Connecticut Quality Council
Measure Proposals to Fill Behavioral Health and Equity Gaps
Measure Specifications

Quality ID #134 (NQF 0418): Preventive Care and Screening: Screening for Depression and Follow-Up Plan
– National Quality Strategy Domain: Community/Population Health
– Meaningful Measure Area: Prevention, Treatment, and Management of Mental Health

2020COLLECTION TYPE:
MEDICARE PART B CLAIMS

MEASURE TYPE:
Process

DESCRIPTION:
Percentage of patients aged 12 years and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the eligible encounter

INSTRUCTIONS:
This measure is to be submitted a minimum of **once per measurement period** for patients seen during the measurement period. The most recent quality-data code submitted will be used for performance calculation. This measure may be submitted by Merit-based Incentive Payment System (MIPS) eligible clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding. The follow-up plan must be related to a positive depression screening, example: "Patient referred for psychiatric evaluation due to positive depression screening".

Measure Submission Type:
Measure data may be submitted by individual MIPS eligible clinicians using Medicare Part B claims. The listed denominator criteria are used to identify the intended patient population. The numerator quality-data codes included in this specification are used to submit the quality actions allowed by the measure on the claim form(s). All measure-specific coding should be submitted on the claim(s) representing the denominator eligible encounter and selected numerator option.

DENOMINATOR:
All patients aged 12 years and older at the beginning of the measurement period with at least one eligible encounter during the measurement period

> ***DENOMINATOR NOTE:*** **Signifies that this CPT Category I code is a non-covered service under the Medicare Part B Physician Fee Schedule (PFS). These non-covered services will not be counted in the denominator population for Medicare Part B claims measures.*
>
> **Denominator Criteria (Eligible Cases):**
> Patients aged ≥ 12 years on date of encounter
> **AND**
> **Patient encounter during the performance period (CPT or HCPCS):** 59400, 59510, 59610, 59618, 90791, 90792, 90832, 90834, 90837, 92625, 96105, 96110, 96112, 96116, 96125, 96136, 96138, 96156, 96158, 97161, 97162, 97163, 97165, 97166, 97167, 99078, 99201, 99202, 99203, 99204, 99205, 99212,99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324,99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99339, 99340, 99401*, 99402*, 99403*, 99483, 99484, 99492, 99493,99384*, 99385*, 99386*, 99387*, 99394*, 99395*, 99396*, 99397*, G0101, G0402, G0438, G0439, G0444

NUMERATOR:
Patients screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age appropriate standardized tool AND, if positive, a follow-up plan is documented on the date of the eligible encounter

Definitions:
Screening – Completion of a clinical or diagnostic tool used to identify people at risk of developing or having a certain disease or condition, even in the absence of symptoms.
Standardized Depression Screening Tool – A normalized and validated depression screening tool developed for the patient population in which it is being utilized. The name of the age appropriate standardized depression screening tool utilized must be documented in the medical record.
Examples of depression screening tools include but are not limited to:

- **Adolescent Screening Tools (12-17 years)**
  Patient Health Questionnaire for Adolescents (PHQ-A), Beck Depression Inventory-Primary Care Version (BDI-PC), Mood Feeling Questionnaire (MFQ), Center for Epidemiologic Studies Depression Scale (CES-D), Patient Health Questionnaire (PHQ-9), Pediatric Symptom Checklist (PSC-17), and PRIME MD-PHQ-2
- **Adult Screening Tools (18 years and older)**
  Patient Health Questionnaire (PHQ-9), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety-Depression Scale (DADS), Geriatric Depression Scale (GDS), Cornell Scale for Depression in Dementia (CSDD), PRIME MD-PHQ-2, Hamilton Rating Scale for Depression (HAM-D), Quick Inventory of Depressive Symptomatology Self-Report (QID-SR), Computerized Adaptive Testing Depression Inventory (CAT-DI), and Computerized Adaptive Diagnostic Screener (CAD-MDD)
- **Perinatal Screening Tools**
  Edinburgh Postnatal Depression Scale, Postpartum Depression Screening Scale, Patient Health Questionnaire 9 (PHQ-9), Beck Depression Inventory, Beck Depression Inventory–II, Center for Epidemiologic Studies Depression Scale, and Zung Self-rating Depression Scale

Follow-Up Plan – Documented follow-up for a positive depression screening ***must*** include one or more of the following:

- Additional evaluation or assessment for depression
- 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

Examples of a follow-up plan include but are not limited to:
* Additional evaluation or assessment for depression such as psychiatric interview, psychiatric evaluation, or assessment for bipolar disorder
* Completion of any Suicide Risk Assessment such as Beck Depression Inventory or Beck Hopelessness Scale
* Referral to a practitioner or program for further evaluation for depression, for example, referral to a psychiatrist, psychologist, social worker, mental health counselor, or other mental health service such as family or group therapy, support group, depression management program, or other service for treatment of depression
* Other interventions designed to treat depression such as psychotherapy, pharmacological interventions, or additional treatment options
* Pharmacologic treatment for depression is often indicated during pregnancy and/or lactation. Review and discussion of the risks of untreated versus treated depression is advised. Consideration of each patient's prior disease and treatment history, along with the risk profiles for individual pharmacologic agents, is important when selecting pharmacologic therapy with the greatest likelihood of treatment effect.

Not Eligible for Depression Screening or Follow-Up Plan (Denominator Exclusion) –

- Patient has an active diagnosis of depression prior to any encounter during the measurement period- F01.51, F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F32.89, F32.9, F33.0, F33.1, F33.2, F33.3, F33.40, F33.41, F33.42, F33.8, F33.9, F34.1, F34.81, F34.89, F43.21, F43.23, F53.0, F53.1, O90.6, O99.340, O99.341, O99.342, O99.343, O99.345
- Patient has a diagnosed bipolar disorder prior to any encounter during the measurement period- F31.10, F31.11, F31.12, F31.13, F31.2, F31.30, F31.31, F31.32, F31.4, F31.5, F31.60, F31.61, F31.62, F31.63, F31.64, F31.70, F31.71, F31.72, F31.73, F31.74, F31.75, F31.76, F31.77, F31.78, F31.81, F31.89, F31.9

Patients with a Documented Reason for not Screening for Depression (Denominator Exception) – One or more of the following conditions are documented during the encounter during the measurement period:

- Patient refuses to participate
- Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status
- Situations where the patient's cognitive capacity, functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools. For example: certain court appointed cases or cases of delirium

Numerator Instructions:

A depression screen is completed on the date of the encounter or up to 14 days prior to the date of the encounter using an age appropriate standardized depression screening tool AND if positive, either additional evaluation for depression, suicide risk assessment, referral to a practitioner who is qualified to diagnose and treat depression, pharmacological interventions, or other interventions or follow-up for the diagnosis or treatment of depression is documented on the date of the eligible encounter . Depression screening is required once per measurement period, not at all encounters; this is patient based and not an encounter based measure. The name of the age appropriate standardized depression screening tool utilized must be documented in the medical record. The depression screening must be reviewed and addressed in the office of the provider filing the code on the date of the encounter. Positive pre-screening results indicating a patient is at high risk for self-harm should receive more urgent intervention as determined by the provider practice. The screening should occur during a qualified encounter or up to 14 days prior to the date of the qualifying encounter.

Numerator Quality-Data Coding Options:

Depression Screening or Follow-Up Plan not Documented, Patient not Eligible

Denominator Exclusion: **G9717:** Documentation stating the patient has an active diagnosis of depression or has a diagnosed bipolar disorder, therefore screening or follow-up not required

OR

Screening for Depression Documented as Positive, AND Follow-Up Plan Documented

Performance Met: **G8431:** Screening for depression is documented as being positive AND a follow-up plan is documented

OR

Screening for Depression Documented as Negative, Follow-Up Plan not Required

Performance Met: **G8510:** Screening for depression is documented as negative, a follow-up plan is not required

OR

Screening for Depression not Completed, Documented Reason

Denominator Exception: **G8433:** Screening for depression not completed, documented reason

OR

Screening for Depression not Documented, Reason not Given

***Performance Not Met:* G8432:** Depression screening not documented, reason not given

OR

Screening for Depression Documented as Positive, Follow-Up Plan not Documented, Reason not Given

***Performance Not Met:* G8511:** Screening for depression documented as positive, follow-up plan not documented, reason not given

RATIONALE:

Depression is a serious medical illness associated with higher rates of chronic disease increased health care utilization, and impaired functioning (Pratt & Brody, 2014). 2016 U.S. survey data indicate that 12.8 percent of adolescents (2.2 million adolescents) had a major depressive episode (MDE) in the past year, with nine percent of adolescents (2.2 million adolescents) having one MDE with severe impairment; 6.7 percent of adults aged 18 or older (16.2 million adults) had at least one MDE in the past year, with 4.3 percent of adults (10.3 million adults) having one MDE with severe impairment in the past year (Substance Abuse and Mental Health Services Administration, 2017). Data indicate that severity of depressive symptoms factor into having difficulty with work, home, or social activities. For example, as the severity of depressive symptoms increased, rates of having difficulty with work, home, or social activities related to depressive symptoms increased. For those twelve and older with mild depressive symptoms, 45.7% reported difficulty with activities and those with severe depressive symptoms, 88.0% reported difficulty (Pratt & Brody, 2014). Children and teens with major depressive disorder (MDD) has been found to have difficulty carrying out their daily activities, relating to others, and growing up healthy with an increased risk of suicide (Siu & the U.S. Preventive Services Task Force [USPSTF], 2016). Additionally, perinatal depression (considered here as depression arising in the period from conception to the end of the first postnatal year) affects up to 15% of women. Depression and other mood disorders, such as bipolar disorder and anxiety disorders, especially during the perinatal period, can have devastating effects on women, infants, and families (Molenaar et al., 2018). Maternal suicide rates rise over hemorrhage and hypertensive disorders as a cause of maternal mortality (American College of Obstetricians and Gynecologists, 2015).

Negative outcomes associated with depression make it crucial to screen in order to identify and treat depression in its early stages. While Primary Care Providers (PCPs) serve as the first line of defense in the detection of depression, studies show that PCPs fail to recognize up to 50% of depressed patients: "Coyle et al. (2003), suggested that the picture is more grim for adolescents, and that more than 70% of children and adolescents suffering from serious mood disorders go unrecognized or inadequately treated" (Borner et al., 2010, p. 948). “In nationally representative U.S. surveys, about eight percent of adolescents reported having major depression in the past year. Only 36% to 44% of children and adolescents with depression receive treatment, suggesting that the majority of depressed youth are undiagnosed and untreated” (Sui on behalf of USPSTF, 2016, p. 360 & p. 364) Evidence supports that screening for depression in pregnant and postpartum women is of moderate net benefit and treatment options for positive depression screening should be available for patients twelve and older including pregnant and postpartum women.

If preventing negative patient outcomes is not enough, the substantial economic burden of depression for individuals and society alike makes a case for screening for depression on a regular basis. Depression imposes economic burden through direct and indirect costs. “In the United States, an estimated $22.8 billion was spent on depression treatment in 2009, and lost productivity cost an additional estimated $23 billion in 2011” (Sui & USPSTF, 2016, p. 383-384).

This measure seeks to align with clinical guideline recommendations as well as the Healthy People 2020 recommendation for routine screening for mental health problems as a part of primary care for both children and adults (U.S. Department of Health and Human Services, 2014) and makes an important contribution to the quality domain of community and population health.

CLINICAL RECOMMENDATION STATEMENTS:

Adolescent Recommendation (12-18 years):

"The USPSTF recommends screening for MDD in adolescents aged 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up (B recommendation)" (Sui on behalf of, USPSTF, 2016, p. 360).

"Clinicians and health care systems should try to consistently screen adolescents ages 12-18 for major depressive disorder, but only when systems are in place to ensure accurate diagnosis, careful selection of treatment, and close follow-up" (Wilkinson et al., 2013, p. 16).

Adult Recommendation (18 years and older):

"The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up (B recommendation)" (Sui 2016, p. 380).

The Institute for Clinical Systems Improvement (ICSI) health care guideline, Adult Depression in Primary Care, provides the following recommendations:

1. "Clinicians should routinely screen all adults for depression using a standardized instrument."

2. "Clinicians should establish and maintain follow-up with patients."

3. "Clinicians should screen and monitor depression in pregnant and post-partum women." (Trangle et al., 2016 p.p. 8–10)

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PHQ-9/PHQ-9M UTILIZATION MEASURE SPECIFICATIONS AND CALCULATION

Clinic population counts, submitted via the Denominator Worksheet, are used to calculate the PHQ-9 Utilization measure.

- The PHQ-9/PHQ-9M Utilization measure has three four-month measurement periods.
  - The measure results are stratified by age: 12 to 17 at the time of the qualifying encounter and 18 and older at the time of the qualifying encounter.
  - Two sets of counts (adolescent and adult) for each of the three measure periods are required per clinic.
  - Six measure results are calculated per measurement year: one adolescent and one adult rate per measure period.

Summary of Changes	• References for measure periods changed from numeric to alpha characters. • Preliminary 2021 MY dates added to Measurement Periods for reference. • Clarifying language added to Eligible Specialties and Eligible Providers sections. • Clarification regarding permissible administration of the PHQ-9 and PHQ-9M tools added as a footnote. See appendices of Data Collection Technical Guide for specific guidance regarding assessment tool administration.

Measure Description	The percentage of adolescent patients (12 to 17 years of age) and adult patients (18 years of age and older) with Major Depression or Dysthymia who have completed a PHQ-9 or PHQ-9M tool during the applicable four-month measurement period in which there was a qualifying encounter.	
Measurement Periods (3)	**FINAL 2020 MY:** • **Period A:** 01/01/2020 – 04/30/2020 • **Period B:** 05/01/2020 – 08/31/2020 • **Period C:** 09/01/2020 – 12/31/2020 **PRELIMINARY 2021 MY:** • **Period A:** 01/01/2021 – 04/30/2021 • **Period B:** 05/01/2021 – 08/31/2021 • **Period C:** 09/01/2021 – 12/31/2021	
Eligible population	**Eligible specialties for diagnosing Depression/ Dysthymia^**	Family Practice, Internal Medicine, Geriatric Medicine, Psychiatry, Behavioral Health, Pediatric/Adolescent Medicine
	Eligible providers for diagnosing Depression/ Dysthymia^	Medical Doctor (MD), Doctor of Osteopathy (DO), Physician Assistant (PA), Advanced Practice Registered Nurses (APRN) These providers are also eligible, if supervised by a physician: Licensed Psychologist (LP), Licensed Independent Clinical Social Worker (LICSW), Licensed Professional Clinical Counselor (LPCC), Licensed Marriage & Family Therapist (LMFT)
	Ages	12 years or older at the time of the qualifying encounter

	Event	Patients with an encounter* coded with Major Depression or Dysthymia (*Major Depression or Dysthymia* Value Set) during the specific measurement period *For this measure, an encounter includes but is not limited to any of the following: office visit, psychiatry, or psychotherapy visit, telephone, or online encounter.
Denominator (Count #1)⁺	The eligible population	
Numerator (Count #2)⁺	The number of patients in the denominator who had a PHQ-9 or PHQ-9M tool administered and completed during the measurement period	
Required Exclusions	The following exclusions must be applied to the eligible population: • Patient had an active diagnosis of Bipolar Disorder (*Bipolar Disorder* Value Set) any time prior to the end of the measure assessment period • Patient had an active diagnosis of Schizophrenia or Psychotic Disorder (*Schizophrenia Psychotic Disorder* Value Set) any time prior to the end of the measurement assessment period	
Allowable Exclusions (Optional)	The following exclusions can be applied to the eligible population: • Patient died prior to the end of the measurement period • Patient was a permanent nursing home resident at any time during the measurement period • Patient was in hospice or receiving palliative care (*Palliative Care* Value Set) at any time during the measurement period • Patient had an active diagnosis of Personality Disorder – Emotionally Labile Conditions (*Personality Disorder Emotionally Labile* Value Set) any time prior to the end of the measurement period • Patient had an active diagnosis of Pervasive Developmental Disorder (*Pervasive Disorder* Value Set) any time prior to the end of the measurement period	
Measure Scoring	Rate/Proportion Results are always stratified by age: • Adolescents (12-17 years of age) • Adults (18 years of age or older)	
Interpretation of Score	Higher score indicates better quality	
Measure Type	Process	

^Any member of the health care team can administer a PHQ-9 or PHQ-9M assessment tool to a patient. Additionally, patients can self-administer via patient portal, email, or mail
⁺Each measurement period has its own denominator and numerator counts

Follow-Up After Hospitalization for Mental Illness (FUH)

SUMMARY OF CHANGES TO HEDIS MY 2020 & MY 2021

- Replaced “mental health practitioner” with “mental health provider.”
- Removed the mental health provider requirement for follow-up visits for intensive outpatient encounters, partial hospitalizations, community mental health centers and electroconvulsive therapy settings.
- Added visits in a behavioral healthcare setting to the numerator.
- Added telephone visits to the numerator.
- Deleted the Mental Health Practitioner Value Set.
- Revised the instructions in the *Notes* for identifying mental health providers.

Description

The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Two rates are reported:

1. The percentage of discharges for which the member received follow-up within 30 days after discharge.
2. The percentage of discharges for which the member received follow-up within 7 days after discharge.

Eligible Population

Note: *Members in hospice are excluded from the eligible population. Refer to General Guideline 17: Members in Hospice*.

Product lines	Commercial, Medicaid, Medicare (report each product line separately).
Ages	6 years and older as of the date of discharge. Report three age stratifications and total rate: • 6–17 years. • 18–64 years. • 65 years and older. • Total.
Continuous enrollment	The total is the sum of the age stratifications. 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).
Event/diagnosis	An acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm (Mental Illness Value Set; Intentional Self-Harm Value Set) on the discharge claim on or between January 1 and December 1 of the measurement year. To identify acute inpatient discharges:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
3. Identify the discharge date for the stay.

