CREDIBLE
Behavioral Health Software

Reporting Guide for CCBHC
HEDIS-Derived Measures and PQRS 431 for the SAMHSA Section 223 Demonstration Grant

Version 1.0 – November 2017

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HEDIS-Derived Measures and PQRS 431 for the
SAMHSA Section 223 Demonstration Grant

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Contents

Introduction

This guide is for Credible Partners that are using the Credible CQM Tool for pursuing HEDIS-derived measures and a PQRS-based measure required for the CCBHC demonstration grant from SAMHSA. It provides the information necessary to use Credible in a meaningful way and capture the data needed for attestation. On September 28, 2015, Credible Behavioral Health 10.1 successfully passed the meaningful use certification criteria for ONC HIT 2014 Edition certification.

Disclaimer

The instructions in this guide are based on the steps Credible followed for certification purposes. Regardless of whether you follow these instructions or adjust them to suit the needs of your Agency, it is your responsibility to ensure that the steps you follow and the results you generate comply with all reporting requirements.

HEDIS® (Healthcare Effectiveness Data and Information Set) is a registered trademark of the National Committee for Quality Assurance (NCQA)

Resources

- Section 223 Demonstration Program for Certified Community Behavioral Health Clinics
  https://www.samhsa.gov/section-223

- Section 223 Demonstration Program to Improve Community Mental Health Services
  https://www.medicaid.gov/medicaid/financing-and-reimbursement/223-demonstration/index.html

- SAMHSA Webinar Series on Quality Measures
  https://www.samhsa.gov/section-223/webinars

- PQRS Measure 431 (NQF 2152): Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling
  https://pqrs.cms.gov/dataset/2016-PQRS-Measure-431-11-17-2015/xaip-bz3j/data

- The Healthcare Effectiveness Data and Information Set (HEDIS) / National Committee for Quality Assurance (NCQA)
  http://www.ncqa.org/hedis-quality-measurement/hedis-measures

- HEDIS & Quality Measurement: What is HEDIS?
  http://www.ncqa.org/hedis-quality-measurement/what-is-hedis

HEDIS® Background

The Healthcare Effectiveness Data and Information Set (HEDIS®) is one of the most widely used set of health care performance measures in the United States. The term "HEDIS" originated in the late 1980s as the product of a group of forward-thinking employers and quality experts, and was entrusted to NCQA in the early 1990s. NCQA has expanded the size and scope of HEDIS to include measures for physicians, PPOs and other organizations.

HEDIS is published across a number of volumes and includes 91 measures across 7 domains of care:

- *Effectiveness of Care.*

- *Access/Availability of Care.*

- *Experience of Care.*

- *Utilization and Risk Adjusted Utilization.*

- *Relative Resource Use.*

- *Health Plan Descriptive Information.*

- *Measures Collected Using Electronic Clinical Data Systems.*

HEDIS has evolved into a critical component of an emerging measurement system to establish accountability in health care. HEDIS measures are equally useful as part of a quality improvement effort in a physician practice; as a purchaser request for quality information at the health plan or clinician level; as elements of NCQA Accreditation, Certification or Recognition programs; and as the basis of consumer report cards. HEDIS is also the model for emerging systems of performance measurement in other areas of health care delivery.
(excerpt from "HEDIS 2017 Volume 2: Technical Specifications for Health Plans")

How are HEDIS Measures Collected?

Three primary data collection methods for performance measures:

- **Medical Record Method** abstracts data annually from paper or electronic medical records (EMR)/ electronic health records (EHR). Despite being more expensive, medical record data provides clinical information that is not available in electronic transactional data.

- **Electronic Method** collects data captured during the course of routine care delivery for either payment or care documentation purposes. Health plans (e.g., medical claims), health systems (e.g., patient registries), public health agencies (e.g., immunization records), benefit managers (e.g., pharmacy claims) and ancillary physicians (e.g., laboratory results) gather these data from sources that include EMR/EHR databases used by physician practices or health systems. Although the Electronic Method allows the use of large data sets that can be joined and analyzed through complex algorithms, the most common captured electronic data are currently diagnosis and procedure codes, not more robust clinical detail.

- **Hybrid Method** leverages the strengths of the Medical Record Method and the Electronic Method, relying on large electronic data sets to identify an eligible population (denominator) and then allowing medical record data to supplement electronic data when identifying the numerator of a measure that may call for clinical detail. The Hybrid Method is an option for any measure that specifies both an Electronic and Medical Record Method of data collection.

How are HEDIS Measures Used?

HEDIS data sets promote standardized measurement of important aspects of evidence-based care and for outcomes measurement, and are used by various public and private organizations. Some examples are:

- *NCQA Health Plan Accreditation – Fifty percent of the total score for accreditation is driven by performance on HEDIS and CAHPS (Consumer Assessment of Healthcare Providers and Systems) survey measures.*
- *Centers for Medicare & Medicaid Services (CMS) has adopted many HEDIS measures and includes these in their Medicare Advantage Star ratings system.*
- *State agencies and other organizations often set contractual performance guarantees for health plans around specific measures within the HEDIS set.*
- *Many states also define additional state-specific measures that may be "HEDIS-like" in nature or come from other sources.*

SAMHSA Section 223 Demonstration Grant

In January 2017, the US Department of Health and Human Services announced the selection of eight states for participation in a two-year **Certified Community Behavioral Health Clinic (CCBHC)** demonstration program designed with certain aims:

- *improve behavioral health services in their communities*
- *integrate behavioral health with physical health care*
- *increase consistent use of evidence-based practices*
- *improve access to high quality care for people with mental and substance use disorders*

The eight states selected for this two-year program are Missouri, New York, New Jersey, Nevada, Oklahoma, Oregon, and Pennsylvania. States will commence their demonstration no later than July 1, 2017.

The following measures required for this demonstration period are CQM-aligned:

Behavioral Health Clinic Quality Measures	SAMHSA Identifier	NQF Number	CQM Number
Screening for Clinical Depression and Follow-Up Plan	CDF-BH	418	**2**
Preventive Care and Screening: Adult Body Mass Index (BMI) Screening and Follow-Up	BMI-SF	421	**69**
Antidepressant Medication Management	AMM-BH	105	**128**
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	ADD-BH	108	**136**
Initiation and engagement of alcohol and other drug dependence treatment	IET-BH	4	**137**
Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	TSC	28	**138**
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	WCC-BH	24	**155**
Depression Remission at 12 months	DEP-REM-12	710	**159**
Adult major depressive disorder (MDD): Suicide risk assessment	SRA-A	104	**161**
Child and adolescent major depressive disorder (MDD): Suicide Risk Assessment	SRA-BH-C	1365	**177**

* Please refer to Credible's Help for the current "Clinical Quality Measures (CQM) Guide for Credible Software"

In addition to Clinical Quality Measurements, the SAMHSA Section 223 Demonstration Grant utilizes HEDIS-derived measures, as well as other reporting modalities such as the Universal Reporting System (URS) and Mental Health System Improvement Program (MHSIP) Consumer Satisfaction Survey.

The HEDIS-derived measures for the SAMHSA Section 223 Demonstration Grant are as follows:

Behavioral Health Clinic Quality Measures	NQF Number	HEDIS
Follow-Up After Discharge from the Emergency Department for Mental Health or Alcohol or Other Dependence: *Follow-Up After Emergency Department for Mental Health*	2605	FUM
Follow-Up After Discharge from the Emergency Department for Mental Health or Alcohol or Other Dependence: *Follow-Up After Emergency Department for Alcohol or Other Dependence*	2605	FUA
Plan All-Cause Readmission Rate (PCR-AD) (see Medicaid Adult Core Set)	1768	PCR-BH
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	1932	SSD
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (see Medicaid Adult Core Set)	N/A	SAA-BH
Follow-Up After Hospitalization for Mental Illness, ages 21+ (*adult*) (see Medicaid Adult Core Set)	0576	FUH-BH-A
Follow-Up After Hospitalization for Mental Illness, ages 6 to 21 (*child/adolescent*) (see Medicaid Child Core Set)	0576	FUH-BH-C

> *For more information on the Section 223 Demonstration Program for CCBHCs visit:*
> https://www.samhsa.gov/section-223
>
> *For more information on Clinical Quality Measures with Credible, please visit our Help for the "Clinical Quality Measures (CQM) Guide for Credible Software"*

CCBHC State-Specific Billing

Located in Credible's Help, the state-specific rules, changes and guidance for Partners operating in states participating in the CCBHC grant is easily and readily available. Navigate to Credible Help > Home > State-Specific Information for the state-related billing information.

