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Behavioral Health and Substance Use, Fall 2020 Cycle: CDP Report

TECHNICAL REPORT
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Contents

Executive Summary

Behavioral health refers to the study of how cognitive habits and conditions affect overall well-being, biology, and behavior. Sometimes used interchangeably with mental health, behavioral health encompasses broader concepts that include mental wellness and its effects on human behaviors and choices. Thus, behavioral health comprises not only mental health but also substance use disorders (SUDs). These two important components of behavioral health represent a key construct of healthcare across the globe, unified by brain-based etiology and behavioral symptomology.

The review and evaluation of behavioral health measures have long been priorities of the National Quality Forum (NQF), with endorsement for mental health and SUD measures dating back over a decade. At present, there are 43 NQF-endorsed behavioral health measures. The background and description of NQF's most recent Behavioral Health and Substance Use (BHSU) Standing Committee meeting, as well as previous meetings, are available on NQF's project webpage. This Standing Committee oversees the measurement portfolio used to advance accountability and quality in the delivery of BHSU services.

During the fall 2020 measure evaluation cycle, the BHSU Standing Committee reviewed measures in two primary topic areas: appropriate interventions following psychiatric discharge and treatment for SUDs. For this project, the Standing Committee evaluated two newly submitted measures and two measures undergoing maintenance review against NQF's standard evaluation criteria. The Standing Committee recommended three measures for endorsement but did not recommend the remaining measure. The Consensus Standards Approval Committee (CSAC) upheld the Standing Committee's recommendations.

Endorsed Measures:

- **#0576** Follow-Up After Hospitalization for Mental Illness (National Committee for Quality Assurance)
- **#3589** Prescription or Administration of Pharmacotherapy to Treat Opioid Use Disorder (RTI International)
- **#3590** Continuity of Care After Receiving Hospital or Residential Substance Use Disorder (SUD) Treatment (RTI International)

Measure Not Endorsed:

- **#3205** Medication Continuation Following Inpatient Psychiatric Discharge (Mathematica/Centers for Medicare & Medicaid Services)

Brief summaries of the measures are included in the body of the report; detailed summaries of the Standing Committee's discussion and ratings of the criteria for each measure are in Appendix A.

Introduction

Behavioral healthcare refers to a continuum of services for individuals at risk of or suffering from mental or addictive disorders, including challenges broadly ranging from mood and anxiety disorder to learning disabilities and substance abuse or dependence (including tobacco dependence). A comprehensive annual report of behavioral health prevalence data is found in the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Survey on Drug Use and Health (NSDUH). Results from the 2019 NSDUH indicated that in the United States (U.S.), 19.2 million persons 18 years of age or older suffered from an apparent SUD (not including tobacco dependence), and 51.5 million persons 18 years of age or older suffered from a mental illness. Furthermore, there were 9.5 million persons 18 years of age or older who suffered from both an SUD and a mental illness. These numbers jointly suggest that substantive behavioral health disease was evident in at least 61.2 million adult Americans in 2019, or roughly 24 percent of the adult population.[1] This rate is consistent with other epidemiologic studies that have previously revealed the prevalence of behavioral health conditions in the U.S.[2] Behavioral disorders cause considerable pain and dysfunction in the U.S. population, so much so that it represents the leading cause of death and disability when compared to other major illness clusters, such as cancers, circulatory disease (e.g., heart disease, stroke, and arteriosclerosis), injuries, and kidney disease.[2]

There are deep challenges posed by behavioral health illnesses. Such illnesses are typically cycling, chronic, and serious. Nonetheless, many evidence-based approaches exist to prevent such illnesses and to treat the persons and families affected by them.[3-5] Applications of these strategies are neither easy nor universal; furthermore, they are made challenging by the complexity and uncertainty of the underlying pathology and by the stigma that shrouds a category of diseases that often negatively affect social functioning.[6-9]

Appropriate Interventions Following Psychiatric Discharge

Ensuring appropriate treatment for mental health and SUDs is a critical component for addressing behavioral health broadly. The 2019 NSDUH discusses an important concern about receiving treatment for behavioral healthcare in the U.S.: Only 10.3 percent of persons 12 years of age and older with an SUD reported receiving treatment during that year, and only 44.8 percent of persons 18 years of age and older with any mental illness reported receiving care for that condition.[1] These gaps in behavioral health pathology and treatment represent unmet needs among those with behavioral health conditions that may lead to increased hospitalization and other undesirable outcomes associated with SUDs and mental health conditions.[1]