The denominator for this measure is based on discharges, not on members. If members have more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year.

Acute readmission or direct transfer

Identify readmissions and direct transfers to an acute inpatient care setting during the 30-day follow-up period:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
3. Identify the admission date for the stay.

Exclude both the initial discharge and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year.

If the readmission/direct transfer to the acute inpatient care setting was for a principal diagnosis (use only the principal diagnosis on the discharge claim) of mental health disorder or intentional self-harm (Mental Health Diagnosis Value Set; Intentional Self-Harm Value Set), count only the last discharge.

If the readmission/direct transfer to the acute inpatient care setting was for any other principal diagnosis (use only the principal diagnosis on the discharge claim) exclude both the original and the readmission/direct transfer discharge.

Nonacute readmission or direct transfer

Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period, regardless of principal diagnosis for the readmission. To identify readmissions and direct transfers to a nonacute inpatient care setting:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
3. Identify the admission date for the stay.

These discharges are excluded from the measure because rehospitalization or direct transfer may prevent an outpatient follow-up visit from taking place.

Administrative Specification

Denominator The eligible population.

Numerators

30-Day Follow-Up A follow-up visit with a mental health provider within 30 days after discharge. Do not include visits that occur on the date of discharge.

7-Day Follow-Up A follow-up visit with a mental health provider within 7 days after discharge. Do not include visits that occur on the date of discharge.

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

- An outpatient visit (Visit Setting Unspecified Value Set) ***with*** (Outpatient POS Value Set) ***with*** a mental health provider.

- An outpatient visit (BH Outpatient Value Set) ***with*** a mental health provider.
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) ***with*** (Partial Hospitalization POS Value Set).
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set).
- A community mental health center visit (Visit Setting Unspecified Value Set; BH Outpatient Value Set; Observation Value Set; Transitional Care Management Services Value Set) ***with*** (Community Mental Health Center POS Value Set).
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) ***with*** (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set).
- A telehealth visit: (Visit Setting Unspecified Value Set) ***with*** (Telehealth POS Value Set) ***with*** a mental health provider.
- An observation visit (Observation Value Set) ***with*** a mental health provider.
- Transitional care management services (Transitional Care Management Services Value Set), ***with*** a mental health provider.
- A visit in a behavioral healthcare setting (Behavioral Healthcare Setting Value Set).
- A telephone visit (Telephone Visits Value Set) ***with*** a mental health provider.

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 (e.g., within 30 days after discharge or within 7 days after discharge).*
- *Refer to Appendix 3 for the definition of "mental health provider." Organizations must develop their own methods to identify mental health providers. Methods are subject to review by the HEDIS auditor.*

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table FUH-1/2/3: Data Elements for Follow-Up After Hospitalization for Mental Illness

	Administrative
Measurement year	✓
Eligible population	*For each age stratification and total*
Numerator events by administrative data	*Each of the 2 rates for each age stratification and total*
Numerator events by supplemental data	*Each of the 2 rates for each age stratification and total*
Reported rate	*Each of the 2 rates for each age stratification and total*

Rules for Allowable Adjustments of HEDIS

This section *may not* be used for reporting health plan HEDIS.

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

Rules for Allowable Adjustments for Follow-Up After Hospitalization for Mental Illness

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product Lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes	The age determination dates may be changed (e.g., select, "age as of June 30"). Changing the denominator age range is allowed.
Continuous enrollment, Allowable gap, Anchor Date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on a population of interest such as gender, sociodemographic characteristic or geographic region.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/Diagnosis	Yes, with limits	Only events or diagnoses that contain (or map to) codes in the value sets may be used to identify inpatient stays and diagnoses. Value sets and logic may not be changed. ***Note:*** *Organizations may assess at the member level (vs. discharge level) by applying measure logic appropriately (i.e., percentage of members who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses who had a follow-up visit with a mental health practitioner).*
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Optional Exclusions	NA	There are no exclusions for this measure.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
• 30-Day Follow-Up • 7-Day Follow-Up	No	Value sets and logic may not be changed.

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

SUMMARY OF CHANGES TO HEDIS MY 2020 & MY 2021

- Added telephone visits, e-visits and virtual check-ins to the numerator.

Description

The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. Two rates are reported:

1. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
2. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).

Eligible Population

Note: *Members in hospice are excluded from the eligible population. Refer to General Guideline 17: Members in Hospice.*

Product lines	Commercial, Medicaid, Medicare (report each product line separately).
Ages	6 years and older as of the date of the ED visit. Report three age stratifications and total rate: • 6–17 years. • 18–64 years. • 65 years and older. • Total. The total is the sum of the age stratifications.
Continuous enrollment	Date of the ED visit through 30 days after the ED visit (31 total days).
Allowable gap	No gaps in enrollment.
Anchor date	None.
Benefit	Medical and mental health.
Event/diagnosis	An ED visit (ED Value Set) with a principal diagnosis of mental illness or intentional self-harm (Mental Illness Value Set; Intentional Self-Harm Value Set) on or between January 1 and December 1 of the measurement year where the member was 6 years or older on the date of the visit. The denominator for this measure is based on ED visits, not on members. If a member has more than one ED visit, identify all eligible ED visits between January 1 and December 1 of the measurement year and do not include more than one visit per 31-day period as described below.

Multiple visits in a 31-day period

If a member has more than one ED visit in a 31-day period, include only the first eligible ED visit. For example, if a member has an ED visit on January 1, include the January 1 visit and do not include ED visits that occur on or between January 2 and January 31; then, if applicable, include the next ED visit that occurs on or after February 1. Identify visits chronologically, including only one per 31-day period.

Note: *Removal of multiple visits in a 31-day period is based on* ***eligible*** *visits. Assess each ED visit for exclusions before removing multiple visits in a 31-day period.*

ED visits followed by inpatient admission

Exclude ED visits that result in an inpatient stay and ED visits followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit (31 total days), regardless of the principal diagnosis for the admission. To identify admissions to an acute or nonacute inpatient care setting:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Identify the admission date for the stay.

These events are excluded from the measure because admission to an acute or nonacute inpatient setting may prevent an outpatient follow-up visit from taking place.

Administrative Specification

Denominator

The eligible population.

Numerators

30-Day Follow-Up

A follow-up visit with any practitioner, with a principal diagnosis of a mental health disorder or with a principal diagnosis of intentional self-harm and any diagnosis of a mental health disorder within 30 days after the ED visit (31 total days). Include visits that occur on the date of the ED visit.

7-Day Follow-Up

A follow-up visit with any practitioner, with a principal diagnosis of a mental health disorder or with a principal diagnosis of intentional self-harm and any diagnosis of a mental health disorder within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit.

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

- An outpatient visit (Visit Setting Unspecified Value Set ***with*** Outpatient POS Value Set) ***with*** a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An outpatient visit (BH Outpatient Value Set) ***with*** a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set ***with*** Partial Hospitalization POS Value Set), ***with*** a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) ***with*** a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

- A community mental health center visit (Visit Setting Unspecified Value Set ***with*** Community Mental Health Center POS Value Set), ***with*** a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) ***with*** (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set) ***with*** a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- A telehealth visit (Visit Setting Unspecified Value Set ***with*** Telehealth POS Value Set), ***with*** a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An observation visit (Observation Value Set) ***with*** a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- A telephone visit (Telephone Visits Value Set) ***with*** a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An e-visit or virtual check-in (Online Assessments Value Set) ***with*** a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An outpatient visit (Visit Setting Unspecified Value Set ***with*** Outpatient POS Value Set) ***with*** a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), ***with*** any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An outpatient visit (BH Outpatient Value Set) ***with*** a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), ***with*** any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set ***with*** Partial Hospitalization POS Value Set), ***with*** a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), ***with*** any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) ***with*** a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), ***with*** any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- A community mental health center visit (Visit Setting Unspecified Value Set ***with*** Community Mental Health Center POS Value Set), ***with*** a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), ***with*** any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) ***with*** (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set) ***with*** a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), ***with*** any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

- A telehealth visit (Visit Setting Unspecified Value Set ***with*** Telehealth POS Value Set), ***with*** a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), ***with*** any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An observation visit (Observation Value Set) ***with*** a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), ***with*** any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- A telephone visit (Telephone Visits Value Set) ***with*** a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), ***with*** any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An e-visit or virtual check-in (Online Assessments Value Set) ***with*** a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), ***with*** any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

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 (within 30 days after the ED visit or within 7 days after the ED visit).*

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table FUM-1/2/3: Data Elements for Follow-Up After Emergency Department Visit for Mental Illness

	Administrative
Measurement year	✓
Eligible population	*For each age stratification and total*
Numerator events by administrative data	*Each of the 2 rates for each age stratification and total*
Numerator events by supplemental data	*Each of the 2 rates for each age stratification and total*
Reported rate	*Each of the 2 rates for each age stratification and total*

Rules for Allowable Adjustments of HEDIS

This section *may not* be used for reporting health plan HEDIS.

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

Rules for Allowable Adjustments for Follow-Up After Emergency Department Visit for Mental Illness

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product Lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes	Age determination dates may be changed (i.e., age 6 as of the date of the ED visit). Changing the denominator age range is allowed.
Continuous enrollment, Allowable gap, Anchor Date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on a population of interest such as gender, sociodemographic characteristic or geographic region.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/Diagnosis	Yes, with limits	Only events or diagnoses that contain (or map to) codes in the value sets may be used to identify visits with a diagnosis. Value sets and logic may not be changed. ***Note:*** *Organizations may assess at the member level by applying measure logic appropriately (i.e., percentage of members with documentation of an emergency department visit with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness).*
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Optional Exclusions	NA	There are no exclusions for this measure.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
• 30-Day Follow-Up • 7-Day Follow-Up	No	Value sets and logic may not be changed.

Antidepressant Medication Management (AMM)

SUMMARY OF CHANGES TO HEDIS MY 2020 & MY 2021

- Added e-visits and virtual check-ins to the event/diagnosis (step 2 required exclusion).

Description

The percentage of members 18 years of age 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.

1. *Effective Acute Phase Treatment.* The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks).
2. *Effective Continuation Phase Treatment.* The percentage of members who remained on an antidepressant medication for at least 180 days (6 months).

Definitions

Intake Period	The 12-month window starting on May 1 of the year prior to the measurement year and ending on April 30 of the measurement year.
IPSD	Index Prescription Start Date. The earliest prescription dispensing date for an antidepressant medication where the date is in the Intake Period and there is a Negative Medication History.
Negative Medication History	A period of 105 days prior to the IPSD when the member had no pharmacy claims for either new or refill prescriptions for an antidepressant medication.
Treatment days	The actual number of calendar days covered with prescriptions within the specified 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.

Eligible Population

Note: *Members in hospice are excluded from the eligible population. Refer to General Guideline 17: Members in Hospice.*

Product lines	Commercial, Medicaid, Medicare (report each product line separately).
Ages	18 years and older as of April 30 of the measurement year.
Continuous enrollment	105 days prior to the IPSD through 231 days after the IPSD.
Allowable gap	One gap in enrollment of up to 45 days. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled.

Anchor date IPSD.

Benefits Medical and pharmacy.

Event/diagnosis Follow the steps below to identify the eligible population, which is used for both rates.

Step 1 Determine the IPSD. Identify the date of the earliest dispensing event for an antidepressant medication (Antidepressant Medications List) during the Intake Period.

Step 2: Required exclusion Exclude members who did not have an encounter with a diagnosis of major depression during the 121-day period from 60 days prior to the IPSD, through the IPSD and the 60 days after the IPSD. Members who meet any of the following criteria remain in the eligible population:

- An acute or nonacute inpatient stay with any diagnosis of major depression (Major Depression Value Set) on the discharge claim. To identify acute and nonacute inpatient stays:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Identify the admission and discharge dates for the stay. Either an admission or discharge during the required time frame meets criteria.
- An acute inpatient encounter with any diagnosis of major depression: Acute Inpatient Value Set ***with*** Major Depression Value Set.
- A nonacute inpatient encounter with any diagnosis of major depression: Nonacute Inpatient Value Set ***with*** Major Depression Value Set.
- An outpatient visit with any diagnosis of major depression: Visit Setting Unspecified Value Set ***with*** Outpatient POS Value Set ***with*** Major Depression Value Set.
- An outpatient visit with any diagnosis of major depression: BH Outpatient Value Set ***with*** Major Depression Value Set.
- An intensive outpatient encounter or partial hospitalization with any diagnosis of major depression: Visit Setting Unspecified Value Set ***with*** Partial Hospitalization POS Value Set ***with*** Major Depression Value Set.
- An intensive outpatient encounter or partial hospitalization with any diagnosis of major depression: Partial Hospitalization or Intensive Outpatient Value Set ***with*** Major Depression Value Set.
- A community mental health center visit with any diagnosis of major depression: Visit Setting Unspecified Value Set ***with*** Community Mental Health Center POS Value Set ***with*** Major Depression Value Set.
- Electroconvulsive therapy with any diagnosis of major depression: Electroconvulsive Therapy Value Set ***with*** Major Depression Value Set.
- Transcranial magnetic stimulation visit with any diagnosis of major depression: Transcranial Magnetic Stimulation Value Set ***with*** Major Depression Value Set.

- A telehealth visit with any diagnosis of major depression: Visit Setting Unspecified Value Set ***with*** Telehealth POS Value Set ***with*** Major Depression Value Set.
- An observation visit (Observation Value Set) ***with*** any diagnosis of major depression (Major Depression Value Set).
- An ED visit (ED Value Set) ***with*** any diagnosis of major depression (Major Depression Value Set).
- An ED visit with any diagnosis of major depression: Visit Setting Unspecified Value Set ***with*** ED POS Value Set ***with*** Major Depression Value Set.
- A telephone visit (Telephone Visits Value Set) ***with*** any diagnosis of major depression (Major Depression Value Set).
- An e-visit or virtual check-in (Online Assessments Value Set) ***with*** any diagnosis of major depression (Major Depression Value Set).

Step 3 Test for Negative Medication History. Exclude members who filled a prescription for an antidepressant medication 105 days prior to the IPSD.

Step 4 Calculate continuous enrollment. Members must be continuously enrolled for 105 days prior to the IPSD to 231 days after the IPSD.

Administrative Specification

Denominator The eligible population.

Numerators

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

Antidepressant Medications

Description	Prescription		
Miscellaneous antidepressants	• Bupropion	• Vilazodone	• Vortioxetine
Monoamine oxidase inhibitors	• Isocarboxazid • Phenelzine	• Selegiline • Tranylcypromine	
Phenylpiperazine antidepressants	• Nefazodone	• Trazodone	
Psychotherapeutic combinations	• Amitriptyline-chlordiazepoxide • Amitriptyline-perphenazine		• Fluoxetine-olanzapine
SNRI antidepressants	• Desvenlafaxine • Duloxetine	• Levomilnacipran • Venlafaxine	
SSRI antidepressants	• Citalopram • Escitalopram	• Fluoxetine • Fluvoxamine	• Paroxetine • Sertraline
Tetracyclic antidepressants	• Maprotiline	• Mirtazapine	
Tricyclic antidepressants	• Amitriptyline • Amoxapine • Clomipramine	• Desipramine • Doxepin (>6 mg) • Imipramine	• Nortriptyline • Protriptyline • Trimipramine

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

Note

- *Organizations may have 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. 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 period specified.*

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table AMM-1/2/3: Data Elements for Antidepressant Medication Management

	Administrative
Measurement year	✓
Eligible population	✓
Number of required exclusions	✓
Numerator events by administrative data	*Each of the 2 rates*
Numerator events by supplemental data	*Each of the 2 rates*
Reported rate	*Each of the 2 rates*

Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)

SUMMARY OF CHANGES TO HEDIS MY 2020 & MY 2021

- Clarified the Episode Date when detoxification occurs during an acute inpatient stay.
- Updated the step 3 instructions for ED and observation visits that result in an inpatient stay, to make them consistent with instructions in the *Definitions* section.
- Added value sets for opioid treatment services that are billed weekly or monthly to the denominator and numerators.
- Updated the continuous enrollment period.

Description

The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following.

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

Definitions

Intake Period

January 1–November 14 of the measurement year. The Intake Period is used to capture new episodes of AOD abuse and dependence.

Index Episode

The earliest eligible encounter during the Intake Period with a diagnosis of AOD abuse or dependence.

For ED or observation visits that result in an inpatient stay, the inpatient discharge is the Index Episode.

Date of service for services billed weekly or monthly

For an opioid treatment service that bills monthly or weekly (OUD Weekly Non Drug Service Value Set; OUD Monthly Office Based Treatment Value Set; OUD Weekly Drug Treatment Service Value Set), if the service includes a range of dates, then use the earliest date as the date of service. Use this date for all relevant events (the IESD, negative diagnosis history and numerator events).

IESD

Index Episode Start Date. The earliest date of service for an eligible encounter during the Intake Period with a diagnosis of AOD abuse or dependence.

For an outpatient, intensive outpatient, partial hospitalization, observation, telehealth, or ED visit (not resulting in an inpatient stay), the IESD is the date of service.

For an inpatient stay or for detoxification that occurred during an inpatient stay, the IESD is the date of discharge.

For detoxification (other than detoxification that occurred during an inpatient stay), the IESD is the date of service.

For ED or observation visits that result in an inpatient stay, the IESD is the date of the inpatient discharge (an AOD diagnosis is not required for the inpatient stay; use the diagnosis from the ED or observation visit to determine the diagnosis cohort).

For direct transfers, the IESD is the discharge date from the last admission (an AOD diagnosis is not required for the transfer; use the diagnosis from the initial admission to determine the diagnosis cohort).

