS Group 2 Value Set **and** AOD Dependence Value Set

Note: Do not count events that include inpatient detoxification or detoxification codes (Detoxification Value Set) when identifying initiation of treatment.

Note: For the Initiation numerator, the measurement period covers the 13 days following the IESD. It begins on the 1st day of the first month and ends 13 days after the measurement period for the IESD ends.

Rate 2: Engagement of AOD Treatment

Initiation of treatment with two or more additional services with a diagnosis of AOD within 30 days of the initiation visit

Identify all consumers who meet the following criteria:

- Numerator compliant for Rate 1 **and**
- Two or more inpatient admissions, outpatient visits, intensive outpatient visits, or partial hospitalizations with any AOD diagnosis, beginning on the day after the initiation encounter through 29 days after the initiation event (29 total days). Multiple engagement visits may occur on the same day, but they must be with different providers in order to count. **Any of the following code combinations meet criteria:**

1. An acute or nonacute inpatient admission **with** a diagnosis of AOD (AOD Dependence Value Set). To identify acute and nonacute inpatient admissions:
    a. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
    b. Identify the admission date for the stay.
2. IET Stand Alone Visits Value Set **with** AOD Dependence Value Set
3. IET Visits Group 1 Value Set **with** IET POS Group 1 Value Set and AOD Dependence Value Set

    OR

4. IET Visits Group 2 Value Set **with** IET POS Group 2 Value Set and AOD Dependence Value Set

Note: For consumers who initiated treatment via an inpatient admission, the 29-day period for the two engagement visits begins the day after discharge.

Note: Do not count events that include inpatient detoxification or detoxification codes (Detoxification Value Set) when identifying the engagement of AOD treatment.

Note: The time frame for engagement, which includes the initiation event, is 30 total days.

Note: For the Engagement numerator, the measurement period covers the 29 days following Initiation of AOD Treatment. It begins on the 2nd day of the first month and ends 29 days after the measurement period for Initiation.

Exclusions

Exclude consumers from the denominator for both rates if the initiation of treatment event is an inpatient stay with a discharge date after the 11th month of the measurement year.

E. ADDITIONAL NOTES

The source measure is designed for the Medicaid population and is not risk adjusted. The source measure was specified and tested at the health plan level. This measure is modified to require clinic-level reporting, and to be consistent in format with other measures in this set of BHC measures, but is not tested at the clinic level.

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.

Interpretation of score: Better quality = Higher score