Once a patient has been hospitalized for mental illness or an SUD, ensuring appropriate follow-up and care continuity has been shown to reduce risks for readmission and mortality.[10] For example, studies of patients in the U.S. Department of Veterans Affairs (VA) health system and elsewhere have documented elevated mortality from suicide during a critical period within 30 to 90 days post-discharge from inpatient mental health units.[11] Continuance of pharmacotherapy during the post-discharge period has been shown to reduce hospitalizations and mortality as well.[12]

Treatment for Substance Use Disorders

Opioid overdose deaths have recently become a particular concern in the U.S., and data compiled by the U.S. Centers for Disease Control and Prevention (CDC) placed such deaths at nearly 47,000 in 2018

alone.[13] U.S. deaths attributable to alcohol use (e.g., overdose, accidents, cirrhosis, and cancers) numbered approximately 88,000 per annum, which makes alcohol use the third most common cause of preventable mortality behind tobacco use (first) and poor diet and physical inactivity (second).[14-15] Medications for opioid use disorder (OUD) and other SUDs have been shown to reduce mortality and morbidity associated with OUD and SUD.[16]

NQF Portfolio of Performance Measures for Behavioral Health and Substance Use Conditions

The BHSU Standing Committee (Appendix C) oversees NQF's portfolio of Behavioral Health and Substance Use measures (Appendix B), which includes measures for alcohol and drug use, care coordination, depression, medication use, experience of care, tobacco, and physical health. This portfolio contains 48 measures: 41 process measures, 6 outcome and resource use measures, and one composite measure (see table below).

Table 1. NQF Behavioral Health and Substance Use Portfolio of Measures

Measures	Process	Outcome/Resource Use	Composite
Alcohol and Drug Use	6	0	1
Care Coordination	5	0	0
Depression	5	4	0
Medication Use	11	0	0
Experience of Care	2	0	0
Tobacco	4	0	0
Physical Health	8	2	0
Total	41	6	1

Additional measures have been assigned to other portfolios. These include healthcare-associated infection measures (Patient Safety), care coordination measures (Geriatrics and Palliative Care), imaging efficiency measures (Cost and Resource Use), and a variety of condition- or procedure-specific outcome measures (Cardiovascular, Cancer, Renal, etc.).

Behavioral Health and Substance Use Measure Evaluation

On February 8, 11, and 22, 2021, the BHSU Standing Committee evaluated two new measures and two measures undergoing maintenance review against NQF's standard measure evaluation criteria.

Table 2. Behavioral Health and Substance Use Measure Evaluation Summary

Measures	Maintenance	New	Total
Measures under consideration	2	2	4
Measures endorsed	1	2	3
Measures not endorsed	1	0	1
Reasons for not endorsing	Importance - 0 Scientific Acceptability - 0 Use - 0 Overall - 1 Competing Measure - 0	Importance - 0 Scientific Acceptability - 0 Use - 0 Overall - 0 Competing Measure – 0	*

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Comments Received Prior to Standing Committee Evaluation

NQF accepts comments on endorsed measures on an ongoing basis through the Quality Positioning System (QPS). In addition, NQF solicits comments for a continuous 16-week period during each evaluation cycle via an online tool located on the project webpage. For this evaluation cycle, the commenting period opened on December 15, 2020. During the commenting period, pre-evaluation comments were accepted until January 15, 2021. As of January 15, no pre-evaluation comments were submitted to be shared with the Standing Committee prior to the measure evaluation meeting(s) (Appendix F).

Comments Received After Standing Committee Evaluation

The continuous 16-week public commenting period with NQF member support closed on April 23, 2021. Following the Standing Committee's evaluation of the measures under review, NQF received four comments from three organizations (including two member organizations) and individuals pertaining to the draft report and to the measures under review. All comments for each measure under review have been summarized in Appendix A.

Throughout the 16-week continuous public commenting period, NQF members had the opportunity to express their support ("support" or "do not support") for each measure submitted for endorsement consideration to inform the Standing Committee's recommendations. No NQF members provided their expression of support.