Negative Diagnosis History

A period of 60 days (2 months) before the IESD when the member had no claims/encounters with a diagnosis of AOD abuse or dependence.

For an inpatient stay, use the admission date to determine the Negative Diagnosis History.

For ED or observation visits that result in an inpatient stay, use the earliest date of service (either the ED/observation date of service or the inpatient admission date) to determine the Negative Diagnosis History.

For direct transfers, use the first admission to determine the Negative Diagnosis History.

Direct transfer

A direct transfer is when the discharge date from the first inpatient setting precedes the admission date to a second inpatient setting by one calendar day or less. For example:

- An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1, is a direct transfer.
- An inpatient discharge on June 1, followed by an admission to an inpatient setting on June 2, is a direct transfer.
- An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 3, is not a direct transfer; these are two distinct inpatient stays.

Use the following method to identify admissions to and discharges from inpatient settings.

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Identify the admission and discharge dates for the stay.

Eligible Population

Note: *Members in hospice are excluded from the eligible population. Refer to General Guideline 17: Members in Hospice.*

Product lines

Commercial, Medicaid, Medicare (report each product line separately).

Age

13 years and older as of December 31 of the measurement year. Report two age stratifications and a total rate:

- 13–17 years.
- 18+ years.
- Total.

The total is the sum of the age stratifications.

AOD diagnosis cohorts

Report the following diagnosis cohorts for each age stratification and the total rate:

- Alcohol abuse or dependence.
- Opioid abuse or dependence.
- Other drug abuse or dependence.
- Total.

Continuous enrollment

60 days (2 months) prior to the IESD through 47 days after the IESD (108 total days).

Allowable gap

None.

Anchor date

None.

Benefits

Medical, pharmacy and chemical dependency (inpatient and outpatient).

Note: *Members with detoxification-only chemical dependency benefits do not meet these criteria.*

Event/diagnosis

New episode of AOD abuse or dependence during the Intake Period.

Follow the steps below to identify the eligible population, which is the denominator for both rates.

Step 1 Identify the Index Episode. Identify all members in the specified age range who during the Intake Period had one of the following:

- An outpatient visit, telehealth, intensive outpatient visit or partial hospitalization with a diagnosis of AOD abuse or dependence. Any of the following code combinations meet criteria:
  - IET Stand Alone Visits Value Set ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
  - IET Visits Group 1 Value Set ***with*** IET POS Group 1 Value Set and with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
  - IET Visits Group 2 Value Set ***with*** IET POS Group 2 Value Set and ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
  - OUD Weekly Non Drug Service Value Set ***with*** Opioid Abuse and Dependence Value Set.
  - OUD Monthly Office Based Treatment Value Set ***with*** Opioid Abuse and Dependence Value Set.
  - OUD Weekly Drug Treatment Service Value Set ***with*** Opioid Abuse and Dependence Value Set.
- A detoxification visit (Detoxification Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An ED visit (ED Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.

- An observation visit (Observation Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An acute or nonacute inpatient discharge ***with*** one of the following on the discharge claim: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute and nonacute inpatient discharges:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Identify the discharge date for the stay.
- A telephone visit (Telephone Visits Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An e-visit or virtual check-in (Online Assessments Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An opioid treatment service (OUD Weekly Non Drug Service Value Set; OUD Monthly Office Based Treatment Value Set; OUD Weekly Drug Treatment Service Value Set) with a diagnosis of opioid abuse of dependence (Opioid Abuse and Dependence Value Set).

For members with more than one episode of AOD abuse or dependence, use the first episode.

For members whose first episode was an ED or observation visit that resulted in an inpatient stay, use the diagnosis from the ED or observation visit to determine the diagnosis cohort and use the inpatient discharge date as the IESD.

Step 2 Select the Index Episode and stratify based on age and AOD diagnosis cohort.

- If the member has a diagnosis of alcohol abuse or dependence (Alcohol Abuse and Dependence Value Set), place the member in the alcohol cohort.
- If the member has a diagnosis of opioid abuse of dependence (Opioid Abuse and Dependence Value Set), place the member in the opioid cohort.
- If the member has a drug abuse or dependence that is neither for opioid or alcohol (Other Drug Abuse and Dependence Value Set), place the member in the other drug cohort.

If the member has multiple substance use diagnosis for the visit, report the member in all AOD diagnosis stratifications for which they meet criteria.

The total is not a sum of the diagnosis cohorts. Count members in the total denominator rate if they had at least one alcohol, opioid or other drug abuse or dependence diagnosis during the measurement period. Report member with multiple diagnoses during the Index Episode only once for the total rate for the denominator.

Step 3 Test for Negative Diagnosis History. Exclude members who had a claim/ encounter with a diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), AOD medication treatment (AOD Medication Treatment Value Set) or an alcohol or opioid dependency treatment medication dispensing event (Alcohol Use Disorder Treatment Medications List; Opioid Use Disorder Treatment Medications List) during the 60 days (2 months) before the IESD.

For an inpatient IESD, use the admission date to determine the 60-day Negative Diagnosis History period.

For ED or observation visits that result in an inpatient stay, use the earliest date of service (either the ED/observation date of service or the inpatient admission date) to determine the Negative Diagnosis History.

Step 4 Calculate continuous enrollment. Members must be continuously enrolled for 60 days (2 months) before the IESD through 47 days after the IESD (108 total days), with no gaps.

Administrative Specification

Denominator The eligible population.

Numerator

Initiation of AOD Treatment Initiation of AOD treatment within 14 days of the IESD.

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

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

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

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

- IET Visits Group 1 Value Set ***with*** IET POS Group 1 Value Set ***and*** a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- IET Visits Group 2 Value Set ***with*** IET POS Group 2 Value Set ***and*** a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A telephone visit (Telephone Visit Value Set) ***with*** a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An e-visit or virtual check-in (Online Assessments Value Set) ***with*** a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- If the Index Episode was for a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set) an opioid treatment service (OUD Weekly Non Drug Service Value Set).
- If the Index Episode was for a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set) an opioid treatment service (OUD Monthly Office Based Treatment Value Set).
- If the Index Episode was for a diagnosis of alcohol abuse or dependence (Alcohol Abuse and Dependence Value Set) a medication treatment dispensing event (Alcohol Use Disorder Treatment Medications List) or medication treatment during a visit (AOD Medication Treatment Value Set).
- If the Index Episode was for a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set) a medication treatment dispensing event (Opioid Use Disorder Treatment Medications List) or medication treatment during a visit (AOD Medication Treatment Value Set; OUD Weekly Drug Treatment Service Value Set).

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

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

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

Engagement of AOD Treatment

Step 1 Identify all members compliant for the Initiation of AOD Treatment numerator.

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

Step 2 Identify members who had an opioid treatment service that bills monthly (OUD Monthly Office Based Treatment Value Set) or who had a visit that included medication administration (OUD Weekly Drug Treatment Service Value Set) beginning on the day after the initiation encounter through 34 days after the initiation event.

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

Step 3 Identify members whose initiation of AOD treatment was a medication treatment event (Alcohol Use Disorder Treatment Medications List; Opioid Use Disorder Treatment Medications List; AOD Medication Treatment Value Set).

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

Step 4 Identify the remaining members whose initiation of AOD treatment was *not* a medication treatment event (members not identified in step 3).

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

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

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

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

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

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

- IET Stand Alone Visits Value Set ***with*** a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- Observation Value Set ***with*** a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- IET Visits Group 1 Value Set ***with*** IET POS Group 1 Value Set ***with*** a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- IET Visits Group 2 Value Set ***with*** IET POS Group 2 Value Set ***with*** a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A telephone visit (Telephone Visits Value Set) ***with*** a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An e-visit or virtual check-in (Online Assessments Value Set) ***with*** a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- If the IESD Diagnosis cohort was a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set) an opioid treatment service (OUD Weekly Non Drug Service Value Set).

Engagement medication treatment events

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

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

If the member is compliant for multiple cohorts, only count the member once for the Total Engagement numerator. The Total column is not the sum of the Diagnosis columns.

Alcohol Use Disorder Treatment Medications

Description	Prescription
Aldehyde dehydrogenase inhibitor	• Disulfiram (oral)
Antagonist	• Naltrexone (oral and injectable)
Other	• Acamprosate (oral; delayed-release tablet)

Opioid Use Disorder Treatment Medications

Description	Prescription
Antagonist	• Naltrexone (oral and injectable)
Partial agonist	• Buprenorphine (sublingual tablet, injection, implant) • Buprenorphine/naloxone (sublingual tablet, buccal film, sublingual film)

Note

- *Organizations may have different methods for billing intensive outpatient encounters and partial hospitalizations. Some organizations may bill comparable to outpatient billing, with separate claims for each date of service; others may bill comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing is comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the required time frame for the rate.*
- *For members in the "other drug abuse or dependence" cohort, medication treatment does not meet numerator criteria for Initiation of AOD Treatment or Engagement of AOD Treatment.*
- *Methadone is not included in the medication lists for this measure. Methadone for opioid use disorder is only administered or dispensed by federally certified opioid treatment programs and does not show up in pharmacy claims data. A pharmacy claim for methadone would be more indicative of treatment for pain than treatment for an opioid use disorder; therefore they are not included in the medication lists. The AOD Medication Treatment Value Set includes some codes that identify methadone treatment because these codes are used on medical claims, not pharmacy claims.*

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table IET-1/2/3: Data Elements for Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

	Administrative
Measurement year	✓
Eligible population	*For each age stratification, diagnosis stratification and total*
Numerator events by administrative data	*Each rate, for each age stratification, diagnosis stratification and total*
Reported rate	*Each rate, for each age stratification, diagnosis stratification and total*

Rules for Allowable Adjustments of HEDIS

This section *may not* be used for reporting health plan HEDIS.

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

Rules for Allowable Adjustments for Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product Lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes	The age determination dates may be changed (e.g., select, "age as of June 30"). Changing the denominator age range is allowed.
AOD diagnosis cohorts	Yes, with limits	Reporting each stratum or combined strata is allowed.
Continuous enrollment, Allowable gap, Anchor Date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Organizations are not required to use a benefit; adjustments are allowed.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/Diagnosis	Yes, with limits	Only events that contain (or map to) codes in the medication lists and value sets may be used to identify visits. Medication lists and value sets and logic may not be changed. ***Note:*** *This measure uses new episodes of AOD abuse and dependence; modifying the Intake period can affect the Index Episode and other dates; however, the order and relationship of the events may not be changed.*
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Exclusions	NA	There are no exclusions for this measure.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
• Initiation of AOD Treatment • Engagement of AOD Treatment	No	Medication lists, value sets and logic may not be changed.

Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)

SUMMARY OF CHANGES TO HEDIS MY 2020 & MY 2021

- Added value sets to the numerators.

Description

The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD. Two rates are reported:

1. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
2. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).

Eligible Population

Note: *Members in hospice are excluded from the eligible population. Refer to General Guideline 17: Members in Hospice.*

Product lines	Commercial, Medicaid, Medicare (report each product line separately).
Ages	13 years and older as of the ED visit. Report two age stratifications and a total rate: • 13–17 years. • 18 and older. • Total. The total is the sum of the age stratifications.
Continuous enrollment	Date of the ED visit through 30 days after the ED visit (31 total days).
Allowable gap	No gaps in enrollment.
Anchor date	None.
Benefit	Medical and chemical dependency. ***Note:*** *Members with detoxification-only chemical dependency benefits do not meet these criteria.*
Event/diagnosis	An ED visit (ED Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set) on or between January 1 and December 1 of the measurement year where the member was 13 years or older on the date of the visit.

The denominator for this measure is based on ED visits, not on members. If a member has more than one ED visit, identify all eligible ED visits between January 1 and December 1 of the measurement year and do not include more than one visit per 31-day period, as described below.

Multiple visits in a 31-day period If a member has more than one ED visit in a 31-day period, include only the first eligible ED visit. For example, if a member has an ED visit on January 1, include the January 1 visit and do not include ED visits that occur on or between January 2 and January 31; then, if applicable, include the next ED visit that occurs on or after February 1. Identify visits chronologically, including only one per 31-day period.

Note: *Removal of multiple visits in a 31-day period is based on* ***eligible*** *visits. Assess each ED visit for exclusions before removing multiple visits in a 31-day period.*

ED visits followed by inpatient admission Exclude ED visits that result in an inpatient stay and ED visits followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit, regardless of the principal diagnosis for the admission. To identify admissions to an acute or nonacute inpatient care setting:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Identify the admission date for the stay.

These events are excluded from the measure because admission to an acute or nonacute inpatient setting may prevent an outpatient follow-up visit from taking place.

Administrative Specification

Denominator The eligible population.

Numerators

30-Day Follow-Up A follow-up visit with any practitioner, with a principal diagnosis of AOD within 30 days after the ED visit (31 total days). Include visits that occur on the date of the ED visit.

7-Day Follow-Up A follow-up visit with any practitioner, with a principal diagnosis of AOD within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit.

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

- IET Stand Alone Visits Value Set with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set).
- OUD Weekly Non Drug Service Value Set ***with*** a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set).
- OUD Monthly Office Based Treatment Value Set ***with*** a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set).
- OUD Weekly Drug Treatment Service Value Set ***with*** a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set).

- IET Visits Group 1 Value Set ***with*** IET POS Group 1 Value Set and a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set).
- IET Visits Group 2 Value Set ***with*** IET POS Group 2 Value Set and a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set).
- An observation visit (Observation Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set).
- A telephone visit (Telephone Visits Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set).
- An e-visit or virtual check-in (Online Assessments Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set).

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 (within 30 days after the ED visit or within 7 days after the ED visit).*

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table FUA-1/2/3: Data Elements for Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence

	Administrative
Measurement year	✓
Eligible population	*For each age stratification and total*
Numerator events by administrative data	*Each of the 2 rates for each age stratification and total*
Numerator events by supplemental data	*Each of the 2 rates for each age stratification and total*
Reported rate	*Each of the 2 rates for each age stratification and total*

Alcohol and Drug Misuse

Screening, Brief Intervention and Referral to Treatment (SBIRT)

Measure Basic Information

Name and date of specifications used: The measure specifications were developed by OHA in collaboration with a workgroup including CCOs and clinics and included clinical piloting. The measure calls for use of standardized assessment tools.

URL of Specifications: N/A. Value sets used in this measure may be accessed through the Value Set Authority Center (VSAC): https://vsac.nlm.nih.gov/.

Measure Type:

☐ HEDIS ☐ PQI ☐ Survey ■ Other. Specify: OHA-developed

Measure Utility:

■ CCO Incentive ☐ State Quality ☐ CMS Adult Core Set ☐ CMS Child Core Set

☐ Other. Specify:

Data Source: Electronic Health Records

Measurement Period: January 1, 2021 – December 31, 2021

Benchmark:

	2019	**2020-2021**
Benchmark for OHA measurement year	n/a *	n/a*
Source		

* CCOs must report minimum population threshold and other reporting parameters as specified in OHA reporting guidance to qualify for 100% of quality pool (in addition to meeting 75% of remaining measures).

Note on telehealth: This measure is telehealth eligible. The denominator for SBIRT rate 1 (screening) is the same as the depression screening and follow-up measure (CMS2), which is telehealth eligible according to CMS 2021 telehealth guidance. For further information specific to Oregon, the Health Evidence Review Commission (HERC) has provided this guideline on telehealth services.

Changes in Specifications from 2020 to 2021:

- For the Rate 1 denominator, SBIRT uses the same eligible encounters as CMS2v10, depression screening and follow-up. The CMS2v10 denominator criteria have changed as follows:

- New data element was added to allow for Physical Therapy Evaluation as an eligible encounter, per specialty society request.
- Value set (2.16.840.1.113883.3.600.1916) was renamed to Encounter to Screen for Depression to align with best practices, based on expert review and/or public feedback.

- For the dementia or mental degenerations exclusions (used in CMS149v8), new codes were added to the value set.
- For the Patient Reason exception, the value set has been replaced to remain consistent with the exception used in CMS2v10.
- For the Medical Reason exception, the value set has been replaced to remain consistent with the exception used in CMS2v10.

Value Set Name and OID	Status
Value set (2.16.840.1.113883.3.600.1916)	**Renamed** to Encounter to Screen for Depression to align with best practices, based on expert review and/or public feedback.
Value set Encounter to Screen for Depression (2.16.840.1.113883.3.600.1916)	Added 2 CPT codes (96156, 96158) and deleted 2 CPT codes (96150, 96151) based on terminology update. Deleted 1 SNOMED CT code (32537008) based on terminology update.
Value set Physical Therapy Evaluation (2.16.840.1.113883.3.526.3.1022)	Added Physical Therapy Evaluation based on expert review and/or public feedback.
Value set Dementia & Mental Degenerations (2.16.840.1.113883.3.526.3.1005)	Added 46 SNOMED CT codes.
SNOMED CT value set Patient Reason refused (2.16.840.1.113883.3.600.791)	**Replaced** with grouping value set Patient Declined (2.16.840.1.113883.3.526.3.1582) to align with best practices, based on expert review and/or public feedback.
SNOMED CT value set Medical or Other reason not done (2.16.840.1.113883.3.600.1.1502)	**Replaced** with grouping value set Medical Reason (2.16.840.1.113883.3.526.3.1007) for harmonization purposes, based on expert review and/or public feedback.

Denied claims: n/a

Measure Details

Measure Components and Scoring

Detailed measure specifications for the depression screening and follow-up measure, which is used in SBIRT for the Rate 1 denominator and for denominator exceptions, are available in the eCQI Resource Center: https://ecqi.healthit.gov/ecqm/ep/2021/cms002v10. Detailed value set contents are available in the Value Set Authority Center.

Two rates are reported for this SBIRT measure:

(1) The percentage of patients who received age-appropriate screening and

(2) The percentage of patients with a positive full screen who received a brief intervention, a referral to treatment, or both

Screening in an ambulatory setting is required once per measurement year. This measure does not require screening to occur at all encounters.