HEDIS-Derived Reporting with the CQM Tool

Step 1: Create a User

1. CQM Tool > Administration > Users > Add User

User Details

❋ First Name:

First Name identification (Partner Defined)

❋ Last Name:

Last Name identification (Partner Defined)

❋ External User ID:

Billing Group Name

Role:

Clinician

In creating a generic agency-level user, please follow enter a value in each section:

1. First Name
2. Last Name
3. **External User ID = Billing Group Name**

This allows a report for all employees and will use the billing group info as the "provider"

Report Generation Options

☑ **Generate QRDA Cat III**
☐ **QRDA Cat III - Enable Text Section Zip Codes**
PQRS Types
    ⦿ **None**
    ○ **Generate PQRS_INDIVIDUAL**
    ○ **Generate PQRS_GROUP**
☑ **CCBHC**

Report Generation Options:

1. Generate QRDA Cat III = True
2. CCBHC = True

2. **Do not** select any Pre-Selected Measures > Save

Step 2: Generate Report

1. CQM Tool > Create Report

2. Enter Description

3. Enter Start Date / End Date

4. CQM Update Year = CCBHC_2017

5. Select generic agency-level user from list

6. Override all provider pre-selected measures = TRUE

7. Queue Report

Description:

[Description]

Begin Date:

[07/01/2017] [Add ▾]

End Date:

[12/31/2017]

CQM Update year:

[CCBHC_2017 ▾]

Use Zip Folder: ☐

[Queue Report]

Select Provider

Select All Unselect All

☐

☐

☐

☐

☐ **Override all provider pre-selected measures**

☑ **Override all provider pre-selected measures**

Select Measures

Select All Unselect All

Search: [   ]

☐ FUM/NQF 2605 - Follow-up After Emergency Department Visit for Mental Illness

☐ FUA/NQF 2605 - Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence

☐ PCR-BH/NQF 1768 - Plan All-Cause Readmissions Rate

☐ SSD/NQF 1932 - Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

☐ SAA-BH - Adherence to Antipsychotic Medications for Individuals with Schizophrenia

☐ FUH-BH-A/NQF 0576 - Follow-Up After Hospitalization for Mental Illness

☐ FUH-BH-C/NQF 0576 - FUH-BH-C Follow-Up after Hospitalization for Mental Illness

General Report Guidelines

📌 Due to pulling data across the domain, this report will run longer than other CQM reports. *Please allow ample time for this report to run. Credible strongly suggests queuing this report to run after hours.*

PQRS Measure 431 (NQF 2152): Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

National Quality Strategy Domain: Community/ Population Health

2016 PQRS Options: Registry Only / 2017 MIPS Quality Category: Registry Only

Measure Description

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

Measure Instructions

- This measure is to be reported once per reporting period for patients seen during the reporting period. This measure is intended to reflect the quality of services provided for preventive screening for unhealthy alcohol use.

- There is no diagnosis associated with this measure. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry

CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

Denominator	Numerator
All patients aged 18 years and older who were seen twice for any visits or who had at least one preventive care visit during the 12-month measurement period	Patients who were screened at least once within the last 24 months for unhealthy alcohol use using a systematic screening method AND who received brief counseling if identified as an unhealthy alcohol user

Denominator

All patients aged 18 years and older who were seen twice for any visits or who had at least one preventive care visit during the 12-month measurement period

Denominator Criteria (Eligible Cases)

Patients aged ≥ 18 years
AND

Patient encounter during the performance period (CPT or HCPCS):
90791, 90792, 90832, 90834, 90837, 90845, 96150, 96151, 96152, 97003, 97004, 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0270, G0271, G0438, G0439
AND
Two Denominator Eligible Visits
OR
At Least One Preventive Care Visit

Numerator

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

Numerator Definitions

- **Systematic screening method** - For purposes of this measure, one of the following systematic methods to assess unhealthy alcohol use must be utilized. Systematic screening methods and thresholds for defining unhealthy alcohol use includes:
  - *AUDIT Screening Instrument (score ≥ 8)*
  - *AUDIT-C Screening Instrument (score ≥ 4 for men; score ≥ 3 for women)*
  - *Single Question Screening - How many times in the past year have you had 5 (for men) or 4 (for women and all adults older than 65 years) or more drinks in a day? (response ≥2)*
- **Brief counseling** - Brief counseling for unhealthy alcohol use refers to one or more counseling sessions, a minimum of 5-15 minutes, which may include: feedback on alcohol use and harms; identification of high risk situations for drinking and coping strategies; increased motivation and the development of a personal plan to reduce drinking.

Numerator Note: In the event that a patient is screened for unhealthy alcohol use and identified as a user but did not receive alcohol cessation counseling report G9624.

Numerator Options:	
Performance Met	Patient identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method and received brief counseling **(G9621)**
OR	
Performance Met	Patient not identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method **(G9622)**
OR	
Medical Performance Exclusion	Documentation of medical reason(s) for not screening for unhealthy alcohol use (e.g., limited life expectancy, other medical reasons) **(G9623)**
OR	

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

Rationale

This measure is intended to promote unhealthy alcohol use screening and brief counseling which have been shown to be effective in reducing alcohol consumption. About 30% of the U.S. population misuse alcohol, with most engaging in what is considered risky drinking. (SAMHSA, 2012) A recent analysis of data from the National Alcohol Survey shows that approximately one-third of at-risk drinkers (32.4%) and persons with a current alcohol use disorder (31.5%) in the United States had at least 1 primary care visit during the prior year, demonstrating the potential reach of screening and brief counseling for unhealthy alcohol use in the primary care setting. (Mulia et al., 2011) A number of studies, including patient and provider surveys, have documented low rates of alcohol misuse screening and counseling in primary care settings. In the national Healthcare for Communities Survey, only 8.7% of problem drinkers reported having been asked and counseled about their alcohol use in the last 12 months. (D'Amico et al., 2005) A nationally representative sample of 648 primary care physicians were surveyed to determine how such physicians identify--or fail to identify--substance abuse in their patients, what efforts they make to help these patients and what are the barriers to effective diagnosis and treatment. Of physicians who conducted annual health histories, less than half ask about the quantity and frequency of alcohol use (45.3 percent). Only 31.8 percent say they ever administer standard alcohol or drug use screening instruments to patients. (CASA, 2000)

Clinical Recommendation Statements

The USPSTF recommends that clinicians screen adults aged 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse. (Grade B recommendation) (USPSTF, 2014)

2016 Registry Individual Measure Flow
PQRS #431 (NQF 2152): Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

Denominator

Numerator

Start

Patient Age at Date of Service ≥ 18 Years

No → Not Included in Eligible Population/Denominator

Yes

Encounter as Listed in Denominator* (1/1/2016 thru 12/31/2016)

No

Yes

At Least One Preventive Care Visit

Two Denominator Eligible Visits

No

Yes

No

Yes

Include in Eligible Population/Denominator (8 patients)   d

Patient Identified as an Unhealthy Alcohol User Using a Systematic Screening Method AND Received Brief Counseling

Yes → **Reporting Met + Performance Met** G9621 or equivalent (3 patients) a^1

No

Patient Not Identified as an Unhealthy Alcohol User When Screened for Unhealthy Alcohol Use Using a Systematic Screening Method

Yes → **Reporting Met + Performance Met** G9622 or equivalent (1 patient) a^2

No

Documentation of Medical Reason(s) for Not Screening for Unhealthy Alcohol Use

Yes → **Reporting Met + Performance Exclusion** G9623 or equivalent (1 patient)   b

No

Patient Not Screened for Unhealthy Alcohol Screening Using a Systematic Screening Method OR Patient did Not Receive Brief Counseling, Reason Not Given

Yes → **Reporting Met + Performance Not Met** G9624 or equivalent (2 patients)   c

No

Reporting Not Met Quality-Data Code or equivalent not reported (1 patient)

SAMPLE CALCULATIONS:

Reporting Rate=

$$\frac{\text{Performance Met } (a^1+a^2 = 4 \text{ patients}) + \text{Performance Exclusion } (b=1 \text{ patient}) + \text{Performance Not Met } (c=2 \text{ patients})}{\text{Eligible Population / Denominator } (d=8 \text{ patients})} = \frac{7 \text{ episodes}}{8 \text{ episodes}} = 87.50\%$$

Performance Rate=

$$\frac{\text{Performance Met } (a^1+a^2 = 4 \text{ patients})}{\text{Reporting Numerator } (7 \text{ patients}) - \text{Performance Exclusion } (b=1 \text{ patient})} = \frac{4 \text{ episodes}}{6 \text{ episodes}} = 66.67\%$$

*See the posted Measure Specification for specific coding and instructions to report this measure.
Note: Reporting Frequency: Patient-Process

