Health Services
Bureau of Medicaid Care Management and Customer Service
Bureau of Specialty Behavioral Health Services

PRE-PAID INPATIENT HEATH PLAN (PIHP) SPECIFICATIONS FOR:

- ***Implementation of Joint Care Management Processes- Child***
- ***Implementation of Joint Care Management Processes- Adult***
- ***Follow-Up After Hospitalization for Mental Illness within 30 Days (FUH)***
- ***Initiation and Engagement of Substance Use Disorder Treatment (IET)***
- ***Follow-Up After Emergency Department (ED) Visit for Substance Use (FUA)***

FY 2026

Implementation of Joint Care Management Processes - Child

MEASURE	
The percentage of child enrollees, in managed care, who meet the CC360 risk stratification criteria and had a joint care plan opened or updated during the 15-month numerator compliance window.	
MINIMUM STANDARD	
N/A – This measure is Informational Only.	
ELIGIBLE POPULATION	
Age	Age 20 and younger as of the last day of the measurement period.
Continuous Enrollment	MHP – Member must be continuously enrolled in the same Health Plan during the 6-month eligibility period. In addition, the member must be enrolled with the same Health Plan on the last day of the numerator compliance window. PIHP – Member must be with the given PIHP for the first and the last month of the 6-month eligibility period.
Allowable Gap	MHP – No more than a one-month gap in enrollment during the 6-month eligibility period. PIHP – Based on member's county of residence; member must be with the given PIHP for the first and the last month of the 6-month eligibility period.
Anchor Date	MHP – Member must be enrolled with the Health Plan on the measurement period end date. In addition, the member must be enrolled with the same Health Plan on the last day of the numerator compliance window. PIHP – Member must be with the given PIHP for the first and the last month of the 6-month eligibility period
Event/Diagnosis	Member must have at least one PIHP-submitted behavioral health service (Member Identifier Type CID '89') during the 6-month eligibility period. (This intentionally excludes SUD claims.) Member must have at least 2 ED visits during the 6-month eligibility period. Member must have at least 1 chronic physical health conditions during the 6-month eligibility period.

	Determination of ED visits and chronic physical health conditions will be based on the criteria outlined in the CC360 Risk Stratification job aid.
Exclusions	None.
ADMINISTRATIVE SPECIFICATIONS	
Denominator	The eligible population.
Numerator	Member must have at least one joint care plan record in a status of 'open' or 'completed' and it must have been 'opened' (i.e. created) or 'updated' during the 15-month numerator compliance window.
DATA ELEMENTS	

Data is extracted from the Medicaid Data Warehouse.

Member level CC360 risk stratification data will be saved monthly and used as the basis for denominator, applying additional criteria as appropriate (e.g., continuous coverage).

Month of Extract	Measurement Period End Date	Eligibility Period	Numerator Compliance Window
Apr 2026	12/31/2025	7/1/2025 – 12/31/2025	1/1/2025 – 3/31/2026
Jul 2026	3/31/2026	10/1/2025 – 3/31/2026	4/1/2025 – 6/30/2026
Oct 2026	6/30/2026	1/1/2026 – 6/30/2026	7/1/2025 – 9/30/2026
Jan 2027	9/30/2026	4/1/2026 – 9/30/2026	10/1/2025 – 12/31/2026

PROCESS

The plan-specific percentages will be electronically transmitted to each MHP and PIHP.

MEASUREMENT FREQUENCY

Quarterly.

NOTE: For purposes of this specification, “eligibility period” is the 6-month period when the eligible population criteria are applied. The “numerator compliance window” is the 15-month window starting 6 months prior to the “eligibility period” and extending through 3 months after the eligibility period.

EXAMPLE: A measurement period end date of 12/31/25 would use 7/1/25 – 12/31/25 as the 6-month “eligibility period”. This period is used for the purpose of identifying the eligible population (via CC360 risk stratification tool). The “numerator compliance window” for the 12/31/25 measurement period end date would be 1/1/25 – 3/31/26 (15 months). This is used for determining whether the Joint Care Plan was created and/or updated as required.