Rate 1

Data elements required denominator: All patients aged 12 years and older before the beginning of the measurement period with at least one eligible encounter during the measurement period.

These denominator criteria for SBIRT Rate 1 are identical to the denominator criteria for the depression screening and follow-up measure (NQF0418e/ CMS2v10). The denominator *exclusions* for depression screening and follow-up, however, are different from the exclusions for SBIRT. SBIRT exclusions are set out below. Eligible encounters are identified through the value sets Encounter to Screen for Depression (2.16.840.1.113883.3.600.1916) and Physical Therapy Evaluation (2.16.840.1.113883.3.526.3.1022).

Required denominator exclusions and exceptions: See below.

Data elements required numerator: Patients who received an age-appropriate screening, using an SBIRT screening tool approved by OHA, during the measurement period **AND** had either a brief screen with a negative result or a full screen.

> **Note**: This measure leaves flexibility for clinical preferences on whether to do a brief screen before a full screen. Although a negative brief screen is numerator compliant, a positive brief screen, by itself, is **not** numerator compliant. If a patient has a positive brief screen, then a full screen must be completed for numerator compliance on Rate 1. A full screen is numerator compliant, regardless of the result.
>
> **Note**: Approved SBIRT screening tools are available on the HSD-Approved Evidence-Based Screening Resources/ Tools (SBIRT) page: https://www.oregon.gov/oha/HSD/AMH/Pages/EB-Tools.aspx . The name of the screening tool used must be documented in the medical record, but it does not need to be captured in a queryable field.
>
> The clinician should interpret the age-appropriate screening tool to determine if the result is positive or negative. Where the screening tool includes guidance on interpreting scores, the clinician should consult that guidance. This is the same approach used to identify positive or negative results for depression screening in NQF0418e/ CMS2. There may be instances in which it is appropriate for clinicians to use their discretion in interpreting whether a result is positive or negative, such as for patients reporting use of topical medicinal marijuana.
>
> **Note**: The screening(s) and result(s) must be captured as queryable structured data in the EHR. The EHR does not need to capture each response to each question in the screening tool as structured data. It is acceptable to capture the interpretation and the follow-up as structured

data, without having a field for each question in the screening tool used. For supporting documentation, keeping a scan or other non-structured documentation of the screening tool (including the name of the screening tool used) is acceptable. The intent of this guidance is that the data elements needed to calculate the measure can be reported out of the EHR, without chart review. OHA does not intend to be prescriptive about how supporting documentation is maintained in a patient's medical record.

Required exclusions for numerator: SBIRT services received in an emergency department (Place of Service 23) or hospital setting (POS 21).

Rate 2

Data elements required denominator: All patients in Rate 1 denominator who had a positive full screen during the measurement period.

Required denominator exclusions and exceptions: See below.

Data elements required numerator: Patients who received a brief intervention, a referral to treatment, or both that is documented within 48 hours of the date of a positive full screen.

Note – Brief Intervention: Brief interventions are interactions with patients that are intended to induce a change in a health-related behavior. They are short, one-on-one counseling sessions ideally suited for people who use substances or drink in ways that are harmful or abusive. Examples of brief interventions include assessment of the patient's commitment to quit and offer of pharmacological or behavioral support, provision of self-help material, or referral to other supportive resources.

As explained by SAMHSA:

> "Brief interventions are evidence-based practices designed to motivate individuals at risk of substance abuse and related health problems to change their behavior by helping them understand how their substance use puts them at risk and to reduce or give up their substance use. Healthcare providers can also use brief interventions to encourage those with more serious dependence to accept more intensive treatment within the primary care setting or a referral to a specialized alcohol and drug treatment agency.
>
> "In primary care settings, brief interventions last from 5 minutes of brief advice to 15-30 minutes of brief counseling. Brief interventions are not intended to treat people with serious substance dependence, but rather to treat problematic or risky substance use. Skillfully conducted, brief interventions are essential to successful SBIRT implementation. The two most common behavioral therapies used in SBIRT programs are brief versions of cognitive behavioral therapy and motivational interviewing, or some combination of the two."

https://www.integration.samhsa.gov/clinical-practice/sbirt/brief-interventions

A brief intervention of less than 15 minutes can count for Rate 2 numerator compliance. Because reimbursement codes for brief intervention services may require services of at least 15

minutes, such codes would undercount services that qualify for the Rate 2 numerator. Although clinics may bill for SBIRT services when appropriate, this measure (unlike the earlier claims-based CCO SBIRT measure) does not require use of billing codes to determine whether screening or a brief intervention or referral occurred. Documentation in the medical record (e.g., through checkboxes, flowsheets, or other structured data) that a brief intervention was completed is sufficient.

Note – Referral to Treatment: A referral is counted for Rate 2 numerator compliance when the referral is made. Given the challenges of documenting whether a referral was completed (that is, whether the patient actually saw the provider to whom the patient was referred), numerator compliance is not dependent on referral completion.

Required exclusions for numerator: SBIRT services received in an emergency department or hospital setting.

Denominator Exclusions and Exceptions – Rate 1 and Rate 2

Required exclusions for denominator: Patients with:

Exclusions	Value Set Name	Value Set OID
Active diagnosis of alcohol or drug dependency	Alcohol and Drug Dependence	2.16.840.1.113883.3.464.1003.106.12.1001
Engagement in treatment	Alcohol and Drug Dependence Treatment	2.16.840.1.113883.3.464.1003.106.12.1005
Dementia or mental degeneration	Dementia & Mental Degenerations	2.16.840.1.113883.3.526.3.1005
Limited life expectancy	Limited Life Expectancy	2.16.840.1.113883.3.526.3.1259
Palliative care (includes comfort care and hospice)	Palliative or Hospice Care	2.16.840.1.113883.3.600.1.1579

Note: As with the earlier, claims-based version of this measure, SBIRT screening and intervention services are designed to prevent Oregon Health Plan members from developing a substance abuse disorder or for early detection. These services are not intended to treat members already diagnosed with a substance abuse disorder or those members already receiving substance abuse treatment services.

The exclusions for active diagnosis of alcohol or drug dependency, dementia or mental degeneration, limited life expectancy, and palliative care apply if they occur before the qualifying encounter (that is, before a visit that puts the patient in the denominator for Rate 1).

The exclusion for engagement in treatment applies if the patient was engaged in treatment before the qualifying visit and up to one year before the start of the measurement year.

Denominator Exceptions: Any of the following criteria also remove patients from the denominator.

Exception	Grouping Value Set

Patient Reason Patient refuses to participate	Patient Declined (2.16.840.1.113883.3.526.3.1582)
Medical Reason(s) Documentation of medical reason for not screening patient (e.g., cognitive, functional, or motivational limitations that may impact accuracy of results; patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status)	Medical Reason(s) (2.16.840.1.113883.3.526.3.1007)

Note: For this SBIRT measure, these exception criteria may be captured using the SNOMED-CT codes in the value sets listed above *or* otherwise captured in a queryable field, such as a checkbox for noting patient refusal of screening. In other words, as the measure steward for this CCO SBIRT measure, OHA uses the same concepts but is less stringent than the measure steward for the depression screening and follow-up measure (NQF0418e/ CMS2) about how data is captured for these denominator exceptions.

Note: These exceptions could be applied at different points in the SBIRT process. For example, if the patient refuses screening at any point before the needed screening is completed, the patient would be excepted from Rate 1. Because a positive full screen is required for a patient to be counted in Rate 2, a patient who is an exception for Rate 1 would not be counted in Rate 2.

- Patient refuses brief screen. = Exception. Patient is not counted in rate 1.
- Patient completes brief screen, which is negative. = Process complete, and patient is numerator compliant for Rate 1.
- Patient completes brief screen, which is positive. Patient then completes full screen. = Process complete for rate 1, and patient is numerator compliant. (If full screen is positive, proceed to evaluate brief intervention or referral for rate 2.)
- Patient completes brief screen, which is positive. Patient then refuses full screen, either before starting or partway through. = Exception. Patient is not counted in rate 1.
- Patient completes full screen, which is positive. Patient then refuses brief intervention or referral to treatment. = Patient is numerator compliant for rate 1 but is not counted for rate 2.

Deviations from cited specifications for denominator: None.

Deviations from cited specifications for numerator: None.

What are the continuous enrollment criteria: For now, OHA does not use continuous enrollment criteria for EHR-based measures; the “eligible as of the last date of the reporting period” rule may be used to identify beneficiaries.

What are allowable gaps in enrollment: n/a

Define Anchor Date (if applicable): n/a

For more information:

- Educational materials and other resources related to EHR-sourced quality measurement can be accessed through the CMS/ ONC eCQI Resource Center: https://ecqi.healthit.gov/ep-ec-ecqms
- Value set content can be accessed through the Value Set Authority Center (VSAC) at the National Library of Medicine. https://vsac.nlm.nih.gov/
    - For more information about value sets and the code systems used, a guide can be found in the CMS Measure Management Blueprint: https://www.cms.gov/files/document/blueprint-codes-code-systems-value-sets.pdf
- Additional information on OHA reporting requirements will be available in the Year Nine (2021) Guidance Documentation, which will be posted at https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx

Version Control

Definitions:

Screening – Completion of a clinical or diagnostic tool used to identify people at risk of developing or having a certain disease or condition, even in the absence of symptoms.

Standardized Depression Screening Tool – A normalized and validated depression screening tool developed for the Member population in which it is being utilized. The name of the age appropriate standardized depression screening tool utilized must be documented in the medical record.

Examples of depression screening tools include but are not limited to:

- **Adolescent Screening Tools (12-17 years):** Patient Health Questionnaire for Adolescents (PHQ-A), Beck Depression Inventory-Primary Care Version (BDI-PC), Mood Feeling Questionnaire (MFQ), Center for Epidemiologic Studies Depression Scale (CES-D), and PRIME MD-PHQ2
- **Adult Screening Tools (18 years and older):** Patient Health Questionnaire (PHQ-9 or PHQ-2), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety-Depression Scale (DADS), Geriatric Depression Scale (GDS), Cornell Scale Screening, and PRIME MD-PHQ2

Substance Use Assessment in Primary Care

Methodology: IEHP-Defined Quality Measure

Measure Description: The percentage of members 18 years and older who were screened for substance use during the measurement year (2020).

CODES TO IDENTIFY SUBSTANCE USE ASSESSMENT IN PRIMARY CARE:			
Service	**Code Type**	**Code**	**Code Description**
Substance Use Assessment in Primary Care	CPT	99408	Alcohol and/or Substance (other than tobacco) Abuse Structured Screening (e.g. Audit DAST) and Brief Intervention (SBI) Services 15 to 30 Minutes
Substance Use Assessment in Primary Care	CPT	99409	Alcohol and/or Substance (other than tobacco) Abuse Structured Screening (e.g. Audit DAST) and Brief Intervention (SBI) Services Greater than 30 Minutes
Substance Use Assessment in Primary Care	HCPCS	G0396	Alcohol and/or Substance (other than tobacco) Abuse Structured Screening (e.g. Audit DAST) and Brief Intervention 15 to 30 Minutes

CODES TO IDENTIFY SUBSTANCE USE ASSESSMENT IN PRIMARY CARE:			
Service	**Code Type**	**Code**	**Code Description**
Substance Use Assessment in Primary Care	HCPCS	G0397	Alcohol and/or Substance (other than tobacco) Abuse Structured Screening (e.g. Audit DAST) and Brief Intervention Greater than 30 Minutes
Substance Use Assessment in Primary Care	HCPCS	G0442	Annual Alcohol Misuse Screening 15 Minutes
Substance Use Assessment in Primary Care	HCPCS	G0443	Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes
Substance Use Assessment in Primary Care	HCPCS	H0049	Alcohol and/or Drug Assessment
Substance Use Assessment in Primary Care	HCPCS	H0050	Alcohol and/or Drug Service Brief Intervention Per 15 Minutes

Denominator: All Members aged 18 years and older during the measurement year (2020). Member counted only once in the denominator.

Numerator: Members who were screened for substance use at least once during the measurement year (2020).

Population: Women

Breast Cancer Screening (BCS)

Methodology: HEDIS®

Measure Description: The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer any time on or between October 1 two years prior to the measurement year (2018) and December 31 of the measurement year (2020).

- The eligible population in the measure meets all of the following criteria:
    1. Women 52-74 years as of December 31 of the measurement year (2020).
    2. Continuous enrollment from October 1 two years prior to the measurement year (2018) through December 31 of the measurement year (2020) with no more than one gap in enrollment of up to 45 days for each calendar year of continuous enrollment. No gaps in enrollment are allowed from October 1 two years prior to the measurement year (2018) through December 31 two years prior to the measurement year (2018).

Concurrent Use of Opioids and Benzodiazepines (COB-

NQF Endorsement Status	Endorsed
NQF ID	3389
Measure Type	Process
Measure Content Last Updated	2021-02-01
Info As Of	Not Available

Properties

Description	Percentage of Medicaid beneficiaries age 18 and older with concurrent use of prescription opioids and benzodiazepines.
Numerator	The number of individuals from the denominator with: Two or more prescription claims for any benzodiazepine (Table COB-B) with unique dates of service, AND Concurrent use of opioids and benzodiazepines for 30 or more cumulative days. Table COB-B. Benzodiazepinesa Benzodiazepine Medications Alprazolam Chlordiazepoxide Clobazam Clonazepam Clorazepate Diazepam Estazolam Flurazepam Lorazepam Midazolam Oxazepam Quazepam Temazepam Triazolam
Denominator	Age 18 and older as of January 1 of the measurement year. Identify individuals with 2 or more prescriptions for opioids (Table COB-A) with unique dates of service, for which the sum of the days supply is 15 or more during the measurement year. Exclude individuals who met at least one of the following during the

Concurrent Use of Opioids and Benzodiazepines (COB-

	measurement year: Hospice Cancer Diagnosis Table COB-A. Opioid Medications Opioid Medications Buprenorphinec Butorphanol Codeine Dihydrocodeine Fentanyld Hydrocodone Hydromorphone Levorphanol Meperidine Methadone Morphine Opium Oxycodone Oxymorphone Pentazocine Tapentadol Tramadol
Denominator Exclusions	Beneficiaries with cancer are excluded from this measure and may be identified using the ICD-10 codes in Table COB-C, available at https://www.medicaid.gov/license-agreement.html file=%2Fmedicaid%2Fquality-of-care%2Fdownloads%2F2018-adult-non-hedis-value-set-directory.zip. The cancer exclusion criterion is for beneficiaries with a diagnosis code for cancer during the measurement year. Their initial diagnosis may have occurred previously; however, the diagnosis code for cancer must be present
Rationale	Not Available
Evidence	Not Available

Developer/Steward

Steward	Pharmacy Quality Alliance
Contact	Not Available
Measure Developer	Not Available

Concurrent Use of Opioids and Benzodiazepines (COB-

Development Stage	Fully Developed

Characteristics

Measure Type	Process
Meaningful Measure Area	Not Available
Healthcare Priority	Making Care Safer by Reducing Harm Caused in the Delivery of Care
eCQM Spec Available	No
NQF Endorsement Status	Endorsed
NQF ID	3389
Last NQF Update	2020-10-19
Target Population Age	18+
Target Population Age (High)	Not Available
Target Population Age (Low)	18
Reporting Level	Not Available
Conditions	Substance Abuse
Subconditions	Opioid Dependency
Care Settings	Hospital Outpatient; Other; Outpatient

Groups

Core Measure Set	Medicaid Adult Core Set

Measure Group	Group Identifier
Adult Core Set	

Concurrent Use of Opioids and Benzodiazepines (COB-

Measure Links

Measure Program: Medicaid

Info As Of	Not Available
Program / Model Notes	
Data Sources	Claims Data
Purposes	Not Available
Quality Domain	Not Available
Reporting Frequency	Not Available
Impacts Payment	No
Reporting Status	Active
Data Reporting Begin Date	2018-10-01
Data Reporting End Date	Not Available

Measure Program Links

https://www.medicaid.gov/

Use of Pharmacotherapy for Opioid Use Disorder (OUD-HH)

NQF Endorsement Status	Endorsed
NQF ID	3400
Measure Type	Process
Measure Content Last Updated	2021-02-01
Info As Of	Not Available

Properties

Description	The percentage of Medicaid beneficiaries ages 18 to 64 with an OUD who filled a prescription for or were administered or ordered an FDA-approved medication for the disorder during the measure year. The measure will report any medications used in medication-assisted treatment of opioid dependence and addiction and four separate rates representing the following types of FDA-approved drug products: buprenorphine; oral naltrexone; long-acting, injectable naltrexone; and methadone.
Numerator	Medicaid beneficiaries ages 18 to 64 with an OUD who filled a prescription for or were administered or ordered an FDA-approved medication for the disorder during the measure year.
Denominator	Number of Medicaid beneficiaries with at least one encounter with a diagnosis of opioid abuse, dependence, or remission (primary or other) at any time during the measurement year.
Denominator Exclusions	Not Available
Rationale	Not Available
Evidence	Not Available

Developer/Steward

Steward	CMS

Use of Pharmacotherapy for Opioid Use Disorder (OUD-HH)

Contact	Not Available
Measure Developer	Not Available
Development Stage	Fully Developed

Characteristics

Measure Type	Process
Meaningful Measure Area	Prevention, Treatment, and Management of Mental Health
Healthcare Priority	Promote Effective Prevention & Treatment of Chronic Disease
eCQM Spec Available	No
NQF Endorsement Status	Endorsed
NQF ID	3400
Last NQF Update	2020-08-12
Target Population Age	18-64
Target Population Age (High)	64
Target Population Age (Low)	18
Reporting Level	State
Conditions	Substance Abuse
Subconditions	Opioid Dependency
Care Settings	Ambulatory Care- Clinician Office/Clinic; Ambulatory Care: Outpatient Rehabilitation; Behavioral Health/Psychiatric: Inpatient; Behavioral Health/Psychiatric: Outpatient ; Hospital/Acute Care Facility

Groups

Use of Pharmacotherapy for Opioid Use Disorder (OUD-HH)

Core Measure Set	Not Available

Measure Group	Group Identifier
Innovation Accelerator Program	

Measure Links

Measure Program: Medicaid

Info As Of	Not Available
Program / Model Notes	
Data Sources	Administrative Data (non-claims); Claims Data
Purposes	Not Available
Quality Domain	Behavioral Health Care
Reporting Frequency	Not Available
Impacts Payment	Not Available
Reporting Status	Active
Data Reporting Begin Date	2020-01-01
Data Reporting End Date	Not Available

Measure Program Links

https://www.medicaid.gov/

Quality ID #402 (NQF 2803): Tobacco Use and Help with Quitting Among Adolescents
– National Quality Strategy Domain: Community/Population Health
– Meaningful Measure Area: Prevention and Treatment of Opioid and Substance Use Disorders

2021 COLLECTION TYPE:
MIPS CLINICAL QUALITY MEASURES (CQMS)

MEASURE TYPE:
Process

DESCRIPTION:
The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user

INSTRUCTIONS:
This measure is to be submitted **once per performance period** for patients seen during the performance period. This measure is intended to reflect the quality of services provided for preventive screening for tobacco use. This measure may be submitted by Merit-based Incentive Payment System (MIPS) eligible clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

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

Measure Submission Type:
Measure data may be submitted by individual MIPS eligible clinicians, groups, or third party intermediaries. The listed denominator criteria are used to identify the intended patient population. The numerator options included in this specification are used to submit the quality actions as allowed by the measure. The quality-data codes listed do not need to be submitted by MIPS eligible clinicians, groups, or third party intermediaries that utilize this modality for submissions; however, these codes may be submitted for those third party intermediaries that utilize Medicare Part B claims data. For more information regarding Application Programming Interface (API), please refer to the Quality Payment Program (QPP) website.