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The measures diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.

v2

Version 10.0

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https://pqrs.cms.gov/dataset/2016-PQRS-Measure-431-11-17-2015/xaip-bz3j/data

Measure: Follow-Up After Emergency Department Visit for Mental Illness (FUM) / NQF 2605

Measure Description

The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness, 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.*
2. *The percentage of ED visits for which the member received follow-up within 7 days of the ED visit.*

Eligible Population	
Product lines:	Commercial, Medicaid, Medicare (report each product line separately).
Ages:	6 years and older as of the date of the ED visit.
Continuous enrollment:	Date of the ED visit through 30 days after the ED visit.
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 (Mental Illness Value Set) on or between January 1 and December 1 of the measurement year. • The denominator for this measure is based on ED visits, not on members. If a member has more than one ED visit, identify all 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 ED visit. For example, if a member has an ED visit on January 1 then include the January 1 visit and do not include ED visits that occur on or between January 2 and January 31; then, if applicable, include the next
Exclusions	Exclude ED visits followed by admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit, regardless of 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:	*Equals the Eligible Population*
Numerators:	
30-Day Follow-up	A follow-up visit with any practitioner, with a principal diagnosis of a mental health disorder within 30 days after the ED visit. 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 within 7 days after the ED visit. Include visits that occur on the date of the ED visit.

📌 **Note:**

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

- *A visit (FUH Stand Alone Visits Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).*

- *A visit (FUH Visits Group 1 Value Set and FUH POS Group 1 Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).*

- *A visit (FUH Visits Group 2 Value Set and FUH POS Group 2 Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).*

- *A visit to a behavioral healthcare setting (FUH RevCodes Group 1 Value Set).*

- *A visit to a nonbehavioral healthcare setting (FUH RevCodes Group 2 Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).*

- *A telehealth visit (Telehealth Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).*

Reporting Criteria:

Patient Population	Denominator	Numerator
The percentage of ED visits for which the member received follow-up within 30 days of the ED visit.	Eligible Population	A follow-up visit with any practitioner, with a principal diagnosis of mental health disorder within 30 days after the ED visit. Include visits that occur on the date of the ED visit.

Patient Population	Denominator	Numerator
The percentage of ED visits for which the member received follow-up within 7 days of the ED visit.	Eligible Population	A follow-up visit with any practitioner, with a principal diagnosis of mental health disorder within 7 days after the ED visit. Include visits that occur on the date of the ED visit.

First Year Measure Background:

Many individuals are affected by a serious mental illness (SMI). Data from the National Survey on Drug Use and Health showed that in 2013, an estimated 10 million Americans 18 or older had an SMI (4.2 percent of all U.S. adults) (NIMH, 2013). Mental illness can affect people of all ages. The Centers for Disease Control and Prevention's (CDC) National Health and Nutrition Examination Survey showed that approximately 13 percent of children 8–15 had a diagnosable mental illness within the previous year, and estimated that 21.4 percent of adolescents 13–18 had experienced a severe mental disorder at some point in their lives (NIMH, 2015; Merikangas et al., 2010). The CDC's National Health Interview Survey of 2011–2012 also revealed that 7.5 percent of children 6–17 had used prescribed medication during the past 6 months for emotional or behavioral difficulties (CDC, 2014).

Data suggest that mental illness manifests at differing rates in certain minority groups. In 2013, 21.2 percent of adult American Indians and Alaska Natives reported having mental illness, which is significantly higher than Hispanics and Latinos (15.6 percent) and Asian Americans (13.1 percent). In addition, 4 percent of adult American Indians and Alaska Natives admitted to having mental illness, compared to a rate of 1.2 for Native Hawaiian or other Pacific Islanders (SAMHSA, 2015).

Although emergency department (ED) visits are common among patients suffering from mental illness, many may be avoidable. In 2007, approximately 12 million ED visits were related to mental health or substance abuse—1 out of 8 (12.5 percent) of all ED visits (Owens et al., 2010). More than 7.6 million were related to mental health conditions only. Two million (28.9 percent) of mental health-related ED visits listed a mental health disorder as the primary diagnosis.

Diagnoses range from mood and anxiety disorders to more serious conditions such as schizophrenia. The most common mental health conditions for ED visits were mood disorders (42.7 percent) and anxiety disorders (26.1 percent) (Owens et al., 2010). Recent Healthcare Cost and Utilization Project data confirm that mood disorders (226,300 visits) are the primary reasons for ED visits among adults 18–44 (Weiss et al., 2011). Schizophrenia and other psychotic disorders were the fourth most common condition (120,400 visits) in this same age group.

Among ED visits for mental health or substance abuse, Medicare was billed most frequently (30.1 percent), followed by private insurance (25.7 percent) and Medicaid (19.8 percent) (Owens et al., 2010).

Measure: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA) / NQF 2605

Measure 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) 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.*
2. *The percentage of ED visits for which the member received follow-up within 7 days of the ED visit.*

Note: *Members in hospice are excluded from the eligible population. Refer to HEDIS General Guideline 20: Members in Hospice.*

Eligible Population	
Product lines:	Commercial, Medicaid, Medicare (report each product line separately).
Ages:	13 years and older as of the ED visit. Report three 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.
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 (AOD Dependence Value Set) on or between January 1 and December 1 of the measurement year. • The denominator for this measure is based on ED visits, not on members. If a member has more than one ED visit, identify all 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 ED visit. For example, if a member has an ED visit on January 1

	then include the January 1 visit and do not include ED visits that occur on or between January 2 and January 31; then, if applicable, include the next ED visit that occurs on or after February 1. Identify visits chronologically including only one per 31-day period.
Exclusions	Exclude 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 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:	*Equals 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. 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. Include visits that occur on the date of the ED visit.

📌 **Note:** 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 (AOD Dependence Value Set).*
- *IET Visits Group 1 Value Set with IET POS Group 1 Value Set and a principal diagnosis of AOD (AOD Dependence Value Set).*
- *IET Visits Group 2 Value Set with IET POS Group 2 Value Set and a principal diagnosis of AOD (AOD Dependence Value Set.*
- *A telehealth visit (Telehealth Value Set) with a principal diagnosis of AOD (AOD Dependence Value Set).*

📌 **Note:** Organizations may have different methods for billing intensive outpatient visits and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service.

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

Reporting Criteria:

Patient Population	Denominator	Numerator
Age 13 years and older as of the ED visit AND ED visit (ED Value Set) with a principal diagnosis of AOD (AOD Dependence Value Set) on or between January 1 and December 1 of the measurement year.	Eligible Population	A follow-up visit with any practitioner, with a principal diagnosis of AOD within **30 days after the ED visit.** Include visits that occur on the date of the ED visit.

Patient Population	Denominator	Numerator
Age 13 years and older as of the ED visit AND ED visit (ED Value Set) with a principal diagnosis of AOD (AOD Dependence Value Set) on or between January 1 and December 1 of the measurement year.	Eligible Population	A follow-up visit with any practitioner, with a principal diagnosis of AOD within **7 days after the ED visit**. Include visits that occur on the date of the ED visit.

Data Elements for Reporting

Table FUA-1/2/3: Data Elements for Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence	
Organizations that submit HEDIS data to NCQA must provide the following data elements:	
Measurement Year	✓
Data Collection Methodology (Administrative)	✓
Eligible Population	✓
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*
Lower 95% confidence level **Upper 95% confidence level**	*Each of the 2 rates for each age stratification and total* *Each of the 2 rates for each age stratification and total*

First Year Measure Background:

Alcohol and other drug dependence (AOD) is a serious public health issue. According to 2013 data from the Substance Abuse and Mental Health Service Administration (SAMHSA), young adults aged 18–25 had the highest percentage of alcohol dependence or abuse (13 percent) among individuals aged 12 or older (SAMHSA, 2014). In the same year, young adults aged 18–25 had the highest percentage of illicit drug dependence or abuse (7.4 percent) among persons 12 or older. In the United States, 6.6 percent of persons aged 12 or older (an estimated 17.3 million individuals) in 2013 were dependent on or abused alcohol within the year prior to being surveyed (SAMHSA, 2014).

With a large number of individuals experiencing AOD, the use of emergency department (ED) services is common and a serious issue. In 2007, approximately 12 million ED visits were related to mental health or substance abuse—1 out of 8 (12.5 percent) of all ED visits (Owens et al., 2010). Nearly three million of these ED visits were related to substance abuse only. Among those, 33 percent listed substance abuse as the primary diagnosis (Owens et al., 2010). In 2011, the Drug Abuse Warning Network indicated that there were approximately 2.5 million drug misuse or abuse ED visits nationwide. Of these visits, 50.5 percent involved nonmedical use of pharmaceuticals, 50.9 percent involved illicit drugs and 24.6 percent involved alcohol in combination with other drugs (SAMHSA, 2011).