Overarching Issues

During the Standing Committee's discussion of the measures, an overarching issue emerged that was factored into the Standing Committee's ratings and recommendations for multiple measures and is not repeated in detail with each individual measure.

Consistency in Reported Follow-Up Rates

The Standing Committee noted inconsistencies in the follow-up times reported within the measures in the BHSU portfolio and considered whether it would be preferable for the measures to be fully aligned. Many measures report two rates (e.g., seven- and 14-day follow-up or seven- and 30-day follow-up). According to the Standing Committee, there tends to be evidence to support the seven-day follow-up rate because patients are at the highest risk for undesired outcomes in the period immediately following

psychiatric discharge. However, the exact time frames for defining appropriate follow-up were noted by the Standing Committee to be untested for comparative effectiveness and somewhat arbitrary.

Summary of Measure Evaluation

The following brief summaries of the measure evaluation highlight the major issues that the Standing Committee considered. Details of the Standing Committee's discussion and ratings of the criteria for each measure are included in Appendix A.

#0576 Follow-Up After Hospitalization for Mental Illness (National Committee for Quality Assurance): Endorsed

Description: The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Two rates are reported: (1) the percentage of discharges for which the member received follow-up within 30 days after discharge and (2) the percentage of discharges for which the member received follow-up within 7 days after discharge. **Measure Type**: Process; **Level of Analysis**: Health Plan; **Setting of Care**: Inpatient/Hospital, Outpatient Services; **Data Source**: Claims

NQF staff provided the brief description of the measure, as presented above. The measure developer provided an overview of the submission, including the specifications and highlights from the evidence and testing. The Standing Committee noted updated evidence from the developer, specifically a new article that supported previously submitted evidence. The Standing Committee asked the developer for justification for the seven-day and 30-day rates, to which the developer responded by stating that the National Institute for Health and Care Excellence (NICE) guidelines cited in their submission supported this recommendation. The developer emphasized that deaths by suicide were lower for those who received a seven-day follow-up and that readmissions were reduced for patients with mental health conditions when the follow-up occurred within 30 days. During the review of the performance gap analysis, the Standing Committee requested that the measure developer perform stratification by race and ethnicity. The National Committee for Quality Assurance (NCQA) responded, stating that adding this type of stratification to their measures is a current initiative of NCQA. They hope to add this stratification to most of their measures over the next couple of years.

The Standing Committee also asked the developer about improvements in performance over time. The developer suggested that the measure has indeed shown improvements since it was implemented. The Standing Committee reviewed the reliability portion of the submission and noted that the developer used an appropriate method for conducting the testing; they also noted that the results fell within acceptable ranges. When discussing validity, the Standing Committee asked whether telehealth visits count for the numerator, which the developer confirmed. The Standing Committee expressed concerns related to the exclusion of primary care, noting that only mental health specialist visits are counted for the measure and that rural health communities may find it more challenging to participate. The developer noted that collaborative care coding is being considered for measurement year 2021. The Standing Committee agreed that the feasibility of the measure meets an appropriate standard. During the discussion on usability and use, the Standing Committee noted that the measure exhibited some performance fluctuations over time. The developer stated that their analysis of performance over time suggests that the fluctuations were appropriate and even expected, given the changes in the measure specifications. The Standing Committee stated that the measure does not appear to exhibit significant

change in performance over time, and the submission still meets the usability criterion requirements. Ultimately, the Standing Committee recommended the measure for continued endorsement. No comments were received on the measure. The CSAC upheld the Standing Committee's recommendation and maintained endorsement of the measure.

#3205 Medication Continuation Following Inpatient Psychiatric Discharge (Centers for Medicare & Medicaid Services/Mathematica): Not Endorsed

Description: This measure assesses whether patients discharged from an inpatient psychiatric facility (IPF) with major depressive disorder (MDD), schizophrenia, or bipolar disorder filled a prescription for evidence-based medication within two days prior to discharge and 30 days post-discharge. This measure evaluates admissions over a two-year period. **Measure Type**: Process; **Level of Analysis**: Facility; **Setting of Care**: Inpatient/Hospital; **Data Source**: Claims