DENOMINATOR:
All patients aged 12-20 years with a visit during the measurement period

Denominator Criteria (Eligible Cases):
Patients aged 12-20 years on date of encounter
AND
Patient encounter during the performance period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 90839, 90845, 92002, 92004, 92012, 92014, 96156, 96158, 97165, 97166, 97167, 97168, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99406, 99407, G0438, G0439

NUMERATOR:
Patients who were screened for tobacco use at least once within 18 months (during the measurement period or the six months prior to the measurement period) **AND** who received tobacco cessation counseling intervention if identified as a tobacco user

Definitions:
Tobacco Use Status – Any documentation of smoking or tobacco use status, including 'never' or 'non-use'.
Tobacco User – Any documentation of active or current use of tobacco products, including smoking.

NUMERATOR NOTE: *In the event that a patient is screened for tobacco use and identified as a user but did not receive tobacco cessation counseling, submit* ***G9460****.*

Numerator Options:

Performance Met:	Patient documented as tobacco user AND received tobacco cessation intervention (must include at least one of the following: advice given to quit smoking or tobacco use, counseling on the benefits of quitting smoking or tobacco use, assistance with or referral to external smoking or tobacco cessation support programs, or current enrollment in smoking or tobacco use cessation program) if identified as a tobacco user **(G9458)**
OR	
Performance Met:	Currently a tobacco non-user **(G9459)**
OR	
Performance Not Met:	Tobacco assessment OR tobacco cessation intervention not performed, reason not given **(G9460)**

RATIONALE:

This measure is intended to promote adolescent tobacco screening and tobacco cessation interventions for those who use tobacco products. There is good evidence that tobacco screening and brief cessation intervention (including counseling and/or pharmacotherapy) is successful in helping tobacco users quit. Tobacco users who are able to stop smoking lower their risk for heart disease, lung disease, and stroke.

CLINICAL RECOMMENDATION STATEMENTS:

The following evidence statements are quoted verbatim from the referenced clinical guidelines:

The U.S. Preventive Services Task Force recommends that primary care clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents. (Strength of Recommendation = B) (U.S. Preventive Services Task Force, 2013)

All patients should be asked if they use tobacco and should have their tobacco use status documented on a regular basis. Evidence has shown that clinic screening systems, such as expanding the vital signs to include tobacco use status or the use of other reminder systems such as chart stickers or computer prompts, significantly increase rates of clinician intervention. (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

All physicians should strongly advise every patient who smokes to quit because evidence shows that physician advice to quit smoking increases abstinence rates. (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

Minimal interventions lasting less than 3 minutes increase overall tobacco abstinence rates. Every tobacco user should be offered at least a minimal intervention, whether or not he or she is referred to an intensive intervention. (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

The combination of counseling and medication is more effective for smoking cessation than either medication or counseling alone. Therefore, whenever feasible and appropriate, both counseling and medication should be provided to patients trying to quit smoking. (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

Disparity Measure: Emergency Department Utilization for Individuals Experiencing Mental Illness

Measure Basic Information

Name and date of specifications used: HEDIS® MY2020/2021 Technical Specifications for Health Plans (Volume 2) and Oregon-specific definition for identifying individuals with mental illness.

URL of Specifications: N/A

Measure Type:

☐HEDIS ☐PQI ☐Survey ■Other Specify: HEDIS with OHA modification

Measure Utility:

■CCO Incentive ☐State Quality ☐CMS Adult Core Set ☐CMS Child Core Set ☐Other Specify:

Data Source: MMIS/DSSURS

Measurement Period: January 1, 2020 – December 31, 2020; January 1, 2021 – December 31, 2021

Benchmark for OHA MY	2018	2019	2020[1]	2021
MHED	92.9/1000 MM	87.7/1000 MM	N/A (reporting-only)	86.5/1000 MM
Source:	CCO 90th percentile from two years prior			Original 2020 benchmark

2021 Improvement Targets: Minnesota method

Note on telehealth: This measure only counts visits to the emergency department for the numerator. However, the denominator logic for identifying members with mental illness is agnostic about the place of service for the mental illness history claims.

Incentive Measure changes in specifications from 2020 to MY2020/2021:

- HEDIS MY2020/2021 added 38 CPT codes and removed 19 CPT codes for the ED Procedure Code Value Set. Also added 21 ICD10 diagnosis codes for the Mental and Behavioral Disorders Value Set.

Member type: CCO A ■ CCO B ■ CCO G ☐

Specify claims used in the calculation:

MHED	Claim from matching CCO	Denied claims included

[1] Because of disruptions caused by the COVID-19 pandemic, the Metrics & Scoring Committee decided at its July 17, 2020, meeting to make all 2020 CCO incentive measures reporting only.

Mental illness claims for denominator member list	N	N
Numerator ED event	Y	N

Measure Details

Data elements required denominator: 1,000 member months of the adult members enrolled with the organization, who are identified as having experienced mental illness. The adult members are identified as age 18 or older at the end of the measurement year. OHA uses claims from the measurement year, and the two years preceding the measurement year (a rolling look back period for total of 36 months), and the members who had two or more visits[2] with any of the diagnoses in the Members Experiencing Mental Illness Value Set[3] below are identified for inclusion in the denominator:

Members Experiencing Mental Illness Value Set
ICD-10 CM Diagnosis
F200, F201, F202, F203, F205, F2081, F2089, F209, F21, F23, F24, F250, F251, F258, F259, F28, F29, F3010, F3011, F3012, F3013, F302, F303, F304, F308, F309, F310, F3110, F3111, F3112, F3113, F312, F3130, F3131, F3132, F314, F315, F3160, F3161, F3162, F3163, F3164, F3170, F3171, F3172, F3173, F3174, F3175, F3176, F3177, F3178, F3181, F3189, F319, F320, F321, F322, F323, F324, F325, F328, F3289, F329, F330, F331, F332, F333, F3340, F3341, F3342, F338, F339, F348, F3481, F3489, F349, F39, F42, F422, F423, F428, F429, F4310, F4311, F4312, F603

To note, the denominator members are identified on an individual-basis. A member could be included in the measure due to a history of qualifying mental illness claims in the 36-month look back period from any of the organizations in OHP with which they have coverage at the time. Once the members are identified, their length of enrollment (member months) within the measurement year is attributed according to the organizations they have enrolled with for the same year for the denominator. The mental illness claims in the 36-month look back period do not need to match the organization(s) to which the member has enrolled with during the measurement year.

Required exclusions for denominator: Members in hospice are excluded from this measure. These members are identified using HEDIS MY2020/2021 Hospice Encounter Value Set and Hospice Intervention Value Set, with claims within the measurement year. (See HEDIS MY2020/2021 General Guideline 17 for detail.)

Hospice Encounter Value Set	
CPT/HCPCS	**UBREV**
G9473-G9479, Q5003-Q5008, Q5010, S9126, T2042-T2046	0115, 0125, 0135, 0145, 0155, 0235, 0650-0652, 0655-0659

Hospice Intervention Value Set
CPT/HCPCS
99377, 99378, G0182

[2] A 'visit' is defined as a unique member and date of service.
[3] The 'Members Experiencing Mental Illness Value Set' is defined by OHA specifically for the Disparity measure, which should not be confused with the HEDIS Mental Illness Value Set.

Note HEDIS 2020 included SNOMED CT codes in Hospice Encounter Value Set and Hospice Intervention Value Set which are not in the administrative claims data that OHA uses for the measure, therefore these codes are omitted in the above code tables.

Deviations from cited specifications for denominator: None.

Continuous enrollment criteria: None.

Allowable gaps in enrollment: None.

Anchor Date (if applicable): None.

Data elements required numerator: Number of emergency department visits from the denominator members (members experiencing mental illness), during the enrollment span with the organization within the measurement year. Count each visit to an ED that does not result in an inpatient encounter once; count multiple ED visits on the same date of service as one visit. Emergency Department visits are specified by the following codes:

ED Value Set	
CPT	**UB Revenue**
99281-99285	0450, 0451, 0452, 0456, 0459, 0981

OR

ED Procedure Code Value Set		ED POS Value Set
CPT		**POS**
Total of 5,843 CPT codes are included. See HEDIS MY2020/2021 Value Set Dictionary for detail	With	23

Do not include ED visits that result in an inpatient stay (Inpatient Stay Value Set).

HEDIS MY2020/2021 General Guideline 44: When an outpatient, ED or observation visit and an inpatient stay are billed on separate claims, the visit results in a stay when the visit date of service occurs on the day prior to the admission date or any time during the admission (admission date through discharge date). A visit billed on the same claim as a stay is considered a visit that resulted in a stay

Inpatient Stay Visits Value Set	
UBREV	0100, 0101, 0110 – 0114, 0116 – 0124, 0126 – 0134, 0136 – 0144, 0146 – 0154, 0156 – 0160, 0164, 0167, 0169 – 0174, 0179, 0190 – 0194, 0199 – 0204, 0206 – 0214, 0219, 1000 – 1002

Required exclusions for numerator: Mental health and chemical dependency services are excluded, using the following codes. Note OHA applies the exclusions at the claim line level and keeps all paid ED claim lines that do not have the exclusion codes, i.e., unless the entire claim was denied or all claim lines qualify for exclusion, the remaining paid lines without mental health and chemical dependency services would pass through the algorithm.

Mental and Behavioral Disorders Value Set
***Principal* ICD-10 CM Diagnosis**
Total of 745 diagnosis codes are included. See HEDIS MY2020/2021 Value Set Dictionary for detail

OR

Psychiatry Value Set
CPT
90785, 90791, 90792, 90832 – 90834, 90836 – 90840, 90845 – 90847, 90849, 90853, 90863, 90865, 90867 - 90870, 90875, 90876, 90880, 90882, 90885, 90887, 90889, 90899

OR

Electroconvulsive Therapy Value Set	
CPT	**ICD-10 PCS Procedure**
90870	GZB0ZZZ, GZB1ZZZ, GZB2ZZZ, GZB3ZZZ, GZB4ZZZ

Deviations from cited specifications for numerator: None.

Lead Screening in Children (LSC)

SUMMARY OF CHANGES TO HEDIS MY 2020 & MY 2021

- Removed the limits to the Ages column in the *Rules for Allowable Adjustment of HEDIS* section.

Description

The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.

Eligible Population

Note: *Members in hospice are excluded from the eligible population. If an organization reports this measure using the Hybrid method, and a member is found to be in hospice or using hospice services during medical record review, the member is removed from the sample and replaced by a member from the oversample. Refer to General Guideline 17: Members in Hospice.*

Product line	Medicaid.
Age	Children who turn 2 years old during the measurement year.
Continuous enrollment	12 months prior to the child's second birthday.
Allowable gap	No more than one gap in enrollment of up to 45 days during the 12 months prior to the child's second birthday. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	Enrolled on the child's second birthday.
Benefit	Medical.
Event/diagnosis	None.

Administrative Specification

Denominator	The eligible population.
Numerator	At least one lead capillary or venous blood test (Lead Tests Value Set) on or before the child's second birthday.

Hybrid Specification

Denominator

A systematic sample drawn from the eligible population.

Organizations that use the Hybrid Method to report the *Childhood Immunization Status* and *Lead Screening in Children* measures may use the same sample for both measures. If an organization applies optional exclusions to the CIS measure and uses the CIS systematic sample, the same children will be excluded from the LSC measure. Excluding these members will not create a statistically significant difference in the LSC eligible population.

Organizations may reduce the sample size based on the current year's administrative rate or prior year's audited, product line-specific rate for the lowest rate of all CIS antigens, CIS combinations and LSC rate.

If a separate sample from the CIS measure is used for LSC, organizations may reduce the sample based on the product line-specific current measurement year's administrative rate or the prior year's audited, product line-specific rate for LSC.

Numerator

At least one lead capillary or venous blood test on or before the child's second birthday as documented through either administrative data or medical record review.

Administrative

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

Medical record

Documentation in the medical record must include both of the following:

- A note indicating the date the test was performed.
- The result or finding.

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table LSC-1: Data Elements for Lead Screening in Children

	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (Administrative or Hybrid)	✓	✓
Eligible population	✓	✓
Number of numerator events by administrative data in eligible population (before exclusions)		✓
Current year's administrative rate (before exclusions)		✓
Minimum required sample size (MRSS)		✓
Oversampling rate		✓
Number of oversample records		✓
Number of medical records excluded because of valid data errors		✓
Number of administrative records excluded		✓
Number of medical records excluded		✓
Number of employee/dependent medical records excluded		✓
Records added from the oversample list		✓
Denominator		✓
Numerator events by administrative data	✓	✓
Numerator events by medical records		✓
Numerator events by supplemental data	✓	✓
Reported rate	✓	✓

Health Equity Measure: Meaningful Access to Health Care Services for persons with limited English proficiency – MY2021 to MY2023

Measure Basic Information

Name and date of specifications used: The measure specifications were developed by OHA in collaboration with a Health Equity Measure Workgroup.

URL of Specifications: N/A.

Measure Type:

☐HEDIS ☐PQI ☐Survey ■Other Specify: OHA-developed

Measure Utility:

■CCO Incentive ■State Quality ☐CMS Adult Core Set ☐CMS Child Core Set ☐Other Specify:

Data Source: Hybrid and CCO attestation

Measurement Period: January 1, 2021 – December 31, 2021; January 1, 2022 – December 31, 2022; January 1, 2023 – December 31, 2023

2021 Benchmark:

Component 1 – CCO language access self-assessment: minimum points required = 46

Component 2 – N/A

2022 Benchmark:

Component 1 – CCO language access self-assessment: minimum points required = 56

Component 2 – Must report; 2022 is sampled hybrid quantitative report

2023 Benchmark:

Component 1 – CCO language access self-assessment: minimum points required = 77

Component 2 – TBD percentage of interpreter services provided by certified or qualified interpreters (benchmark based on 2022 results); 2023 is CCO hybrid quantitative report for the full eligible population.

Note on telehealth: This measure is telehealth eligible, however, visits without human interaction can be excluded, such as online assessment forms or remote monitoring of blood sugar, blood pressure readings. For further information specific to Oregon, the Health Evidence Review Commission (HERC) has provided this guideline on telehealth services.

Measure Details

Measure Components and Scoring

There are two components in this measure:

(1) CCO language access self-assessment survey – starting MY2021
(2) Quantitative language access report – MY2022 with sampled hybrid review (OHA to provide sample), and starting MY2023, CCO to report the full eligible population and all visits from members with interpreter needs.

Component 1: CCO language access self-assessment survey – Starting MY2021

This measure promotes high quality language services for all Medicaid members. The self-assessment guides your CCO to progressively higher quality and a more robust infrastructure of language services over time. For each measurement year, the CCO must: (1) answer all survey questions, (2) pass the questions required for that measurement period, and (3) meet the minimum points required for each measurement year.

See Appendix 1 for the survey template, and Appendix 2 for point value summary.

Total possible points = 89

- Year 1 minimum points required = 46 or 52%
- Year 2 minimum points required = 56 or 63%
- Year 3 minimum points required = 77 or 87%

	MY 1 (2021)		MY 2 (2022)		MY 3 (2023)	
	Total Points	**Minimum required**	Total Points	**Additional minimum required**	Total Points	**Additional minimum required**
Domain 1: Identification and assessment for communication needs - This domain assesses how well your CCO identifies and tracks services to the Limited English Proficient (LEP), and Deaf and hard of hearing populations you serve.	18	**16**	**4**	**3**	**4**	**4**
Domain 2: Provision of Language Assistance Services - This domain assesses how well you use data and work processes to effectively communicate with the Limited English Proficient (LEP), and Deaf and hard of hearing populations you serve.	26	**23**	3	**3**	19	**16**

Domain 3: Training of staff on policies and procedures - This domain assesses how well your staff who provide services to Limited English Proficient (LEP), and Deaf and hard of hearing populations is trained on language access policies and procedures.	1	**1**	4	**3**	1	**1**
Domain 4: Providing notice of language assistance services - This domain assesses how well your CCO translates outreach materials and explains how Limited English Proficient (LEP), and Deaf and hard of hearing populations you serve may access available language assistance services.	8	**6**	1	**1**	0	**0**
Total minimum required points in MY		**46**		**56**		**77**

CCO must attest to have met all the must-pass items to meet Component 1 each year. No partial credit will be given. OHA reserves the right to audit whether the content of the language access plan meets the requirements above.