An analysis of data between 2004 and 2011, published in a SAMHSA report, shows the annual overall number of ED visits for drug misuse or abuse increased over that time, from 1.6 million to 2.5 million. Nearly half (43.2 percent) of 440,000 drug abuse-related ED visits for patients 20 or younger involved alcohol (SAMHSA, 2011). Data from 2013 revealed that the percentage of alcohol dependence or abuse was higher among those who live in metropolitan areas and among those without health insurance (SAMHSA, 2014).

Research shows a disproportionate rate of minority groups and women have mental health and/or substance abuse. In 2014, SAMHSA reported that 10 percent of Native Hawaiians/Pacific Islanders were affected by substance abuse or dependence, compared with 4.5 percent of Asian Americans (SAMHSA, 2015). Research has also shown that African Americans and women have higher probabilities of developing damaging health conditions from long-term use of alcohol (Le Fauve et al., 2003; NIAAA, 1999).

Among ED visits for mental health and substance abuse, Medicare was billed most frequently (30.1 percent), followed by private insurance (25.7 percent) and Medicaid (19.8 percent) (Owens et al., 2010).

Measure: Plan All-Cause Readmissions (PCR-BH) / NQF 1768

HEDIS Risk Adjusted Utilization Measure

Measure Description:

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

1. *Count of Index Hospital Stays (IHS) (denominator)*
2. *Count of 30-Day Readmissions (numerator)*
3. *Average Adjusted Probability of Readmission*

Note: *For commercial, report only members 18–64 years of age.*

Eligible Population	
Product lines:	Commercial, Medicare (report each product line separately).
Ages:	• For commercial, ages 18–64 as of the Index Discharge Date. • For Medicare, ages 18 and older as of the Index Discharge Date.
Continuous enrollment:	365 days prior to the Index Discharge Date through 30 days after the Index Discharge Date
Allowable gap:	No more than one gap in enrollment of up to 45 days during the 365 days prior to the Index Discharge Date and no gap during the 30 days following the Index Discharge date
Anchor date:	Index Discharge Date
Benefit:	Medical
Event/diagnosis	• An acute inpatient discharge on or between January 1 and December 1 of the measurement year. • The denominator for this measure is based on discharges, not members. Include all acute inpatient discharges for members who had one or more discharges on or between January 1 and December 1 of the measurement year. • Follow the steps below to identify acute inpatient stays.

Administrative Specification	
Denominator:	*Equals the Eligible Population*
Step 1	
	Identify all acute inpatient discharges 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.*
	Inpatient stays where the discharge date from the first setting and the admission date to the second setting are two or more calendar days apart must be considered distinct inpatient stays.
	The measure includes acute discharges from any type of facility (including behavioral healthcare facilities).
Step 2	
	Acute-to-acute direct transfers: Keep the original admission date as the Index Admission Date, but use the direct transfer's discharge date as the Index Discharge Date.
	A direct transfer is when the discharge date from one inpatient setting and the admission date to a second inpatient setting are one calendar day apart or less. For example:
	• *An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1, is a direct transfer.*
	• *An inpatient discharge on June 1, followed by an admission to an inpatient setting on June 2, is a direct transfer.*
	• *An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 3, is not a direct transfer; these are two distinct inpatient stays.*
	Use the following method to identify acute-to-acute direct transfers:
	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 and discharge dates for the stay.
Step 3	
	Exclude hospital stays where the Index Admission Date is the same as the Index Discharge Date.

Step 4 REQUIRED EXCLUSIONS	
	Exclude hospital stays for the following reasons: • The member died during the stay. • A principal diagnosis of pregnancy (Pregnancy Value Set) • A principal diagnosis of a condition originating in the perinatal period (Perinatal Conditions Value Set) ⭐*Note: For hospital stays where there was an acute-to-acute direct transfer (identified in step 2), use both the original stay and the direct transfer stay to identify exclusions in this step.*
Step 5 **REQUIRED EXCLUSIONS**	

	For all acute inpatient discharges identified using steps 1–4, determine if there was a planned hospital stay within 30 days after the acute inpatient discharge. To identify planned hospital stays: identify all acute inpatient discharges on or between January 3 and December 31 of the measurement year:
	
	 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set)
	 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set)
	 3. Identify the admission date for the stay.
	 4. Exclude any hospital stay as an Index Hospital Stay if the admission date of the first stay within 30 days meets any of the following criteria:
	  a. A principal diagnosis of maintenance chemotherapy (Chemotherapy Value Set)
	  b. A principal diagnosis of rehabilitation (Rehabilitation Value Set)
	  c. An organ transplant (Kidney Transplant Value Set, Bone Marrow Transplant Value Set, Organ Transplant Other Than Kidney Value Set)
	  d. A potentially planned procedure (Potentially Planned Procedures Value Set) without a principal acute diagnosis (Acute Condition Value Set)
	
	 ⭐*Note: For hospital stays where there was an acute-to-acute direct transfer (identified in step 2), use only the original stay to identify planned hospital stays in this step (i.e., do not use diagnoses and procedures from the direct transfer stay).*

Step 6	
	Calculate continuous enrollment
Step 7	
	Assign each acute inpatient stay to an age category. *Refer to Table PCR-A-2/3 and Table PCR-B-3.*

Risk Adjustment Determination

For each IHS, use the following steps to identify risk adjustment categories based on presence of surgeries, discharge condition, comorbidity, age and gender.

- **Surgeries**
  Determine if the member underwent surgery during the inpatient stay. Download the list of codes from the NCQA Web site (Table HCC-Surg) and use it to identify surgeries. Consider an IHS to include a surgery if at least one procedure code in Table HCC-Surg is present from any provider between the admission and discharge dates.

- **Discharge Condition**
  Assign a discharge Clinical Condition (CC) category code or codes to the IHS based on its primary discharge diagnosis, using Table PCR-DischCC. For acute-to-acute direct transfers, use the direct transfer's primary discharge diagnosis.

- **Comorbidities**
  Refer to the Utilization Risk Adjustment Determination in the Guidelines for Risk Adjusted Utilization Measures.

Risk Adjustment Weighting

For each IHS, use the following steps to identify risk adjustment weights based on presence of surgeries, discharge condition, comorbidity, age and gender.

Sample Table: PCR—Risk Adjustment Weighting (HEDIS 2017, Volume 2)

Member ID*	Admiss. Counter	Base Risk Weight	Age	Gender	Age and Gender Weight	Surgical Weight	ICD-9 Diagnosis Code	Discharge CC Category	Discharge CC Weight	HCC-PCR Category	HCC-PCR Weight	Sum of Weights	Adjusted Probability	Variance
1250	1	-1.08883	67	Female	0.1000	-0.2800	250.4	15	0.0700	20	0.1400	-0.8600	0.2976	0.2090
										25	0.2000			
4010	1	-1.08883	50.00	Male	0.1200	NA	007.4	5	0.0300	NA	NA	-0.9400	0.2811	0.2021
4010	2	-1.08883	50.00	Male	0.1200	NA	298.00	77	0.0600	5	0.0100	-0.5700	0.3615	0.2308
										47	0.3300			

*Each Member ID field with a value represents a unique IHS.