Implementation of Joint Care Management Processes – Adult

MEASURE	
The percentage of adult enrollees, in managed care, who meet the CC360 risk stratification criteria and had a joint care plan opened or updated during the 15-month numerator compliance window.	
MINIMUM STANDARD	
The minimum standard is at least **25%.**	
ELIGIBLE POPULATION	
Age	Age 21 and older as of the last day of the measurement period.
Continuous Enrollment	MHP – Member must be continuously enrolled in the same Health Plan during the 6-month eligibility period. In addition, the member must be enrolled with the same Health Plan on the last day of the numerator compliance window. PIHP – Member must be with the given PIHP for the first and the last month of the 6-month eligibility period.
Allowable Gap	MHP – No more than a one-month gap in enrollment during the 6-month eligibility period. PIHP – Based on member's county of residence; member must be with the given PIHP for the first and the last month of the 6-month eligibility period.
Anchor Date	MHP – Member must be enrolled with the Health Plan on the measurement period end date. In addition, the member must be enrolled with the same Health Plan on the last day of the numerator compliance window. PIHP – Member must be with the given PIHP for the first and the last month of the 6-month eligibility period
Event/Diagnosis	Member must have at least one PIHP-submitted behavioral health service (Member Identifier Type CID '89') during the 6-month eligibility period. (This intentionally excludes SUD claims.) Member must have at least 4 ED visits during the 6-month eligibility period. Member must have at least 2 chronic physical health conditions during the 6-month eligibility period.

	Determination of ED visits and chronic physical health conditions will be based on the criteria outlined in the CC360 Risk Stratification tool .
Exclusions	None.
ADMINISTRATIVE SPECIFICATIONS	
Denominator	The eligible population.
Numerator	Member must have at least one joint care plan record in a status of 'open' or 'completed' and it must have been 'opened' (i.e. created) or 'updated' during the 15-month numerator compliance window.
DATA ELEMENTS	

Data is extracted from the Medicaid Data Warehouse.

Member level CC360 risk stratification data will be saved monthly and used as the basis for denominator, applying additional criteria as appropriate (e.g., continuous coverage).

Month of Extract	Measurement Period End Date	Eligibility Period	Numerator Compliance Window
Apr 2026	12/31/2025	7/1/2025 – 12/31/2025	1/1/2025 – 3/31/2026
Jul 2026	3/31/2026	10/1/2025 – 3/31/2026	4/1/2025 – 6/30/2026
Oct 2026	6/30/2026	1/1/2026 – 6/30/2026	7/1/2025 – 9/30/2026
Jan 2027	9/30/2026	4/1/2026 – 9/30/2026	10/1/2025 – 12/31/2026

PROCESS

The plan-specific percentages will be electronically transmitted to each MHP and PIHP.

MEASUREMENT FREQUENCY

Quarterly.

NOTE: For purposes of this specification, “eligibility period” is the 6-month period when the eligible population criteria are applied. The “numerator compliance window” is the 15-month window starting 6 months prior to the “eligibility period” and extending through 3 months after the eligibility period.

EXAMPLE: A measurement period end date of 12/31/25 would use 7/1/25 – 12/31/25 as the 6-month “eligibility period”. This period is used for the purpose of identifying the eligible population (via CC360 risk stratification tool). The “numerator compliance window” for the 12/31/25 measurement period end date would be 1/1/25 – 3/31/26 (15 months). This is used for determining whether the Joint Care Plan was created and/or updated as required.

Follow-Up after Hospitalization for Mental Illness within 30 days

MEASURE
The percentage of discharges for individuals age six (6) 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 within 30 days of discharge.
MINIMUM STANDARD
The minimum standard for ages six (6) to 17 is at least **79%**. The minimum standard for ages 18 and older is at least **62%**. Plans will be incentivized to reduce the disparity between the index population and at least one minority group. Measurement period for addressing racial/ethnic disparities will be a comparison of calendar year 2024 with calendar year 2025.

ELIGIBLE POPULATION	
Age	Age six (6) and older as of date of discharge.
Continuous Enrollment	Date of discharge through 30 days after discharge.
Allowable Gap	None.
Anchor Date	None.
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 or between January 1 and December 1 of the measurement year To identify acute inpatient discharges: • Identify all acute and non-acute inpatient stays (Inpatient Stay Value Set). • Exclude non-acute inpatient stays (Non-acute Inpatient Stay Value Set). • Identify the discharge date for the stay. The denominator for this measure is based on discharges, not on beneficiaries. If beneficiaries have more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year.
Exclusions	Exclude discharges followed by readmission or direct transfer to a **non-acute** inpatient care setting within the 30-day follow-up period, regardless of principal diagnosis for the readmission. Exclude discharges followed by readmission or direct transfer to an **acute** inpatient care setting within 30-day follow-up period if the principal diagnosis was for non-mental health. 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. Exclude members who meet either of the following criteria: • Members in hospice or using hospice services anytime during the measurement period. • Members who died anytime during the measurement period.
ADMINISTRATIVE SPECIFICATIONS	
Denominator	The eligible population. **Note:** The denominator for this measure is based on discharges, not individuals.
Numerator	A follow-up visit with a mental health provider within 30 days after discharge. Does not include visits that occur on the date of discharge.
DATA ELEMENTS	

Data is extracted from the Medicaid Data Warehouse.