Component 2: Percent of member visits with interpreter need in which interpreter services were provided – Starting MY2022

Eligible population: Members to be included in the denominator visits.

> **MY2022**: OHA to sample 30% or up to 411 members per CCO[1] who are identified with interpreter needs as of December 31, 2021. They are identified based on MMIS for low English proficiency (LEP; IND_INTERPRETER = Y) or with sign language needs (IND_SL_INTERPRETER = Y). CCO may request to adjust the sample member list based on information available, such as data inaccuracy in MMIS or to substitute with additional members self-identified to the CCO[2].
>
> **MY2023**: CCO to report on the full eligible population for all members identified with interpreter needs in MMIS and other available data sources in 2023.
>
> **Continuous enrollment criteria:** None.
>
> **Anchor date:** None.

Data elements required denominator: Total number of visits during the measurement year from the Eligible Population (members who self-identified with interpreter needs), regardless of whether interpreter services were provided. Only visits during a member's enrollment span with a CCO are required to be reported.

[1] Sample size TBD, pending discussion with CCOs in the Learning Collaborative starting in Spring 2021.
[2] Process for sample member substitution TBD.

The CCO is responsible for reporting all required denominator visits, at the visit level, using the data system(s) best suited for their collection method. The CCO is also required to indicate the visit date, member ID and whether the member already has interpreter needs flag(s) in MMIS/834 file. The following stratifications are required:

By type of care:

- Physical health
- Mental/Behavioral health
- Dental health

By care setting:

- Inpatient Stay
- Emergency Department
- Office Outpatient
- Home Health
- Telehealth
- Other

(see Appendix 3 for quantitative interpreter services reporting template.)

Data elements required denominator exclusion:

- Visits only involving pharmacy, or other ancillary services (such as lab, DME, ambulance transportation, supportive housing, etc.) can be excluded from the denominator reporting.
- Telemedicine visits without human interaction can be excluded, such as online assessment forms or remote monitoring of blood sugar, blood pressure readings.
- CCO can also document if a member refuses the interpreter service, and the visit can be excluded[3].

Note on OHA validation for the denominator visits: OHA performs validation on the portion of eligible population known to OHA (those with interpreter needs flagged in MMIS) and counts the total denominator visits from MMIS/DSSURS claims. OHA utilizes an existing, homegrown Oregon Health Grouper (OHG) and re-categorize claims into the 'type of care' and 'care setting' stratifications for this measure; certain OHG categories are also identified for denominator exclusion. The grouping method and OHG-to-HEM crosswalk table is provided in Appendix 4. For CCOs using claims to report the denominator visits, OHA suggests following the method, but it is not required.

Data elements required numerator: Total number of visits provided with interpreter services. See Appendix 3 for quantitative interpreter services reporting template.

CCO is responsible for tracking and reporting the numerator visits on the reporting with the following stratification:

[3] Note, if a member has interpreter needs indicated in MMIS but regularly refuses interpreter services, the CCO could work with the member to submit MMIS member information correction request with OHP member customer service.

- Services provided by certified, qualified, or non-certified or qualified interpreters – incentive measure based on higher proportion of interpreter services provided by certified or qualified providers - incentive
- Modality of the interpreter services (in-person, telephonic, video remote) - reporting-only, measure is not incentivized for certain modalities of the services.
- Services provided by clinic staff versus contracted language provider – reporting-only.

Note: MY2022 is a reporting-only year for sampled review, but the CCO must report to achieve Component 2. Starting MY2023 OHA will set benchmark and CCO-specific improvement targets for 'percentage of interpreter services provided by certified or qualified interpreters' to determine whether the CCO meets the component.

Data elements required numerator exclusion: none.

Incentive Measure Rate Calculation: Percentage of interpreter services provided by certified or qualified interpreters = Total number of visits with interpreter services provided by certified or qualified interpreters / Total number of visits from members in the eligible population[4]

Note, visits by the eligible members that were not provided with interpreter services, count as '0' for numerator hits; visits with interpreter services by providers that are not certified or qualified, count as '0' for numerator hits.

OHA will report other non-incentive rates for observations, including 'total percentage of visits provided with any interpreter services,' percentage of visits provided with interpreter services by visit types (inpatient, outpatient, mental health, dental, etc.), and percentage of interpreter services by different modality.

Version Control

- The specifications were updated on December 29, 2020:
  - Clarified CCOs are responsible for reporting the measure Component 2 denominator visits with required stratifications, but also introduced a new method using OHG and additional cross-walking and de-duplication methods for OHA to validate the CCO-reported denominator visits. Additional detail added in Appendix 4. (Note, OHA no longer uses HEDIS value sets for this measure).
  - Clarified the incentive measure rate which uses 'the total visits from members with interpreter needs' as the denominator, instead of only the visits when interpreter services were provided.

[4] The measure denominator is NOT restricted to only the visits when interpreter services were provided.

Appendix 1: CCO language self-assessment: Meaningful language access to culturally- responsive health care services (starting MY2021)

Introduction

This online survey asks each Coordinated Care Organization (CCO) to conduct a self-assessment on language services available in your organization. Your responses will be used to determine whether your CCO meets the 2021 incentive metric reporting requirements. Completion of the survey does not guarantee that CCOs have met the metric.

CCOs must answer all questions and meet the minimum points required for the questions marked as must pass for that measurement year (e.g. Must pass beginning in measurement year 2021 – year 1). Questions have a point value and are organized by measurement year within each of the four domains. In general, each statement is worth one point and some questions have multiple statements.

Answers should be based on language services in place on the final day of the measurement year **(December 31, 2021)**. Survey responses are due on or before the 3rd Monday of January following the measurement year (MY). These dates are as follows:

MY2021: Due January 17, 2022
MY2022: Due January 16, 2023
MY2023: Due January 15, 2024

Self-assessment requirements

This measure promotes high quality language services for all Medicaid members. The self-assessment guides your CCO to progressively higher quality and a more robust infrastructure of language services over time. For each measurement year, the CCO must: (1) answer all survey questions, (2) pass the questions required for that measurement period, and (3) meet the minimum points required for each measurement year.

Total possible points = 89

- Year 1 minimum points required = 46 or 52%
- Year 2 minimum points required = 56 or 63%
- Year 3 minimum points required = 77 or 87%

Additional Information

OHA reserves the right to request additional or clarifying information to support responses provided through this survey, including but not limited to further detail on data collected, example policies, or translated materials.

For questions about this survey, or the CCO incentive metric, please contact metrics.questions@state.or.us.

Contact Information

The contact person is the one completing the survey and the first point of contact if OHA has any follow-up or clarifying questions about survey responses. If multiple individuals for the same CCO submit survey responses, OHA will follow-up with the CCO as to which of the respondents should be the primary contact.

Name: _____

CCO Name: _____

Email Address: _____

Domain 1: Identification and assessment for communication needs

Questions in this domain assess how well your CCO identifies and tracks services to the Limited English Proficient (LEP), and Deaf and hard of hearing populations you serve.

CCOs should answer questions based on language services in place on December 31, 2021. Your responses will help OHA to evaluate how well your CCO is performing these critical meaningful language access functions.

1) **Must pass beginning in measurement year 2021 (year 1)**
CCOs must answer "yes" to at least five of the seven statements to meet the must pass criteria for this question.
Minimum points required = 5
Total points possible = 7

Please answer yes or no for each of the following statements on how your CCO identifies members needing communication access (e.g. LEP, sign language users).

	Yes	**No**
The CCO has a **process to respond to individual requests** for language assistance services (including sign language).	( )	( )
The CCO has a **process for self-identification** by the Deaf or hard of hearing person, non-English speaker or LEP individual.	( )	( )
The CCO has a **process for using open-ended questions** to determine language proficiency on the telephone or in person.	( )	( )
The CCO customer service staff are **trained to use video relay or TTY** for patient services.	( )	( )
The CCO **uses "I Speak" language identification cards** or posters.	( )	( )
The CCO has a **process for responding to member complaints** about language access and clearly communicates this process to all members.	( )	( )
The CCO **uses MMIS/ enrollment data** from OHA about primary language.	( )	( )

2) **Must pass beginning in measurement year 2021 (year 1)**
CCOs must answer "yes" to all statements to meet the must pass criteria for this question.
Minimum points required = 3
Total points possible = 3

Please answer yes or no for each of the following statements about collecting data.

	Yes	**No**
The CCO collects data on the **number of members served who are Limited English Proficient (LEP)**.	( )	( )
The CCO collects data on the **number of members served who are Deaf and hard of hearing**.	( )	( )
The CCO collects data on the **number and prevalence of languages spoken by members** in your service area.	( )	( )

3) **Must pass beginning in measurement year 2021 (year 1)**
CCOs must answer "yes" to all statements to meet the must pass criteria for this question.
Minimum points required = 2
Total points possible = 2

Please answer yes or no for each of the following data sources that your CCO uses to determine needs and/or population size of the LEP and Deaf and hard of hearing members in your service area.

	Yes	**No**
OHA MMIS	( )	( )
Information on member interpreter needs collected by CCO	( )	( )

4) **Must pass beginning in measurement year 2021 (year 1)**
CCOs must answer "yes" to meet the must pass criteria for this question. (total points = 1)

Does your CCO record the primary language from LEP or Deaf and hard of hearing members when they first contact your CCO (for example, at intake or first encounter)?
( ) Yes
( ) No

5) Must pass beginning in measurement year 2021 (year 1)
CCOs must answer "yes" to meet the must pass criteria for this question. (total points = 1)

Does your CCO have a process for sharing information about members who need spoken and sign language interpretation with your provider network?
( ) Yes
( ) No

6) **Must pass beginning in measurement year 2021 (year 1)**
CCOs must answer this question to meet the must pass criteria. (total points = 1)

If yes to the previous question, please briefly describe how your CCO shares primary spoken language or hearing assistance needs with provider networks or service coordinators.

_____

7) **Must pass beginning in measurement year 2021 (year 1)**
CCOs must answer this question to meet the must pass criteria. (total points = 1)

If yes to question 5, how frequently do you share this information?
( ) At least Weekly
( ) At least Monthly
( ) At least Quarterly
( ) At least Annually

8) **Must pass beginning in measurement year 2021 (year 1)**
CCOs must answer "yes" to meet the must pass criteria for this question. (total points = 1)

Does your CCO have the capability to identify the number of members needing spoken and sign language interpretation services that were not identified in the form 834 from OHA?
( ) Yes
( ) No

9) **Must pass beginning in measurement year 2021 (year 1)**
CCOs must fill in the required languages to meet the must pass criteria for this question. (total points = 1)

Please list the top SIX most frequently encountered spoken and sign languages by your CCO for the measurement year.

Write in language

10) **Must pass beginning in measurement year 2022 (year 2)**
CCOs must answer "yes" to at least three of the four statements to meet the must pass criteria for this question.
Minimum points required = 3
Total points possible = 4

Please answer yes or no for each of the following statements about members that refused, did not need or needed interpretation services but were not identified as such.

	Yes	**No**
The CCO collects data on the number of members served **who self-identified as LEP but refused interpretation services**.	( )	( )
The CCO collects data on the number of members served **who are Deaf and hard of hearing but refused interpretation services**.	( )	( )
The CCO collects data on the number of members served who **did not have MMIS language flag but requested interpreter services**.	( )	( )
The CCO collects data on the number of members served who **had an MMIS language flag but did not need interpreter services.**	( )	( )

11) **Must pass beginning in measurement year 2023 (year 3)**
CCOs must answer "yes" to all statements to meet the must pass criteria for this question.
Minimum points required = 2
Total points possible = 2

Please answer yes or no for each of the following statements about appointment wait times.

	Yes	**No**
The CCO collects data on the wait times for **LEP members** that need appointments with interpreter services.	( )	( )
The CCO collects data on the wait times for **Deaf and hard of hearing members** that need appointments with interpreter services.	( )	( )

12) **Must pass beginning in measurement year 2023 (year 3)**
The best practice is a wait time of fewer than seven days, however any answer is acceptable to meet the must pass criteria.
Minimum points required = 2
Total points possible = 2

Please mark the average wait time for the each of the following appointments. (choose only one answer per statement).

	Same day	**1-3 days**	**4-7 days**	**More than 7 days**
The average wait time for Limited English Proficient members needing interpretation services is:	( )	( )	( )	( )
The average wait time for Deaf and hard of hearing members needing interpretation services is:	( )	( )	( )	( )

CCOs are required to answer all questions. No point value.
13) What is the average wait time for members that do not need interpreter services?
( ) Same day
( ) 1-3 days
( ) 4-7 days
( ) More than 7 days
( ) The CCO does not collect this information

CCOs are required to answer all questions. No point value.
14) How frequently do you track the average number of encounters by spoken and sign languages and share the data with provider networks or service coordinators?
( ) At least Weekly
( ) At least Monthly
( ) At least Quarterly
( ) At least Annually

CCOs are required to answer all questions. No point value.
15) Does your CCO have a process for identifying the total number of Deaf and hard of hearing members that prefer sign language or assistive communication devices to ensure effective communication in your CCO and provider network?
( ) Yes
( ) No

CCOs are required to answer all questions. No point value.
16) Does your CCO use local community organizations and/or on-line data (e.g. LEP.gov, census data) to determine needs and/or population size of the LEP and Deaf and hard of hearing members in your service area?
( ) Yes
( ) No

CCOs are required to answer all questions. No point value.
17) How often does your CCO use OHA MMIS data, CCO enrollment data, or data from other external sources to assess LEP and Deaf and hard of hearing member needs?
( ) At least Monthly
( ) At least Quarterly
( ) At least Annually

Domain 2: Provision of Language Assistance Services

Questions in this domain assess how well you use data and work processes to effectively communicate with the Limited English Proficient (LEP), and Deaf and hard of hearing populations you serve.

CCOs should answer questions based on language services in place on December 31, 2021. Your responses will help OHA to evaluate how well your CCO is performing these critical meaningful language access functions.

18) **Must pass beginning in measurement year 2021 (year 1)**
CCOs must answer "yes" to at least three of the four statements to meet the must pass criteria for this question.
Minimum points required = 3
Total points possible = 4

Please answer yes or no to each of the following statements about tracking language assistance services at the CCO and provider network levels.

	Yes	**No**
The CCO tracks **the primary language** of persons encountered or served.	( )	( )
The CCO tracks **the use of language assistance services** such as interpreters and translators.	( )	( )
The CCO tracks **bilingual and sign language staff time spent** on language assistance services.	( )	( )
The CCO tracks **the use of spoken and sign language assistance services by modality** (in-person; telephonic, video remote, other modalities).	( )	( )

19) **Must pass beginning in measurement year 2021 (year 1)**
CCOs must answer "yes" to at least five of the seven statements to meet the must pass criteria for this question.
Minimum points required = 5
Total points possible = 7

Please select yes or no to the types of language assistance services that are provided by your CCO and provider network.

	Yes	**No**
Bilingual staff and providers	( )	( )
In-house interpreters (spoken and sign)	( )	( )
In-house translators (for documents)	( )	( )
Contracted in-person interpreters	( )	( )
Contracted translators	( )	( )
Contracted telephonic interpretation services	( )	( )
Contracted video interpretation services	( )	( )

20) **Must pass beginning in measurement year 2021 (year 1)**
CCOs must answer "yes" to all statements to meet the must pass criteria for this question.
Minimum points required = 5
Total points possible = 5

Please select yes or no to the following care delivery settings in which your CCO provides spoken and sign language interpretation service for member visits.

	Yes	**No**
Inpatient Stay	( )	( )
Emergency Department	( )	( )
Office Outpatient	( )	( )

Home Health	( )	( )
Telehealth	( )	( )

21) **Must pass beginning in measurement year 2021 (year 1)**
CCOs must answer "yes" to meet the must pass criteria for this question. (total points = 1)

Does your CCO and provider network have policies on the use of family members or friends to provide interpretation services?
( ) Yes
( ) No

22) **Must pass beginning in measurement year 2021 (year 1)**
CCOs must answer this question to meet the must pass criteria. (total points = 1)

If yes to the previous question, please briefly describe your policies on when or how family members or friends can provide interpretation services.

_____

23) **Must pass beginning in measurement year 2021 (year 1)**
CCOs must answer "yes" to meet the must pass criteria for this question. (total points = 1)

Does your CCO provide staff who coordinate interpreter services with information on how to access OHA approved spoken and sign language interpreters?
( ) Yes
( ) No

24) **Must pass beginning in measurement year 2021 (year 1)**
CCOs must answer "yes" to all statements to meet the must pass criteria for this question.
Minimum points required = 6
Total points possible = 6

Please select yes or no to each of the following statements about the translation of vital written documents into non-English languages.