Step 1

- For each IHS with a surgery, link the surgery weight.
  - *For Medicare product lines ages 18–64: Use Table PCR-MA-OtherWeights-Under65.*
  - *For Medicare product lines ages 65 and older: Use Table PCR-MA-OtherWeights-65plus.*
  - *For commercial product lines: Use Table PCR-Comm-OtherWeights.*

Step 2

- For each IHS with a discharge CC Category, link the primary discharge weights.
  - *For Medicare product lines ages 18-64: Use Table PCR-MA-DischCC-Weight-Under65.*
  - *For Medicare product lines ages 65 and older: Use Table PCR-MA-DischCC-Weight-65plus.*
  - *For commercial product lines: Use Table PCR-Comm-DischCC-Weight.*

Step 3

- For each IHS with a comorbidity HCC Category, link the weights.
  - *For Medicare product lines ages 18–64: Use Table PCR-MA-ComorbHCC-Weight-Under65.*
  - *For Medicare product lines ages 65 and older: Use Table PCR-MA-ComorbHCC-Weight-65plus.*
  - *For commercial product lines: Use Table PCR-Comm-ComorbHCC-Weight.*

Step 4

- *Link the age and gender weights for each IHS.*
  - *For Medicare product lines ages 18–64: Use Table PCR-MA-OtherWeights-Under65.*
  - *For Medicare product lines ages 65 and older: Use Table PCR-MA-OtherWeights-65plus.*
  - *For commercial product lines: Use Table PCR-Comm-OtherWeights.*

Step 5

- *Identify the base risk weight.*
  - *For Medicare product lines ages 18–64: Use Table PCR-MA-OtherWeights-Under65.*
  - *For Medicare product lines ages 65 and older: Use Table PCR-MA-OtherWeights-65plus.*
  - *For commercial product lines: Use Table PCR-Comm-OtherWeights to determine the base risk weight.*

Step 6

- *Sum all weights associated with the IHS (i.e., presence of surgery, primary discharge diagnosis, comorbidities, age, gender and base risk weight).*

Step 7

- *Use the formula below to calculate the adjusted probability of a readmission based on the sum of the weights for each IHS.*
- *Adjusted probability of readmission* $= \dfrac{e^{(\sum \text{WeightsForIHS})}}{1 + e^{(\sum \text{WeightsForIHS})}}$

  OR

  Adjusted probability of readmission = [exp (sum of weights for IHS)] / [1 + exp (sum of weights for IHS)]

Step 8

- *Use the formula below and the adjusted probability of readmission calculated in step 7 to calculate the variance for each IHS.*
- *Variance = Adjusted probability of readmission x (1 – Adjusted probability of readmission)*
- *Note: The variance is calculated at the IHS level. Organizations must sum the variances for each age/gender and total category when populating the Total Variance cells in the reporting tables.*

Measure Reporting

Reporting: Denominator

Count the number of IHS for each age and enter these values into the reporting table.

Reporting: Risk Adjustment

Step 1

Calculate the average adjusted probability for each IHS for each age and the overall total.

Organizations must calculate the probability of readmission for each hospital stay within the applicable age group to calculate the average (which is reported to NCQA). For the total age category, the probability of readmission for all hospital stays in the age categories must be averaged together; organizations cannot take the average of the average adjusted probabilities reported for each age.

Step 2

Round to four decimal places using the .5 rule and enter these values into the reporting table.

- *Note: Do not take the average of the cells in the reporting table.*

Example: For the "18–44" age category:
- *Identify all IHS by 18–44 year-old males and calculate the average adjusted probability.*
- *Identify all IHS by 18–44 year-old females and calculate the average adjusted probability.*
- *Identify all IHS by all 18–44 year-olds and calculate the average adjusted probability.*

Repeat for each subsequent group.

Step 3

Calculate the total (sum) variance for each age and the overall total.

Step 4

Round to four decimal places using the .5 rule and enter these values into the reporting table.

Reporting: Numerator

Count the number of IHS with a readmission within 30 days for each age and enter these values into the reporting table.

Risk Adjustment Tables

Table	Table Description
HCC-Surg	Surgery codes for Risk Adjustment Determination
PCR-DischCC	Discharge Clinical Condition category codes for Risk Adjustment Determination
CC-Comorbid	Comorbid Clinical Condition category codes for Risk Adjustment Determination step 2
HCC-Rank	HCC rankings for Risk Adjustment Determination step 3
HCC-Comb	Combination HCCs for Risk Adjustment Determination step 5
PCR-MA-DischCC-Weight-Under65	MA and SNP primary discharge weights for Risk Adjustment Weighting step 2 for ages under 65
PCR-MA-DischCC-Weight-65plus	MA and SNP primary discharge weights for Risk Adjustment Weighting step 2 for ages 65 and older
PCR-Comm-DischCC-Weight	Commercial primary discharge weights for Risk Adjustment Weighting step 2
PCR-MA-ComorbHCC-Weight-Under65	MA and SNP comorbidity weights for Risk Adjustment Weighting step 3 for ages under 65
PCR-MA-ComorbHCC-Weight-65plus	MA and SNP comorbidity weights for Risk Adjustment Weighting step 3 for ages 65 and older
PCR-Comm-ComorbHCC-Weight	Commercial comorbidity weights for Risk Adjustment Weighting step 3
PCR-MA-OtherWeights-Under65	MA and SNP base risk, surgery, age and gender weights for Risk Adjustment Weighting steps 1, 4, 5 for ages under 65
PCR- MA-OtherWeights-65pl us	MA and SNP base risk, surgery, age and gender weights for Risk Adjustment Weighting steps 1, 4, 5 for ages 65 and older
PCR-Comm-OtherWeights	Commercial base risk, surgery, age and gender weights for Risk Adjustment Weighting steps 1, 4, 5

Table PCR-A-2/3: Plan All-Cause Readmissions Rates by Age and Risk Adjustment

Age	Count of Index Stays (Denominator)	Count of 30-Day Readmissions (Num/Den)	Observed Readmissions (Num/Den)	Average Adjusted Probability	Total Variance	O/E Ratio (Observed Readmissions/ Average Adjusted Probability)	Lower Confidence Interval (O/E Ratio)	Upper Confidence Interval (O/E Ratio)
18-44								
45-54								
55-64								
Total								

Table PCR-B-3: Plan All-Cause Readmissions Rates by Age and Risk Adjustment

Age	Count of Index Stays (Denominator)	Count of 30-Day Readmissions (Num/Den)	Observed Readmissions (Num/Den)	Average Adjusted Probability	Total Variance	O/E Ratio (Observed Readmissions/ Average Adjusted Probability)	Lower Confidence Interval (O/E Ratio)	Upper Confidence Interval (O/E Ratio)
64-74								
75-84								
85+								
Total								

Definitions

- HIS - *Index hospital stay. An acute inpatient stay with a discharge on or between January 1 and December 1 of the measurement year. Exclude stays that meet the exclusion criteria in the denominator section.*

- Index Admission Date - *The IHS admission date*

- Index Discharge Date - *The IHS discharge date. The index discharge date must occur on or between January 1 and December 1 of the measurement year*

- Index Readmission Stay - *An acute inpatient stay for any diagnosis with an admission date within 30 days of a previous Index Discharge Date*

- Index Readmission Date - *The admission date associated with the Index Readmission Stay*

- Planned Hospital Stay - *A hospital stay is considered planned if it meets criteria as described in step 5 (required exclusions) of the Eligible Population*

- Classification Period - *365 days prior to and including an Index Discharge Date*

Measure: Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) / NQF 1932

Measure Description:

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

Note: *Members in hospice are excluded from the eligible population. Refer to HEDIS General Guideline 20: Members in Hospice.*

Eligible Population	
Product lines:	Medicaid
Ages:	18–64 years as of December 31 of the measurement year
Continuous enrollment:	The measurement year
Allowable gap:	No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date:	December 31 of the measurement year.
Benefit:	Medical and pharmacy
Event/diagnosis	Follow the steps below to identify the eligible population:

Step 1	
	Identify members with schizophrenia or bipolar disorder as those who met at least one of the following criteria during the measurement year. • At least one acute inpatient encounter, with any diagnosis of schizophrenia or bipolar disorder. Any of the following code combinations meet criteria: – BH Stand Alone Acute Inpatient Value Set *with* Schizophrenia Value Set. – BH Stand Alone Acute Inpatient Value Set *with* Bipolar Disorder Value Set. – BH Stand Alone Acute Inpatient Value Set *with* Other Bipolar Disorder Value Set. – BH Acute Inpatient Value Set *with* BH Acute Inpatient POS Value Set *and* Schizophrenia Value Set. – BH Acute Inpatient Value Set *with* BH Acute Inpatient POS Value Set *and* Bipolar Disorder Value Set. – BH Acute Inpatient Value Set *with* BH Acute Inpatient POS Value Set *and* Other Bipolar Disorder Value Set. • At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or nonacute inpatient setting, on different dates of

service, with any diagnosis of schizophrenia. Any two of the following code combinations meet criteria:
– BH Stand Alone Outpatient/PH/IOP Value Set *with* Schizophrenia Value Set.
– BH Outpatient/PH/IOP Value Set *with* BH Outpatient/PH/IOP POS Value Set *and* Schizophrenia Value Set.
– ED Value Set *with* Schizophrenia Value Set.
– BH ED Value Set *with* ED POS Value Set *and* Schizophrenia Value Set.
– BH Stand Alone Nonacute Inpatient Value Set *with* Schizophrenia Value Set.
– BH Nonacute Inpatient Value Set *with* BH Nonacute Inpatient POS Value Set *and* Schizophrenia Value Set.