Please refer to the *Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) Technical Specifications and Resource Manual for Federal Fiscal Year 2025 Reporting* for the current list of the specific codes and exclusions for this measure*:*

2025 Core Set of Children's Health Care Quality Measures

Please refer to the *Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) Technical Specifications and Resource Manual for Federal Fiscal Year 2025 Reporting* for the current list of the specific codes and exclusions for this measure*:*

Core Set of Adult's Health Care Quality Measures for Medicaid (Adult Core Set) Technical Specifications and Resource Manual for 2025 Reporting

***These specifications are a summary. The CMS Core Set specifications provide the full detail, and in the case of any differences between the summary and the CMS specifications, the CMS specifications should be considered the full and complete specification.**

Month of Extract	Measurement Period
May 2026	01/01/25 – 12/31/25

Month available in CC360	Month of Extract	Measurement Period
Jan 2026	Nov 2025	07/01/24 – 06/30/25
Apr 2026	Feb 2026	10/01/24 – 09/30/25
Jul 2026	May 2026	01/01/25 – 12/31/25
Oct 2026	Aug 2026	04/01/25 – 03/31/26

PROCESS

The plan-specific percentages will be electronically transmitted to each MHP and PIHP. Quarterly results will also be available via CC360.

MEASUREMENT FREQUENCY

Annually

Initiation and Engagement of Substance Use Disorder Treatment

MEASURE
Percentage of enrollees aged 18 to 64 with new substance use disorder episodes during the measurement period who initiated or engaged in treatment: • **Initiation of SUD Treatment**. Percentage of new substance use disorder (SUD) episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis. • **Engagement of SUD Treatment**. Percentage of new substance use disorder (SUD) episodes that have evidence of treatment engagement within 34 days of initiation
MINIMUM STANDARD
The minimum standard for Initiation (IET 14) is at least **40%**. The minimum standard for Engagement (IET 34) is at least **15%**. Plans will be incentivized to reduce the disparity between the index population and at least one minority group. Measurement period for addressing racial/ethnic disparities will be a comparison of calendar year 2024 with calendar year 2025.

ELIGIBLE POPULATION	
Age	Age 18 to 64 as of the last day of the measurement period.
AOD diagnosis cohorts	Report the following diagnosis cohorts for both the 14- and 34-day measures: • Alcohol use or dependence • Opioid use or dependence • Other substance use disorder Total substance use or dependence
Continuous Enrollment	194 days prior to the index episode start date (IESD) through 47 days after the episode date (242 total days).
Allowable Gap	No allowable gap during the continuous enrollment period.
Anchor Date	None.
Event/Diagnosis	Definition of index episode start date (IESD): New episodes of SUD occurring more than 47 days before the end of the measurement period, to allow time for the follow-up visits to occur. **Step 1** Identify all SUD episodes. **Step 2** Test for negative SUD diagnosis history. **Step 3**

	Test for negative SUD medication history. **Step 4** Remove SUD episodes that do not meet continuous enrollment criteria. Beneficiaries must be continuously enrolled from 194 days before the SUD episode date through 47 days after the SUD episode date (242 total days), with no gaps. **Step 5** Deduplicate eligible episodes. If a beneficiary has more than one eligible episode on the same day, include only one eligible episode. For example, if a beneficiary has two eligible episodes on January 1, only one eligible episode would be included; then, if applicable, include the next eligible episode that occurs after January 1. **Step 6** Identify the SUD diagnosis cohort for each SUD episode. *Please look at the CMS Adult Core Set Technical Specifications for more in-depth criteria for this section.
Exclusions	Dual-enrolled Medicare/Medicaid and Spenddown beneficiaries are excluded. Beneficiaries in hospice are excluded from the eligible population. Beneficiaries who died during the measurement period are excluded.
ADMINISTRATIVE SPECIFICATIONS	
Denominator	The eligible population is defined. The denominator is the same for both 14- and 34-day measures.
Numerator 1 - Initiation of AOD Treatment (14-day)	Follow-up service that meets CMS measure specifications for SUD treatment within 14 days of the IESD (index episode start date).
Numerator 2 - Engagement of AOD treatment (34-day)	Evidence of treatment engagement that meets CMS measure specifications for SUD treatment within 34 days of the IESD.
Numerator Note	If the beneficiary is compliant for multiple diagnosis cohorts, only count the beneficiary once for the Total Engagement numerator. The Total rate is not the sum of the diagnosis cohorts.
Additional Codes	No additional codes have been added by MDHHS.
DATA ELEMENTS	
Data is extracted from the Medicaid Data Warehouse. **Please refer to the *Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) Technical Specifications and Resource Manual for Federal Fiscal Year 2025 Reporting* for the current list of the specific codes and exclusions for this measure*:***	