	Yes	**No**
Consent forms are translated into non-English languages.	( )	( )
Complaint forms are translated into non-English languages.	( )	( )

Intake forms are translated into non-English languages.	( )	( )
Notices of rights are translated into non-English languages.	( )	( )
Notice of denial, loss or decrease in benefits or services are translated into non-English languages.	( )	( )
Information on programs or activities to receive additional benefits or services are translated into non-English languages.	( )	( )

25) **Must pass beginning in measurement year 2021 (year 1)**
CCOs must answer "yes" to meet the must pass criteria for this question. (total points = 1)

Are the translated documents available in alternate formats that include large prints or braille?
( ) Yes
( ) No

26) **Must pass beginning in measurement year 2022 (year 2)**
CCOs must answer "yes" to at least four of the six statements to meet the must pass criteria for this question.
Minimum points required = 3
Total points possible = 3

Does your CCO track the following data regarding language assistance services provided by the CCO and provider network? Please mark yes or no for each of the following statements.

	Yes	**No**
The CCO **validates invoices** from interpreting agencies to ensure they include member level details.	( )	( )
The CCO **compares invoice information with an internal data system** (for example MMIS flag) to confirm member level details.	( )	( )
The CCO **tracks invoices by service modality** (in-person, telephonic, video remote).	( )	( )

27) **Must pass beginning in measurement year 2023 (year 3)**
CCOs must answer "yes" to at least three of the four statements to meet the must pass criteria for this question.
Minimum points required = 3
Total points possible = 4

Please answer yes or no to each of the following statements about tracking language assistance services at the CCO and provider network levels.

	Yes	**No**
The CCO tracks training and **OHA credentialing of contracted interpreters**.	( )	( )
The CCO tracks training and **OHA credentialing of staff members who interpret for patients** (such as full-time staff interpreters or dual-role interpreters).	( )	( )
The CCO tracks the **total cost of interpreter services**.	( )	( )
The CCO tracks the **cost of translation of materials** into non-English languages.	( )	( )

28) **Must pass beginning in measurement year 2023 (year 3)**
CCOs must answer "yes" to at least five of the seven statements to meet the must pass criteria for this question.
Minimum points required = 5
Total points possible = 7

Please select yes or no to the language assistance services that your CCO can provide detailed member level information, such as member ID, date of service, and interpreters' credential.

	Yes	**No**
Bilingual staff and providers	( )	( )
In-house interpreters (spoken and sign)	( )	( )
In-house translators (for documents)	( )	( )
Contracted in-person interpreters	( )	( )

Contracted translators	( )	( )
Contracted telephonic interpretation services	( )	( )
Contracted video interpretation services	( )	( )

29) **Must pass beginning in measurement year 2023 (year 3)**
CCOs must answer "yes" to all statements to meet the must pass criteria for this question.
Minimum points required = 5
Total points possible = 5

When spoken and sign language interpretation services are provided during member visits, can your CCO collect detailed member level information (such as member ID, date of service, and interpreter's credential) for appointments in each of the following care delivery settings? Please select yes or no to the following statements.

	Yes	**No**
Inpatient Stay	( )	( )
Emergency Department	( )	( )
Office Outpatient	( )	( )
Home Health	( )	( )
Telehealth	( )	( )

30) **Must pass beginning in measurement year 2023 (year 3)**
CCOs must answer "yes" to all statements to meet the must pass criteria for this question.
Minimum points required = 2
Total points possible = 2

Please answer yes or no to the following statements related to standardized proficiency assessments for bilingual staff and interpreters.

	Yes	**No**

For Limited English Proficient (LEP) members, the CCO requires a standardized proficiency assessment for bilingual staff interpreters and or bilingual providers before allowing them to interpret or translate documents.	( )	( )
For Deaf and hard of hearing members, the CCO requires a standardized proficiency assessment for bilingual staff interpreters and or bilingual providers before allowing them to interpret.	( )	( )

31) **Must pass beginning in measurement year 2023 (year 3)**
CCOs must answer this question to meet the must pass criteria. (total points = 1)

If yes to either statements in the previous question, please briefly describe your proficiency assessment. (For example, online training, in person training, scored skill test).

_____

CCOs are required to answer all questions. No point value.
32) Please select yes or no to the care delivery settings in which your CCO provides spoken and sign language interpretation service for member visits.

	Yes	**No**
Pharmacy services	( )	( )
Other services such as lab	( )	( )

CCOs are required to answer all questions. No point value.
33) When spoken and sign language interpretation services are provided during member visits, can your CCO collect detailed member level information (such as member ID, date of service, and interpreter's credential) for appointments in each of the following care delivery settings? Please select yes or no to the following statements.

	Yes	**No**
Pharmacy services	( )	( )
Other services such as lab	( )	( )

Domain 3: Training of staff on policies and procedures

Questions in this domain assess how well your staff who provide services to Limited English Proficient (LEP), and Deaf and hard of hearing populations is trained on language access policies and procedures.

CCOs should answer questions based on language services in place on December 31, 2021. Your responses will help OHA to evaluate how well your CCO is performing these critical meaningful language access functions.

34) **Must pass beginning in measurement year 1 (2021)**
CCOs must answer "yes" to meet the must pass criteria for this question. (total points = 1)

Does your CCO staff procedures handbook include specific instructions on how to provide language assistance services to LEP and Deaf and hard of hearing members?
( ) Yes
( ) No

35) **Must pass beginning in measurement year 2 (2022)**
CCOs must answer "yes" to at least three of the four statements to meet the must pass criteria for this question.
Minimum points required = 3
Total points possible = 4

Please select yes or no to each of the following staff groups that receive **training at regular intervals** on working with Limited English Proficient (LEP) and Deaf and hard of hearing members.

	Yes	**No**
Management or senior staff	( )	( )
Employees who interact with or are responsible for interactions with non-English speakers or LEP members	( )	( )
Bilingual staff and providers	( )	( )
New employees	( )	( )

36) **Must pass beginning in measurement year 3 (2023)**
CCOs must answer "yes" to meet the must pass criteria for this question. (total points = 1)

Are staff members who interpret for patients (such as full-time staff interpreters or dual-role interpreters) trained and certified or qualified by OHA?
( ) Yes
( ) No

CCOs are required to answer all questions. No point value.
37) Do staff who provide care or services to Limited English Proficient (LEP) and Deaf and hard of hearing members receive **training at regular intervals** on how to request the translation of written documents into other languages and alternate formats?
( ) Yes
( ) No

Domain 4: Providing notice of language assistance services

Questions in this domain assess how well your CCO translates outreach materials and explains how Limited English Proficient (LEP), and Deaf and hard of hearing populations you serve may access available language assistance services.

CCOs should answer questions based on language services in place on December 31, 2021. Your responses will help OHA to evaluate how well your CCO is performing these critical meaningful language access functions.

38) ***Must pass beginning in measurement year 2021 (year 1)***
CCOs must answer "yes" to meet the must pass criteria for this question. (total points = 1)

Does your CCO translate signs or posters announcing the availability of language assistance services?
( ) Yes
( ) No

39) **Must pass beginning in measurement year 1 (2021)**
CCOs must answer "yes" to at least four of the six statements to meet the must pass criteria for this question.
Minimum points required = 4
Total points possible = 6

Please answer yes or no to the methods that your CCO uses to inform members and communities in your service area about the availability of language assistance services.

	Yes	**No**
Frontline and outreach by multilingual staff	( )	( )
Posters in public areas	( )	( )
"I Speak" language identification cards distributed to frontline staff	( )	( )
Website	( )	( )
Social networking websites (e.g. Facebook, Twitter, other)	( )	( )
E-mail to members or a list serv	( )	( )

40) **Must pass beginning in measurement year 1 (2021)**
CCOs must answer "yes" to meet the must pass criteria for this question. (total points = 1)

Does your CCO inform LEP and Deaf and hard of hearing members about the availability of free language assistance services?
( ) Yes
( ) No

41) **Must pass beginning in measurement year 2 (2022)**
CCOs must answer "yes" to meet the must pass criteria for this question. (total points = 1)

Does the main page of your website include non-English information that is easily accessible to LEP members?
( ) Yes
( ) No

Thank You!

Thank you for taking our survey. Your response is very important to us.

Appendix 2: CCO self-assessment available points and minimum required point value summary

Total possible points for each measurement year =	**89**	
Year 1 minimum points required =	46	52%
Year 2 minimum points required =	56	63%
Year 3 minimum points required =	77	87%

	MY 1 (2021)		MY 2 (2022)		MY 3 (2023)	
	Total Points	**Minimum required**	Total Points	**Additional minimum required**	Total Points	**Additional minimum required**
Domain 1: Identification and assessment for communication needs - This domain assesses how well your CCO identifies and tracks services to the Limited English Proficient (LEP), and Deaf and hard of hearing populations you serve.	18	**16**	**4**	**3**	**4**	**4**
Domain 2: Provision of Language Assistance Services - This domain assesses how well you use data and work processes to effectively communicate with the Limited English Proficient (LEP), and Deaf and hard of hearing populations you serve.	26	23	3	3	19	16
Domain 3: Training of staff on policies and procedures - This domain assesses how well your staff who provide services to Limited English Proficient (LEP), and Deaf and hard of hearing populations is trained on language access policies and procedures.	1	1	4	3	1	1

Domain 4: Providing notice of language assistance services - This domain assesses how well your CCO translates outreach materials and explains how Limited English Proficient (LEP), and Deaf and hard of hearing populations you serve may access available language assistance services.	8	6	1	1	0	0

Point value for each question

Question	year 1	**minimum**	Year 2	**minimum**	Year 3	**minimum**
1	7	**5**				
2	3	**3**				
3	2	**2**				
4	1	**1**				
5	1	**1**				
6	1	**1**				
7	1	**1**				
8	1	**1**				
9	1	**1**				
10			4	**3**		
11					2	**2**
12					2	**2**
13	0					
14	0					
15	0					
16	0					
17	0					
18	4	**3**				
19	7	**5**				
20	5	**5**				
21	1	**1**				
22	1	**1**				
23	1	**1**				
24	6	**6**				
25	1	**1**				
26			3	**3**		
27					4	**3**

28					7	**5**
29					5	**5**
30					2	**2**
31					1	**1**
32	0					
33	0					
34	1	**1**				
35			4	**3**		
36					1	**1**
37	0					
38	1	**1**				
39	6	**4**				
40	1	**1**				
41			1	**1**		
Total points by year and by domain	53	46	12	10	24	21
Minimum required by measurement year		**46**		**56**		**77**

Appendix 3: Quantitative Interpreter Services Reporting Template (starting MY2022)

Health Care Interpreter Services Utilization by CCOs and Provider Network		
Component 2: Template for Reporting Stratified Individual Level Services		
Column Name	**Valid Input Value**	**Additional Instructions**
Member ID	Member's Medicaid ID	
Interpreter need flagged in MMIS	Yes No	Data available in MMIS/834 member enrollment file
Type of Care	Physical Dental Mental/Behavioral	Report separately if a member had more than one type of care on the same day. (See Appendix 4 for reference on OHA's method)
Visit Type/Care Setting	Inpatient Stay Emergency Department Office Outpatient Home Health Telehealth Other	If multiple visit types/care settings occurred on the same day, then please select one type of visit **using the order of selections as a hierarchy: Inpatient Stay > Emergency Department > Office Outpatient > Home Health> Telehealth > Other**. For example, report as 'emergency department' visits only when it did not result in an inpatient stay; if an office outpatient visit and telehealth occurred on the same day, report the office outpatient visit, etc. **Do not report as a visit when only filling prescriptions at a pharmacy is involved on that date. Ancillary or services without human interaction can also be excluded.** (See Appendix 4 for reference on OHA's method)
Visit Date	Visit Date YYYY/MM/DD	**Please report only one visit per member per day**. For an inpatient stay, report the admission date as the visit date, and report one inpatient stay in a facility as one visit regardless of the total length of stay; count as a separate inpatient stay, if the patient is transferred to a different facility.
In-person Interpreter Service	Yes No	Report all that apply during the visit date/inpatient stay
Telephonic Interpreter Service	Yes No	
Video Remote Interpreter Service	Yes No	
Was the Interpreter OHA Certified or Qualified	OHA Certified OHA Qualified Not Certified or Qualified by OHA	

Interpreter's OHA Registry Number	OHA Registry number	
Was the Interpreter a Bilingual Staff	Yes No	
Did the member refuse Interpreter Service	Yes No	

Note: CCO to submit a data table with 'one row per visit' using the columns specified above. This NOT a "form" to fill in for each visit.

Appendix 4: Categorizing Denominator Visits based on Oregon Health Grouper (OHG) and modifications

OHA uses a homegrown Oregon Health Grouper (OHG) with recategorization and modifications to count denominator visits in the required stratifications for the measure[5].

Step1: All MMIS/DSSURS claims data are categorized into OHG categories, then rolled up into larger categories using the following crosswalk table below. Note, only paid claims are used.

OHG-to-HEM Crosswalk Table:

CDE OHG	OHG Description	HEM Type of Care	HEM Care Setting
D-01	Dental Diagnostic	dental	Office Outpatient
D-02	Dental Preventative	dental	Office Outpatient
D-03	Dental Restorative	dental	Office Outpatient
D-04	Dental Endodontics	dental	Office Outpatient
D-05	Dental Periodontics	dental	Office Outpatient
D-06	Dental Prosthodontics Removable	dental	Office Outpatient
D-07	Dental Implants/ Prosthodontics Fixed	dental	Office Outpatient
D-08	Dental Oral Maxillofacial Surgery	dental	Office Outpatient
D-09	Dental Orthodontics	dental	Office Outpatient
D-10	Dental Anesthesia	dental	Office Outpatient
D-99	Dental Adjuctive General Services (Unbucketed)	dental	Office Outpatient
I-08	Inpatient Maternity C-Section Delivery	physical	Inpatient
I-09	Inpatient Maternity Non-Delivery	physical	Inpatient
I-10	Inpatient Maternity Normal	physical	Inpatient
I-11A	Inpatient Newborn Complicated	physical	Inpatient
I-11B	Inpatient Newborn Well	physical	Inpatient
I-12	Inpatient Rehabilitation	physical	Inpatient
I-13	Inpatient Medical/Surgical (Medical Only)	physical	Inpatient
I-14	Inpatient Medical/Surgical (Surgical Only)	physical	Inpatient
I-15	Inpatient Un-Bucketed Missing DRG	physical	Inpatient
I-99	Inpatient Unbucketed	physical	Inpatient
M-01	Emergency Lifeflight	exclude	exclude

[5] More detail documentation in excel format is available on the metrics website: https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx

CDE OHG	OHG Description	HEM Type of Care	HEM Care Setting
M-02	School Based Services	physical	Office Outpatient
M-03	Transportation Ambulance	exclude	exclude
M-04	Outpatient Basic ASC (ASC = Ambulatory Surgical Center)	physical	Office Outpatient
M-05	Physician Primary Care E-M (Evaluation & Management)	physical	Office Outpatient
M-05A	Physician Primary Care E-M (Evaluation & Management) Mental Health	mental/behavioral	Office Outpatient
M-06	Physician Other E-M (Evaluation & Management)	physical	Office Outpatient
M-06A	Physician Other E-M (Evaluation & Management) Mental Health	mental/behavioral	Office Outpatient
M-07	Evaluation & Management PCP (PCP = Primary Care Phsycian)	mental/behavioral	Office Outpatient
M-08	Mental Health ACT (ACT = Assertive Community Treatment)	mental/behavioral	Office Outpatient
M-09	Mental Health AFC (AFC = Adult Foster Care)	exclude	exclude
M-10	Mental Health Assessment & Evaluation	mental/behavioral	Office Outpatient
M-11	Mental Health Case Management	mental/behavioral	Other
M-12	Mental Health Consultation	mental/behavioral	Office Outpatient
M-13	Mental Health Crisis Services	mental/behavioral	Office Outpatient
M-14	Mental Health Interpretive Services	exclude	exclude
M-15	Mental Health Medication Management	mental/behavioral	Other
M-16	Mental Health Alternative to Inpatient	mental/behavioral	Outpatient
M-17	Mental Health MST (MST = Muti-Systemtic Treatment)	mental/behavioral	Office Outpatient
M-18	Mental Health PAITS (PAITS = Post Acute Intensive Treatment Services)	mental/behavioral	Office Outpatient
M-19	Mental Health PDTS (Psyciatric Day Treatment Services)	mental/behavioral	Office Outpatient
M-20	Mental Health Respite	mental/behavioral	Other
M-21	Mental Health RTF Part A (RTF = Residential Treatment Facility)	exclude	exclude
M-22	Mental Health RTF Part B (RTF = Residential Treatment Facility)	exclude	exclude
M-23A	Mental Health SCIP, SAIP, STS (SCIP = Secure Children's Inpatient Program 0 - 11, SAIP = Secure Adolenscent Inpatient Program 12 - 17, & STS = Stabilization Transition Services)	mental/behavioral	Inpatient
M-23B	Mental Health SCIP, SAIP, STS (SCIP = Secure Children's Inpatient Program 0 - 11, SAIP = Secure Adolenscent Inpatient Program 12 - 17, & STS = Stabilization Transition Services)	mental/behavioral	Inpatient
M-24	Mental Health Skills Training	mental/behavioral	Office Outpatient
M-25	Mental Health SRTF (SRTF = Secure Residential Treatment Facility 18+)	exclude	exclude
M-26	Mental Health Sub Acute	mental/behavioral	Office Outpatient
M-27	Mental Health Supportive Employment	exclude	exclude