- At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or nonacute inpatient setting, on different dates of service, with any diagnosis of bipolar disorder. Any two of the following code combinations meet criteria:
  – BH Stand Alone Outpatient/PH/IOP Value Set *with* Bipolar Disorder Value Set.
  – BH Stand Alone Outpatient/PH/IOP Value Set *with* Other Bipolar Disorder Value Set.
  – BH Outpatient/PH/IOP Value Set *with* BH Outpatient/PH/IOP POS Value Set *and* Bipolar Disorder Value Set.
  – BH Outpatient/PH/IOP Value Set *with* BH Outpatient/PH/IOP POS Value Set *and* Other Bipolar Disorder Value Set.
  – ED Value Set *with* Bipolar Disorder Value Set.
  – ED Value Set *with* Other Bipolar Disorder Value Set.
  – BH ED Value Set *with* ED POS Value Set *and* Bipolar Disorder Value Set.
  – BH ED Value Set *with* ED POS Value Set *and* Other Bipolar Disorder Value Set.
  – BH Stand Alone Nonacute Inpatient Value Set *with* Bipolar Disorder Value Set.
  – BH Stand Alone Nonacute Inpatient Value Set *with* Other Bipolar Disorder Value Set.
  – BH Nonacute Inpatient Value Set *with* BH Nonacute Inpatient POS Value Set *and* Bipolar Disorder Value Set.
  – BH Nonacute Inpatient Value Set *with* BH Nonacute Inpatient POS Value Set *and* Other Bipolar Disorder Value Set.

Step 2 REQUIRED EXCUSIONS	

Exclude members who met any of the following criteria:

- *Members with diabetes*. There are two ways to identify members with diabetes: by claim/encounter data and by pharmacy data. The organization must use both methods to identify members with diabetes, but a member need only be identified by one method to be excluded from the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.
  – *Claim/encounter data.* Members who met at any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years).

	o At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set) or nonacute inpatient encounters (Nonacute Inpatient Value Set) on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two visits. o At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of diabetes (Diabetes Value Set). • *Pharmacy data.* Members who were dispensed insulin or oral hypoglycemics/ antihyperglycemics during the measurement year or year prior to the measurement year on an ambulatory basis (Table CDC-A). • Members who had no antipsychotic medications dispensed during the measurement year. There are two ways to identify dispensing events: by claim/ encounter data and by pharmacy data. The organization must use both methods to identify dispensing events, but an event need only be identified by one method to be counted. – *Claim/encounter data*. An antipsychotic medication (Long-Acting Injections Value Set). – *Pharmacy data*. Dispensed an antipsychotic medication (Table SSD-D) on an ambulatory basis.

Administrative Specification

Denominator:	*Equals the Eligible Population*
Numerator:	
Diabetes Screening	A glucose test (Glucose Tests Value Set) or an HbA1c test (HbA1c Tests Value Set) performed during the measurement year, as identified by claim/encounter or automated laboratory data.

Reporting Criteria:

Patient Population	Denominator	Numerator

Age 18–64 years as of December 31 of the measurement year with bipolar or schizophrenia who met at least one of the following:
 	
   o *At least one acute inpatient encounter*
   o *At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or nonacute inpatient setting, on different dates of service*
   o *At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or nonacute inpatient setting, on different dates of service*
	Eligible Population	A glucose test or an HbA1c test performed during the measurement year, as identified by claim/encounter or automated laboratory data.

Measure References:
Table SSD-D: Antipsychotic Medications (HEDIS 2017, Volume 2)

Description	Prescription
Miscellaneous antipsychotic agents	• Aripiprazole • Asenapine • Brexpiprazole • Cariprazine • Clozapine • Haloperidol • Iloperidone • Loxapine • Lurisadone • Molindone • Olanzapine • Paliperidone • Pimozide • Quetiapine • Quetiapine fumarate • Risperidone • Ziprasidone
Phenothiazine antipsychotics	• Chlorpromazine • Fluphenazine • Perphenazine • Perphenazine-amitriptyline • Prochlorperazine • Thioridazine • Trifluoperazine
Psychotherapeutic combinations	• Fluoxetine-olanzapine
Thioxanthenes	• Thiothixene
Long-acting injections	• Aripiprazole • Fluphenazine decanoate • Haloperidol decanoate • Olanzapine • Paliperidone palmitate • Risperidone

Table SSD-1: Data Elements for Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (HEDIS 2017, Volume 2)

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

	Administrative
Measurement Year	✓
Data collection methodology	✓
Eligible population	✓
Number of required exclusions	✓
Numerator events by administrative data	✓
Numerator events by supplemental data	✓
Reported rate	✓
Lower 95% confidence interval	✓
Upper 95% confidence interval	✓

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

Measure Description:

The percentage of members 19–64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period

📌 **Note:**
- *If an oral medication and a long-acting injection are dispensed on the same day, calculate number of days covered by an antipsychotic medication (for the numerator) using the prescription with the longest days supply.*
- *If an oral medication and long-acting injection are dispensed on different days, with some overlapping days of supply, count each day within the treatment period only once toward the numerator.*

Eligible Population	
Product lines:	Medicaid
Ages:	18–64 years as of December 31 of the measurement year
Continuous enrollment:	The measurement year
Allowable gap:	No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date:	December 31 of the measurement year.
Benefit:	Medical and pharmacy
Event/diagnosis	Follow the steps below to identify the eligible population:
Step 1	
	Identify members with schizophrenia as those who met at least one of the following criteria during the measurement year: • At least one acute inpatient encounter with any diagnosis of schizophrenia. Either of the following code combinations meets criteria: – BH Stand Alone Acute Inpatient Value Set **with** Schizophrenia Value Set. – BH Acute Inpatient Value Set **with** BH Acute Inpatient POS Value Set **and** Schizophrenia Value Set. • At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or nonacute inpatient setting, on different dates of

service, with any diagnosis of schizophrenia. Any two of the following code combinations meet criteria:
– BH Stand Alone Outpatient/PH/IOP Value Set *with* Schizophrenia Value Set.
– BH Outpatient/PH/IOP Value Set *with* BH Outpatient/PH/IOP POS Value Set *and* Schizophrenia Value Set.
– ED Value Set *with* Schizophrenia Value Set.
– BH ED Value Set *with* ED POS Value Set *and* Schizophrenia Value Set.
– BH Stand Alone Nonacute Inpatient Value Set *with* Schizophrenia Value Set.
– BH Nonacute Inpatient Value Set *with* BH Nonacute Inpatient POS Value Set *and* Schizophrenia Value Set.

Step 2 REQUIRED EXCUSIONS	
	Exclude members who met at least one of the following during the measurement year.
	• A diagnosis of dementia (Dementia Value Set).
	• *Did not* have at least two antipsychotic medication dispensing events. There are two ways to identify dispensing events: by claim/encounter data and by pharmacy data. The organization must use both methods to identify dispensing events, but an event need only be identified by one method to be counted.
	– *Claim/encounter data*. An antipsychotic medication (Long-Acting Injections 14 Days Supply Value Set or Long-Acting Injections 28 Days Supply Value Set).
	– *Pharmacy data*. Dispensed an antipsychotic medication (Table SAA-A) on an ambulatory basis.

Administrative Specification	
Denominator:	*Equals the Eligible Population*
Numerators:	The number of members who achieved a PDC of at least 80% for their antipsychotic medications (Table SAA-A; Long-Acting Injections 14 Days Supply Value Set; Long-Acting Injections 28 Days Supply Value Set) during the measurement year.
	Follow the steps below to identify numerator compliance:
Step 1:	Identify the **IPSD**. The IPSD is the earliest dispensing event for any antipsychotic medication (Table SAA-A; Long-Acting Injections 14 Days Supply Value Set; Long-Acting Injections 28 Days Supply Value Set) during the measurement year.
Step 2:	To determine the **treatment period**, calculate the number of days beginning on the IPSD through the end of the measurement year.
Step 3:	Count the **days covered** by at least one antipsychotic medications (Table SAA-A; Long-Acting Injections 14 Days Supply Value Set; Long-Acting Injections 28 Days Supply Value Set) during the treatment period. To ensure that days supply that

		extend beyond the measurement year are not counted, subtract any days supply that extends beyond December 31 of the measurement year.
	Step 4:	Calculate the member's **PDC** using the following equation. Round to two decimal places, using the .5 rule. $$\frac{\text{Total Days Covered by an Antipsychotic Medication in the Treatment Period (step 3)}}{\text{Total Days in Treatment Period (step 2)}}$$
	Step 5:	Sum the number of members whose PDC is ≥80% for their treatment period.

Reporting Criteria:

Patient Population	Denominator	Numerator

Age 18–64 years as of December 31 of the measurement year with bipolar or schizophrenia who met at least one of the following:
 	
   o *At least one acute inpatient encounter*
   o *At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or nonacute inpatient setting, on different dates of service*
	Eligible Population	The number of members who achieved a PDC of at least 80% for their antipsychotic medications during the measurement year.