Core Set of Adult's Health Care Quality Measures for Medicaid (Adult Core Set) Technical Specifications and Resource Manual for 2025 Reporting
NCQA's Medication List Directory (MLD) of NDC codes for Medication Treatment for Alcohol Abuse or Dependence Medications and Medication Treatment for Opioid Abuse or Dependence Medications can be found at:

https://store.ncqa.org/hedis-my-2024-medication-list-directory.html

The electronic specification from Health IT.gov is located on the eCQI resource center webpage at https://ecqi.healthit.gov

Month of Performance Report	Month of Extract	Measurement Period
Jan 2026	Nov 2025	07/01/24 – 06/30/25
Apr 2026	Feb 2026	10/01/24 – 09/30/25
Jul 2026	May 2026	01/01/25 – 12/31/25
Oct 2026	Aug 2026	04/01/25 – 03/31/26

PROCESS

The plan-specific percentages will be electronically transmitted to each PIHP and will be available in CC360.

MEASUREMENT FREQUENCY

Quarterly

Follow-Up after Emergency Department (ED) Visit for Substance Use

MEASURE	
The percentage of emergency department (ED) visits for individuals age 13 and older with a principle diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was a follow up within 30 days.	
MINIMUM STANDARD	
Plans will be incentivized to reduce the disparity between the index population and at least one minority group. Measurement period for addressing racial/ethnic disparities will be a comparison of calendar year 2024 with calendar year 2025.	
ELIGIBLE POPULATION	
Age	Age 13 and older as of date of the ED visit.
Continuous Enrollment	Date of the ED visit through 30 days after the ED visit (31 total days).
Allowable Gap	None.
Anchor Date	None.
Event/Diagnosis	An ED visit (ED Value Set) with a principal diagnosis of SUD (AOD Abuse and Dependence Value Set) or any diagnosis of drug overdose (Unintentional Drug Overdose Value Set) on or between January 1 and December 1 of the measurement year where the beneficiary was age 18 or older on the date of the visit. The denominator for this measure is based on ED visits, not on beneficiaries. If a beneficiary has more than one ED visit, identify all eligible ED visits between January 1 and December 1 of the measurement year and do not include more than one visit per 31-day period, as described below.
Exclusions	Exclude ED visits that result in an inpatient stay and ED visits followed by an admission to an acute or non-acute 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 non-acute inpatient stays (Inpatient Stay Value Set). 2. Identify the admission date for the stay. Exclude ED visits followed by residential treatment on the date of the ED visit or within the 30 days after the ED visit. Any of the following meets criteria for residential treatment: 1. Residential Behavioral Treatment Value Set.

	2. Psychiatric Residential Treatment Center (POS Code 56). 3. Residential Substance Abuse Treatment Facility (POS Code 55). 4. Residential Program Detoxification Value Set. Exclude beneficiaries who meet either of the following criteria: • Beneficiaries in hospice or using hospice services anytime during the measurement year. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Adult Core Set. • Beneficiaries who died any time during the measurement year. For additional information, refer to the deceased beneficiaries exclusion guidance in Section II. Data Collection and Reporting of the Adult Core Set.
ADMINISTRATIVE SPECIFICATIONS	
Denominator	The eligible population. **Note:** The denominator for this measure is based on ED visits, not individuals. If the member had more than one ED visit during the measurement period, only one visit per 31-day period will be included.
Numerator	A follow-up visit or pharmacotherapy dispensing event within 30 days after the ED visit (31 total days). Include visits and pharmacotherapy events that occur on the date of the ED visit.
DATA ELEMENTS	

Data is extracted from the Medicaid Data Warehouse.

Please refer to the *Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) Technical Specifications and Resource Manual for Federal Fiscal Year 2025 Reporting* for the current list of the specific codes and exclusions for this measure*:*
2025 Core Set of Children's Health Care Quality Measures

Please refer to the *Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) Technical Specifications and Resource Manual for Federal Fiscal Year 2025 Reporting* for the current list of the specific codes and exclusions for this measure*:*
Core Set of Adult's Health Care Quality Measures for Medicaid (Adult Core Set) Technical Specifications and Resource Manual for 2025 Reporting

***These specifications are a summary. The CMS Core Set specifications provide the full detail, and in the case of any differences between the summary and the**

CMS specifications, the CMS specifications should be considered the full and complete specification.

Month of Extract	Measurement Period
May 2026	01/01/25 – 12/31/25

Month available in CC360	Month of Extract	Measurement Period
Jan 2026	Nov 2025	07/01/24 – 06/30/25
Apr 2026	Feb 2026	10/01/24 – 09/30/25
Jul 2026	May 2026	01/01/25 – 12/31/25
Oct 2026	Aug 2026	04/01/25 – 03/31/26

PROCESS

The plan-specific percentages will be electronically transmitted to each MHP and PIHP.

MEASUREMENT FREQUENCY

Annually