CDE OHG	OHG Description	HEM Type of Care	HEM Care Setting
M-28	Mental Health Therapy	mental/behavioral	Office Outpatient
M-29	Mental Health Therapy Inpatient	mental/behavioral	Inpatient
M-30	Mental Health Wrap-Around Services	mental/behavioral	Other
M-31	Mental Helath Intensive Rehab Services	mental/behavioral	Office Outpatient
M-32A	Physician Therapeutic Abortion Part A	physical	Office Outpatient
M-32B	Physician Therapeutic Abortion Part B	physical	Office Outpatient
M-33	Behavioral Rehab Services	mental/behavioral	Office Outpatient
M-34	Excluded Admin Exams	physical	Other
M-35	Targeted Case Management (TCM) Leveraged	physical	Other
M-36	Non-Emergent Transporation (NEMT)	exclude	exclude
M-37	Checmical Dependency OHP Outpatient (OHP = Oregon Health Plan)	mental/behavioral	Office Outpatient
M-40	Mental Health Outpatient Therapy	mental/behavioral	Office Outpatient
M-41	Mental Health Physician Outpatient	mental/behavioral	Office Outpatient
M-42	Mental Health Supportive Day Treatment	mental/behavioral	Office Outpatient
M-43	Mental Health Supportive Housing	exclude	exclude
M-44	Anesthesia	physical	Office Outpatient
M-45A	Outpatient Dental Anesthesia	dental	Office Outpatient
M-45B	Outpatient Dental Flouride	dental	Office Outpatient
M-46	Physician Family Planning Part B	physical	Office Outpatient
M-47	Physician Family Planning Part C	physical	Office Outpatient
M-48	Physician Hysterectomy	physical	Office Outpatient
M-49	Lab	exclude	exclude
M-50	Other Medical Maternity Management	physical	Office Outpatient
M-51	Other Medical Durable Medical Equipment	exclude	exclude
M-52	Other Medical Supplies	exclude	exclude
M-53	Maternity	physical	Office Outpatient
M-53A	Physcian Maternity Primary Care	physical	Office Outpatient
M-54	Neonate Newborn Care	physical	Office Outpatient
M-55	Radiology	physical	Other
M-56	Physician Sterilization	physical	Office Outpatient
M-57	Surgery	physical	Office Outpatient
M-58	Speech & Hearing	physical	Office Outpatient
M-59	Vision Exams & Therapy	physical	Office Outpatient
M-60	Physician Other Services	physical	Other
M-61	Other Drugs & Supplies	exclude	exclude
M-62	Community Detox	mental/behavioral	Office Outpatient
M-63	Chemical Dependency Assessment Screening	mental/behavioral	Office Outpatient
M-64	Chemical Dependency Methadone Treatment	mental/behavioral	Office Outpatient
M-65	Cemical Dependency Methadone AMH (AMH = Addictions and Mental Health)	mental/behavioral	Office Outpatient
M-66	Physicial Somatic Mental Health	mental/behavioral	Office Outpatient
M-67	Not Covered	exclude	exclude
M-68	SBIRT Part A (SBIRT = Screening, Brief Intervention, & Referral to Treatment)	mental/behavioral	Office Outpatient

CDE OHG	OHG Description	HEM Type of Care	HEM Care Setting
M-69	SBIRT Part B (SBIRT = Screening, Brief Intervention, & Referral to Treatment)	mental/behavioral	Office Outpatient
M-70	Mental Health Children and Adolescent Needs Assessment	mental/behavioral	Office Outpatient
M-71	ABA Services - Mental Health	mental/behavioral	Office Outpatient
M-72A	Chemical Dependency Residential Treatment Child	mental/behavioral	Inpatient
M-72B	Chemical Dependency Residential Treatment Adult	mental/behavioral	Inpatient
M-72C	Psychiatric Residential Treatment Services	physical	Inpatient
M-75	Urgent Care Visits	physical	Office Outpatient
M-76	Preventative Well Baby Exams	physical	Office Outpatient
M-77	Preventative Immunizations	physical	Office Outpatient
M-78	Preventative Care Covered Service	physical	Office Outpatient
M-79	Preventative Care Non-Covered Service	physical	Office Outpatient
M-80	Inpatient Visits	physical	Inpatient
M-81	Outpatient	physical	Office Outpatient
M98-A		mental/behavioral	Other
M98-B		mental/behavioral	Other
M98-C		mental/behavioral	Other
M-99	Professional Unbucketed	physical	Other
O-01	Outpatient Therapeutic Abortion Outpatient Hospital	physical	Office Outpatient
O-02	Outpatient Excluded Administrative Exams	physical	Other
O-03	Outpatient Prescription Drugs Mental Health	mental/behavioral	Office Outpatient
O-04	Outpatient Mental Health Other Outpatient	mental/behavioral	Office Outpatient
O-05	Outpatient Emergency Room Somatic Mental Health	mental/behavioral	ED
O-06A	Outpatient Chemical Dependency -- Part A	mental/behavioral	Office Outpatient
O-06B	Outpatient Chemical Dependency -- Part B	mental/behavioral	Office Outpatient
O-07	Outpatient Hysterectomy	physical	Office Outpatient
O-08	Outpatient Sterilization -- Female	physical	Office Outpatient
O-09A	Outpatient Family Planning -- Part A -- No Modifier	physical	Office Outpatient
O-09B	Outpatient Family Planning -- Part B -- With Modifier	physical	Office Outpatient
O-09C	Outpatient Family Planning -- Part C -- With Modifier	physical	Office Outpatient

CDE OHG	OHG Description	HEM Type of Care	HEM Care Setting
O-10	Outpatient Maternity	physical	Office Outpatient
O-11	Outpatient Prescription Drugs Basic	physical	Office Outpatient
O-11A	Outpatient Skilled Nursing Facility	physical	Office Outpatient
O-12	Outpatient Post Hospital Extended Care	physical	Office Outpatient
O-13	Outpatient Maternity Case Management	physical	Office Outpatient
O-14	Outpatient Hospice Services	physical	Office Outpatient
O-15	Outpatient Transportation Ambulance	exclude	exclude
O-16	Outpatient Emergency Room	physical	ED
O-17A	Outpatient Lab Services -- Part A	exclude	exclude
O-17B	Outpatient Radiology Services CT -- Part B (CT = Computerized Tomography	physical	Other
O-17C	Outpatient Radiology Services MRI -- Part C (MRI = Magnetic Resonance Imaging)	physical	Other
O-17D	Outpatient Radiology Services PET -- Part D (PET = Positron Emission Tomography)	physical	Other
O-18	Outpatient Home Health	physical	Home Health
O-19	Outpatient Somatic Mental Health	mental/behavioral	Office Outpatient
O-20	Outpatient Physician Administered Drugs	physical	Other
O-21	Outpatient Diagnostic Services Other	physical	Office Outpatient
O-22	Outpatient Lab Injections Other	exclude	exclude
O-23	Outpatient Supplies & Devices	exclude	exclude
O-24	Outpatient Operating Room Other	physical	Office Outpatient
O-25	Outpatient Anesthesia Other	physical	Office Outpatient
O-26	Outpatient Clinics	physical	Office Outpatient
O-27	Outpatient Therapy & Rehabilitation	physical	Office Outpatient

CDE OHG	OHG Description	HEM Type of Care	HEM Care Setting
O-28	Outpatient Professional Fees	physical	Office Outpatient
O-29	Outpatient Surgery	physical	Office Outpatient
O-30	Preventative Care Covered Service	physical	Office Outpatient
O-31	Preventative Care Non-Covered Service	physical	Office Outpatient
O-99	Outpatient Unbucketed	physical	other
RX-01	Pharmacy Perscription Drugs Basic	exclude	exclude
RX-02	Pharmacy Over The Counter (OTC)	exclude	exclude
RX-03	Pharmacy Family Planning Contraceptives	exclude	exclude
RX-04	Pharmacy Carved-Out Drugs	exclude	exclude
RX-05	Pharmacy Immunization Drugs	exclude	exclude
RX-06	Pharmacy Durable Medical Equipment (Pill Splitters)	exclude	exclude
RX-07	Pharmacy Medication Assisted Treatment (MAT)	exclude	exclude

Step 2: Telehealth visits are identified separately for claims with:

- Procedure code: 98966-98972, 99421-99458, D9995, D9996, G0427, G0508, G0509, G2010, G2012, G2025, or
- Modifier: GT, GQ, G0, 95, or
- Place of Service code: 02

Step 3: Claims are de-duplicated into unique visit dates, but report separately if a member had more than one type of care (physical, mental/behavioral or dental) on the same day.

Step 4: If multiple visit types/care settings occurred on the same day for a given type of care (physical, mental/behavioral or dental), only one category is selected based on the hierarchy: Inpatient Stay > Emergency Department > Office Outpatient > Home Health> Telehealth > Other.

Appendix B: Social Risk Factor Screening Measures

This appendix contains the current specifications for screening measures used in Massachusetts, North Carolina, and Rhode Island.

Massachusetts

Measure Name: Health-Related Social Needs Screening
Steward: Massachusetts EOHHS
NQF #: -

Description

The Health-Related Social Needs Screening (HRSN) is conducted to identify members who would benefit from receiving community services to address health-related social needs that include but are not limited to housing stabilization services, housing search and placement, utility assistance, transportation, and food insecurity.

Eligible Population

Product lines	Medicaid
Stratification	None
Ages	ACO-attributed members 0 to 64 years of age as of December 31st of the measurement year
Continuous enrollment	The measurement year
Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement year
Anchor date	December 31st of the measurement year
Lookback period	12 months
Event/diagnosis	None
Exclusions	Members in hospice (Hospice Value Set)

Specifications

The percentage of ACO-attributed members 0 to 64 years of age who were screened for health-related social needs in the measurement year.

Data Source	Clinical data
Data Collection Method	Sample
Denominator	A systematic sample drawn from the eligible population
Numerator	ACO-attributed members 0 to 64 years of age who were screened for health-related social needs in the measurement year.
Unit of Measurement	Individual
Setting of the Screen	Clinical and nonclinical settings

Documentation requirements	To satisfy the measure requirements a member must have received one Health-Related Social Needs Screening during the measurement year. Results from an HRSN screening tool must be present in the member's health record in the measurement year and be readily accessible to the primary care provider. The screen may be completed by any member of the ACO care team. The screening may be completed over the phone, electronically, in-person, by mail, or by any other means approved by EOHHS. The numerator is met if the member's health record (as defined above) contains a completed Health-Related Social Needs screening tool which includes: a. All four (4) core domains, and b. At least 1 supplemental domain The following information must be reported to EOHHS for the purpose of measure performance calculation: Was an HRSN screening completed (including 4 core domains and 1 supplemental domain) (Y/N) Name of Screening Tool Source of Information (Mail, Phone, Email, In-person, Other) Was a need identified for each of the following domains? (Y/N/Unclear)
Approved Screening Tools	EOHHS must approve the screening tool. The screening may be completed over the phone, electronically, in-person, by mail, or by any other means approved by EOHHS.
Required Domains	**Core Domains:** The following domains must be completed and *results must be reported to EOHHS* in order to satisfy the measure: 1. Food 2. Housing 3. Transportation 4. Utility **Supplemental Domains:** At least one of the following domains must be completed: 5. Employment, training, or education 6. Experience of Violence 7. Social Supports

North Carolina

Measure Name: Screening for Social Determinants of Health
Steward: North Carolina DHHS
NQF #: -

Description

The percentage of Medicaid managed care enrollees who received a screening for social determinants of health.

Eligible Population

Product lines	Medicaid
Stratification	None
Ages	All
Continuous enrollment	None
Allowable gap	None
Anchor date	Date of enrollment
Lookback period	90 days of enrollment
Event/diagnosis	None
Exclusions	None

Specifications

The percentage of enrollees who received a screening for social determinants of health.

Data Source	Care management data, collected by an MCO or a delegated entity
Data Collection Method	Full population
Denominator	All managed care enrollees
Numerator	All managed care enrollees for whom the Prepaid Health Plan (PHP) completed a social determinants of health screening within 90 days of enrollment.
Unit of Measurement	Individual
Setting of the Screen	Nonclinical setting, completed by PHP
Documentation requirements	Completed screenings are those screenings for which all questions have been addressed. Staff administering the screenings will have an option to indicate that a question was asked, but the enrollee chose not to answer.
Approved Screening Tools	The North Carolina Standardized SDOH Screening Questions: https://files.nc.gov/ncdhhs/documents/SDOH-Screening-Tool_Paper_FINAL_20180405.pdf
Required Domains	1. Food Insecurity 2. Housing Instability 3. Transportation 4. Interpersonal Violence

Rhode Island[1]

Measure Name: Social Determinants of Health (SDOH) Screening
Steward: RI EOHHS
NQF #: -

Description

Social determinants of health are the "conditions in the places where people live, learn, work, and play [that] affect a wide range of health risks and outcomes."[2]

The percentage of attributed patients who were screened for social determinants of health using a screening tool once per measurement year, where the primary care clinician has documented the completion of the screening and the results. Please note that for organizations participating in the Medicaid Accountable Entity (AE) program, the screening tool must be approved by EOHHS to count as meeting numerator requirements.

Eligible Population

Note: Patients in hospice care or who refuse to participate are excluded from the eligible population. Additional details on exclusions can be found below.

Product lines	Medicaid, Commercial
Stratification	None
Ages	All ages
Continuous enrollment	Enrolled in the MCO for 11 out of 12 months during the measurement year.
Allowable gap	No break in coverage lasting more than one month.
Anchor date	December 31st of the measurement year.
Lookback period	12 months

Event/diagnosis	• The patient has been seen by an AE/ACO-affiliated primary care clinician anytime within the last 12 months • For the purpose of this measure "primary care clinician" is any provider defined by the reporting managed care organization as a primary care clinician and holding a patient panel. • Follow the below to determine a primary care visit: o The following are the eligible CPT/HCPCS office visit codes for determining a primary care visit: 99201-99205; 99212-99215; 99324-99337; 99341-99350; 99381-99387; 99391-99397; 99490; 99495-99496 o The following are the eligible telephone visit, e-visit, or virtual check-in codes for determining a primary care visit: ▯ CPT/HCPCS/SNOMED codes: 98966-98968, 98969-98972, 99421-99423, 99441-99443, 99444, 11797002, 185317003, 314849005, 386472008, 386473003, 386479004 ▯ Any of the above CPT/HCPCS office visit codes for determining a primary care visit *with* the following POS codes: 02 • Any of the above CPT/HCPCS office visit codes for determining a primary care visit *with* the following modifiers: 95, GT
Exclusions	• Patients in hospice care (see Appendix A) • Refused to participate

Electronic Data Specifications

The percentage of attributed patients who were screened for social determinants of health using an EOHHS-approved screening tool, where the primary care practice has documentation of the completion of the screening, the date of the screen, and the results.

Data Source	Clinical data
Data Collection Method	Full population
Denominator	The eligible population
Numerator	Individuals attributed to the primary care clinician who were screened for social determinants of health once per measurement year and for whom results are in the primary care clinician's EHR. Notes: • Screens may be rendered asynchronously (i.e., at a time and through a modality other than a visit with a primary care clinician that triggered inclusion in the denominator). • Screens rendered during a telephone visit, e-visit, or virtual check-in meet numerator criteria.
Unit of Measurement	Screens should be performed at the individual patient level for adults and adolescents. Screens may be performed at the individual patient level or the household level for all children 12 and under residing in one household, so long as the screening is documented in each child's medical record.
Setting of the Screen	All clinical and nonclinical settings
Documentation requirements	All screenings must be documented in the attributed primary care clinician's patient health record, regardless of if the primary care clinician screened the individual (or household, as applicable) or if the screen was performed by anyone else, including: another provider, the insurer, or a community partner. The screening results must either be embedded in the EHR or a PDF of the screening results must be accessible in the EHR (i.e., the primary care clinician must not be required to leave the EHR to access a portal or other electronic location to view the screening results). Results for at least one question per required domain must be included for a screen to be considered numerator compliant.

Approved Screening Tools	For those participating in the AE program, all screening tools must be approved by EOHHS prior to the reporting period to be counted in the numerator. Screens performed with tools not approved by EOHHS shall not be included in the numerator of this measure.
Required Domains	1. Housing insecurity; 2. Food insecurity; 3. Transportation; 4. Interpersonal violence; and 5. Utility assistance. Note: If primary care clinicians are conducting the screen during a telephone visit, e-visit, or virtual check-in or independent of a visit, they may use their discretion whether to ask questions related to interpersonal violence. The interpersonal violence domain must, however, be included for screens administered during in-person visits.

Rhode Island Social Determinants of Health (SDOH) Screening Measure Specifications Appendix A

The following codes should be utilized to identify patients in hospice care:

Code System	Code		Code System	Code
UBREV	0115		CPT	99377
UBREV	0125		CPT	99378
UBREV	0135		HCPCS	G0182
UBREV	0145		HCPCS	G9473
UBREV	0155		HCPCS	G9474
UBREV	0235		HCPCS	G9475
UBREV	0650		HCPCS	G9476
UBREV	0651		HCPCS	G9477
UBREV	0652		HCPCS	G9478
UBREV	0655		HCPCS	G9479
UBREV	0656		HCPCS	Q5003
UBREV	0657		HCPCS	Q5004
UBREV	0658		HCPCS	Q5005
UBREV	0659		HCPCS	Q5006
SNOMED CT US EDITION	170935008		HCPCS	Q5007
SNOMED CT US EDITION	170936009		HCPCS	Q5008
SNOMED CT US EDITION	183919006		HCPCS	Q5010
SNOMED CT US EDITION	183920000		HCPCS	S9126
SNOMED CT US EDITION	183921001		HCPCS	T2042
SNOMED CT US EDITION	305336008		HCPCS	T2043
SNOMED CT US EDITION	305911006		HCPCS	T2044
SNOMED CT US EDITION	385763009		HCPCS	T2045
			HCPCS	T2046

1. Rhode Island developed a new SDOH Infrastructure Development measure for use by its Medicaid Accountable Entities for 2020. This is a reporting-only measure intended to help Accountable Entities be prepared to report on the SDOH Screening measure for 2021. The SDOH Infrastructure Development measure assesses the percentage of members for which an Accountable Entity can report whether a screen was performed or not.
2. Definition from the CDC: www.cdc.gov/socialdeterminants/index.htm. Last accessed on March 18, 2019.