Measure References:

Measure Definitions	
IPSD	Index prescription start date. The earliest prescription dispensing date for any antipsychotic medication during the measurement year.
Treatment Period	The period of time beginning on the IPSD through the last day of the measurement year.
PDC	Proportion of days covered. The number of days a member is covered by at least one antipsychotic medication prescription, divided by the number of days in the treatment period.
Oral Medication Dispensing Event	One prescription of an amount lasting 30 days or less. To calculate dispensing events for prescriptions longer than 30 days, divide the days supply by 30 and round down to convert. For example, a 100-day prescription is equal to three dispensing events.

	Multiple prescriptions for different medications dispensed on the same day are counted as separate dispensing events. If multiple prescriptions for the same medication are dispensed on the same day, use the prescription with the longest days supply. Use the Drug ID to determine if the prescriptions are the same or different.
Long-acting injections dispensing event	Injections count as one dispensing event. Multiple J codes or NDCs for the same or different medication on the same day are counted as a single dispensing event.
Calculating number of days covered for oral medications	*If multiple prescriptions for the same or different oral medications are dispensed on the same day,* calculate number of days covered by an antipsychotic medication (for the numerator) using the prescription with the longest days supply. *If multiple prescriptions for different oral medications are dispensed on different days,* count each day within the treatment period only once toward the numerator. *If multiple prescriptions for the same oral medication are dispensed on different days,* sum the days supply and use the total to calculate the number of days covered by an antipsychotic medication (for the numerator). For example, if three antipsychotic prescriptions for the same oral medication are dispensed on different days, each with a 30-day supply; sum the days supply for a total of 90 days covered by an oral antipsychotic (even if there is overlap). Use the Drug ID provided on the NDC list to determine if the prescriptions are the same or different.
Calculating number of days covered for long-acting injections	Calculate number of days covered (for the numerator) for long-acting injections using the days supply specified for the medication in Table SAA-A or in the value set name. *For multiple J Codes or NDCs for the same or different medications on the same day,* use the medication with the longest days supply. *For multiple J Codes or NDCs for the same or different medications on different days* with overlapping days supply, count each day within the treatment period only once toward the numerator.

Table SAA-A: Antipsychotic Medications (HEDIS 2017, Volume 2)

Description	Prescription
Miscellaneous antipsychotic agents (oral)	• Aripiprazole • Asenapine • Brexpiprazole • Cariprazine • Clozapine • Haloperidol • Iloperidone • Loxapine • Lurisadone • Molindone • Olanzapine • Paliperidone • Pimozide • Quetiapine • Quetiapine fumarate • Risperidone • Ziprasidone
Phenothiazine antipsychotics (oral)	• Chlorpromazine • Fluphenazine • Perphenazine • Perphenazine-amitriptyline • Prochlorperazine • Thioridazine • Trifluoperazine
Psychotherapeutic combinations (oral)	• Fluoxetine-olanzapine
Thioxanthenes (oral)	• Thiothixene
Long-acting injections	28-day supply: • *Aripiprazole* • *Fluphenazine decanoate* • *Haloperidol decanoate* • *Olanzapine* • *Paliperidone palmitate* 14-day supply: • *Risperidone*

Table SSA-1: Data Elements for Adherence to Antipsychotic Medications for Individuals With Schizophrenia (HEDIS 2017, Volume 2)

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

	Administrative
Measurement Year	✓
Data collection methodology	✓
Eligible population	✓
Number of required exclusions	✓
Numerator events by administrative data	✓
Numerator events by supplemental data	✓
Reported rate	✓
Lower 95% confidence interval	✓
Upper 95% confidence interval	✓

Measure: Follow-up After Hospitalization for Mental Illness (FUH) / NQF 0576

Measure Description:

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

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

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

Two rates are reported:
- *Percentage of discharges for which **children** received follow-up within 30 days of discharge*
- *Percentage of discharges for which **children** received follow-up within 7 days of discharge*

FUH-BH-A Measure Description
The percentage of discharges for **consumers age 21 and older** (aged 21 to 64, aged 65 years and older) who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner

Two rates are reported:
- *Percentage of discharges for which the **consumer** received follow-up within 30 days of discharge*
- *Percentage of discharges for which the **consumer** received follow-up within 7 days of discharge*

 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 practitioner.*

Eligible Population	
Product lines:	Commercial, Medicare (report each product line separately).
Ages:	6 years and older as of the date of discharge.
Continuous enrollment:	Date of discharge through 30 days after discharge
Allowable gap:	No gaps in enrollment
Anchor date:	None
Benefit:	Medical and mental health (inpatient and outpatient)
Event/diagnosis	An acute inpatient discharge with a principal diagnosis of mental illness (Mental Illness Value Set) 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	If the discharge is followed by readmission or direct transfer to an acute inpatient care setting for a principal mental health diagnosis (Mental Health Diagnosis Value Set) within the 30-day follow-up period, count only the last discharge. Exclude both the initial discharge and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year. To identify readmissions and direct transfers to an acute inpatient care setting: 1. *Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).* 2. *Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).* 3. *Identify the admission date for the stay.*

Exclusions	Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period, regardless of principal diagnosis for the readmission. To identify readmissions 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.* Exclude discharges followed by readmission or direct transfer to an acute inpatient care setting within the 30-day follow-up period if the principal diagnosis was for non-mental health (any principal diagnosis code other than those included in the Mental Health Diagnosis Value Set). To identify readmissions and direct transfers to an acute inpatient care setting: 1. *Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).* 2. *Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).* 3. *Identify the admission date for the stay.* 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:	*Equals the Eligible Population*
Numerators:	
30-Day Follow-Up	A follow-up visit with a mental health practitioner within 30 days after discharge. Include visits that occur on the date of discharge.
7-Day Follow-Up	A follow-up visit with a mental health practitioner within 7 days after discharge. Include visits that occur on the date of discharge. For both indicators, any of the following meet criteria for a follow-up visit: • A visit (FUH Stand Alone Visits Value Set) with a mental health practitioner. • A visit (FUH Visits Group 1 Value Set **and** FUH POS Group 1 Value Set) with a mental health practitioner. • A visit (FUH Visits Group 2 Value Set **and** FUH POS Group 2 Value Set) with a mental health practitioner. • A visit in a behavioral healthcare setting (FUH RevCodes Group 1 Value Set).

- A visit in a nonbehavioral healthcare setting (FUH RevCodes Group 2 Value Set) with a mental health practitioner.
- A visit in a nonbehavioral healthcare setting (FUH RevCodes Group 2 Value Set) with a diagnosis of mental illness (Mental Illness Value Set).
- Transitional care management services (TCM 7 Day Value Set), where the date of service on the claim is 29 days after the eligible population event/diagnosis date of discharge.

The following meets criteria for only the 30-Day Follow-Up indicator:
- Transitional care management services (TCM 14 Day Value Set), where the date of service on the claim is 29 days after the event/diagnosis date of discharge.

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

Reporting Criteria:

Patient Population	Denominator	Numerator
The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner	Eligible Population	A follow-up visit with a mental health practitioner within 30 days after discharge. Include visits that occur on the date of discharge.

Patient Population	Denominator	Numerator
The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner	Eligible Population	A follow-up visit with a mental health practitioner within 7 days after discharge. Include visits that occur on the date of discharge.

Table FUH-1/2/3: Data Elements for Follow-Up After Hospitalization for Mental Illness (HEDIS 2017, Volume 2)

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

	Administrative
Measurement Year	✓
Data collection methodology	✓
Eligible population	✓
Number of required exclusions	*Each of the 2 rates*
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*
Lower 95% confidence interval	*Each of the 2 rates*
Upper 95% confidence interval	*Each of the 2 rates*

HEDIS Key Terms

Value sets and codes

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

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

    o Value sets for the e-measure specifications of the Child and Adolescent Suicide Risk Assessment (SRA-BH-C) and the Adult Suicide Risk Assessment (SRA-A) measures are available from the U.S. National Library of Medicine Value Set Authority Center (VSAC). Access to the VSAC requires a Unified Medical Language System (UMLS) license; states or BHCs may apply for a UMLS license on the UMLS Metathesaurus License webpage. When searching for value sets for the SRA-BH-C measure, use the measure's associated e-Measure number (177) or NQF number (1365). For the SRA-A measure, use the measure's associated e- Measure number (161) or NQF number (0104).

    o Values sets for the Depression Remission at Twelve Months (DEP-REM-12) measure are available from the website of the measure steward, Minnesota Community Measurement, at the Cycle A DDS Guides page on the MN Community Measurement.

    o Value sets for the Diabetes Care For People With Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (SMI-PC) measure have not been updated for public use and are not publicly available at this point.

- **_Measures without value sets:_** Measure specifications without value sets incorporate either the pertinent diagnostic and procedure codes or include links to the source measures where those codes are provided.

Principal Diagnosis/Primary Diagnosis

The diagnosis given at discharge and the one listed in the first position on a claim form.

Secondary Diagnosis

A diagnosis listed on a claim or encounter form that is not classified as the principal diagnosis. A claim form may contain several secondary diagnoses. The organization should follow the specifications stated within each measure to determine whether a diagnosis must be principal or may be secondary.

Using Claims to Identify Events with Diagnoses

Measures require that a visit code or procedure code be used in conjunction with a diagnosis code. Unless otherwise stated in a measure specification, the codes must be on the same claim *or* be found on the same date of service.

If a value set includes codes used on professional claims (e.g., CPT, HCPCS) *and* includes codes used on facility claims (e.g., Uniform Bill), use diagnosis and procedure codes from both facility and professional claims to identify services and diagnoses (the codes can be on the same claim or same date of service).

HEDIS Data Element Definitions

(HEDIS 2017, Volume 2)

	Admin	Hybrid	Research	**Meaning**
Measurement Year	✓	✓		Data year (i.e., year prior to reporting year). For HEDIS 2017, the measurement year is 2016.
Data Collection Methodology	✓	✓		Method used to collect HEDIS data. The Administrative Method is from transactional data for the eligible population and the Hybrid Method is from medical record or electronic medical record and transactional data for the sample.
Eligible Population	✓	✓		• Members who meet all criteria for the population. This is the universe of members for each measure. • For administrative measures, the eligible population is reported after evaluation for optional exclusion criteria and after required exclusions are applied. • For hybrid measures, the eligible population of members is reported prior to optional exclusions and after required exclusions are applied (see Guidelines for Calculations and Sampling for the three approaches to conducting the Hybrid Method).
Number of optional exclusions			✓	Number of members excluded from the eligible population because they did not meet the numerator criteria and did meet the optional exclusion criteria
Number of required exclusions			✓	Number of members excluded from the eligible population because they did meet the required exclusion criteria.
Number of numerator events by administrative data in eligible population (before exclusions)		✓		The number of members in the eligible population who met the numerator criteria.
Current year's administrative rate (before exclusions)		✓		This is a calculated field in IDSS. Numerator events by administrative data in eligible population ÷ eligible population.
Minimum required sample size (MRSS) or other sample size		✓		When selecting the sample, this is the required number of members in the sample. Organizations can reduce their samples using Tables 2 and 3 in the sampling guidelines.
Oversampling rate		✓		The percentage of additional records needed to replace exclusions and valid data errors in the denominator. Organizations that need more than a 20% oversample must contact NCQA.

	Admin	Hybrid	Research	Meaning
Final sample size (FSS)		✔		Minimum required sample size + oversample.
Number of numerator events by administrative data in FSS		✔		Number of members in the final sample size who meet numerator criteria through transactional data.
Administrative rate on FSS		✔		This is a calculated field in IDSS. Numerator events by administrative data in the FSS ÷ FSS.
Number of original sample records excluded because of valid data errors		✔		If the medical record review shows that the member does not meet the criteria outlined in the eligible population, that member is considered a valid data error.
Number of administrative data records excluded		✔		Number of members excluded from the denominator because they did not meet the numerator criteria and did meet the exclusion criteria. In this case, the member met the exclusion criteria using transactional data.
Number of records excluded because of false positive diagnoses*			✔	This is an optional data element in Controlling High Blood Pressure. NCQA will analyze the exclusion criteria. Organizations may choose to report their exclusions using this element, but this element will only be used for analysis and not for calculating the measure.
Number of medical records excluded		✔		Number of members excluded from the denominator because they did not meet the numerator criteria and did meet the exclusion criteria. In this case, the member met the exclusion criteria using medical record data.
Number of employee/dependent medical records excluded		✔		Number of records in the sample excluded because the member was an organization employee or a dependent of an organization employee.
Exclusions			✔	The number of required/optional exclusions. NCQA will use this element for research and analysis. The element will not be used for calculating the measure.
Records added from the oversample list		✔		Replacement records for members in the denominator who had an exclusion or valid data error.

	Admin	Hybrid	Research	Meaning
Denominator		✔		MRSS – exclusions + members added from the auxiliary list. This population is the denominator used to report the measure.
Numerator events by administrative data	✔	✔		The number of members in the denominator who met numerator criteria using transactional data.
Numerator events by supplemental data	✔	✔		The number of members in the denominator who met numerator criteria using supplemental data (includes standard and nonstandard data). This data element is collected for only EOC and EOC-like measures.
Numerator events by medical records		✔		The number of members in the denominator who met numerator criteria using medical record data.

Data element is optional

HEDIS Practitioner Types: Mental Health Practitioner
(HEDIS 2017, Volume 2)

Appendix 3: Practitioner Types	
Mental Health Practitioner	A practitioner who provides mental health services and meets any of the following criteria: • An MD or doctor of osteopathy (DO) who is certified as a psychiatrist or child psychiatrist by the American Medical Specialties Board of Psychiatry and Neurology or by the American Osteopathic Board of Neurology and Psychiatry; or, if not certified, who successfully completed an accredited program of graduate medical or osteopathic education in psychiatry or child psychiatry and is licensed to practice patient care psychiatry or child psychiatry, if required by the state of practice. • An individual who is licensed as a psychologist in his/her state of practice, if required by the state of practice. • An individual who is certified in clinical social work by the American Board of Examiners; who is listed on the National Association of Social Worker's Clinical Register; or who has a master's degree in social work and is licensed or certified to practice as a social worker, if required by the state of practice. • A registered nurse (RN) who is certified by the American Nurses Credentialing Center (a subsidiary of the American Nurses Association) as a psychiatric nurse or mental health clinical nurse specialist, or who has a master's degree in nursing with a specialization in psychiatric/mental health and two years of supervised clinical experience and is licensed to practice as a psychiatric or mental health nurse, if required by the state of practice. • An individual (normally with a master's or a doctoral degree in marital and family therapy and at least two years of supervised clinical experience) who is practicing as a marital and family therapist and is licensed or a certified counselor by the state of practice, or if licensure or certification is not required by the state of practice, who is eligible for clinical membership in the American Association for Marriage and Family Therapy. • An individual (normally with a master's or doctoral degree in counseling and at least two years of supervised clinical experience) who is practicing as a professional counselor and who is licensed or certified to do so by the state of practice, or if licensure or certification is not required by the state of practice, is a National Certified Counselor with a Specialty Certification in Clinical Mental Health Counseling from the National Board for Certified Counselors (NBCC).

HEDIS Summary Table of Measures, Product Line and Changes
(HEDIS 2017, Volume 2)

HEDIS 2017 Measures	Applicable to:			Changes to HEDIS 2017
	Commercial	Medicaid	Medicare	
EFFECTIVENESS OF CARE				
Follow-Up After Hospitalization for Mental Illness	✓	✓	✓	Removed language instructing organizations to use only facility claims to identify discharges and diagnoses for denominator events. This is now addressed in *General Guideline 46.* • Added value sets to identify direct transfers.
Follow-Up After Emergency Department Visit for Mental Illness	✓	✓	✓	First-year measure.
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence	✓	✓	✓	First-year measure.
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		✓		• Replaced all references to BH ED POS Value Set with ED POS Value Set (the codes in these value sets are the same). • Added *cariprazine* to the description of "Miscellaneous antipsychotic agents" in Table SSD-D.
Adherence to Antipsychotic Medications for Individuals with Schizophrenia		✓		• Clarified how to calculate number of days covered if both oral medications and long-acting injections are dispensed in the new Notes in the Definition section. • Replaced all references to BH ED POS Value Set with ED POS Value Set (the codes in these value sets are the same). • Added Cariprazine to the description of "Miscellaneous antipsychotic agents (oral)" in Table SAA-A.

HEDIS 2017 Measures	Applicable to:			Changes to HEDIS 2017
	Commercial	Medicaid	Medicare	
UTILIZATION AND RISK ADJUSTED UTILIZATION				
Plan All-Cause Readmissions	✓		✓	• Moved the Risk Adjustment Determination section to the Guidelines for Risk Adjusted Utilization Measures. • Clarified that organizations may not consolidate stays into a single stay if the discharge date from the first setting and the admission date of the second setting are two or more calendar days apart. • Added instructions to identify direct transfers. • Changed the reference of "discharges" to "admissions" in step 3 of the Numerator.