NQF staff provided the brief description of the measure, as presented above. The measure developer provided an overview of the measure and the submission, outlining the measure specifications and reviewing the testing approach for scientific acceptability. The Standing Committee asked the developer for clarification on whether the medications matched the diagnoses in the measure coding, as well as whether long-acting medications were accounted for. The developer responded, stating that medications are indeed paired with diagnoses, and the long-acting medications are included appropriately as well. In consideration of the evidence submission, the Standing Committee suggested that there were no significant threats to the evidence. In addition, the Standing Committee questioned how discharges with no medications or against medical advice are handled. The developer noted that patients who are not discharged to home or home healthcare are not included in the denominator at all, but patients who are discharged without a prescription are still included. The Standing Committee noted that the severity of illness would typically dictate that all patients in this measure should be on medication; however, the developer noted the difficulty in determining how many patients are contraindicated from receipt of medication. Pregnant patients were noted to be excluded from the measure, which the Standing Committee further noted as a concern since postpartum depression and pregnancy with severe mental illness represent an at-risk population.

The developer was encouraged to explore the possibility of including this population within measurement. During the discussion on performance gap and disparities, the Standing Committee noted a wide performance gap as well as good data submitted by the developer on disparities.
The Standing Committee noted that the developer used a common approach to determining score-level reliability for the measure, namely the beta-binomial signal-to-noise analysis, and that the results fell within an acceptable range. During the validity discussion, the Standing Committee noted the known-group method used for score-level validity as well as abstraction methods for data element-level reliability. They also noted that the measure involves both hospitals and outpatient providers, with the accountability falling on the facility that may not have full control over this aspect of care. This was expressed as especially challenging for mental health patients. The Standing Committee noted that the healthcare system is increasingly moving toward shared accountability for issues such as this.

The developer was encouraged to ensure that long-acting injectables administered within the facility are included in the measure since this allows for more control on the part of the facility. This was concerning from a data-sourcing perspective, given that long-acting injectables would not be captured in Medicare

Part D data. The Standing Committee expressed concern about whether individual drugs given before discharge could be easily retrieved electronically or whether they would be bundled into the diagnosis-related group (DRG), meaning a manual chart review would need to occur. The Standing Committee also expressed concern that the measure is not keeping pace with practice, both pharmacologically and therapeutically, as long-acting injectables are increasingly used within inpatient settings to allow for an extended period of therapeutic coverage post-discharge. The developer was encouraged to analyze their own measure to ensure that this element of care provision is appropriately captured within the measure to further ensure its validity.

During the feasibility discussion, the Standing Committee noted that this measure draws on claims data; however, they expressed further concerns related to the limitations identified during the validity discussion. The Standing Committee expressed no concerns related to use. During the discussion on usability, the Standing Committee noted that the measure has yet to be included in an accountability program; thus, it has not received feedback from end users in the market or a clear line on harms that may outweigh benefits. Ultimately, the Standing Committee did not reach consensus on overall suitability during the evaluation meeting.

During the public commenting period, two commenters stated that ensuring medication adherence is maintained during transitions of care is an important process to measure; however, they agreed with the Standing Committee's concerns regarding the threats to the measure's validity and supported discontinuing endorsement at this time.

During the post-comment meeting, the Standing Committee expressed continued concerns with this issue, specifically regarding the long-acting injectable anti-psychotics (LAIs) portion of the measure. The Standing Committee restated concerns about the quantity of LAIs administered outside of the hospital and who would be held accountable for this since there is no shared accountability between the hospital and outpatient setting. Additionally, the Standing Committee noted that hospitals have limited access to information about what happens after the patient is discharged, which limits their ability to perform continuous quality improvement on this measure. The Standing Committee was also concerned that the data source for this measure—claims data—does not capture all data of relevance. The measure developer confirmed the possibility that certain LAIs that were administered inpatient would not be captured by the measure. The Standing Committee re-voted on overall suitability and did not pass the measure on overall suitability. The CSAC upheld the Standing Committee's recommendation and removed endorsement from the measure.

#3589 Prescription or Administration of Pharmacotherapy to Treat Opioid Use Disorder (RTI International): Endorsed

Description: This measure reports the percentage of a provider's patients who were Medicaid beneficiaries, ages 18 to 64, with an OUD diagnosis who filled a prescription for, or were administered or ordered, an FDA-approved medication to treat OUD within 30 days of the first attributable OUD treatment encounter with that provider. **Measure Type**: Process; **Level of Analysis**: Facility, Clinician: Individual; **Setting of Care**: Emergency Department and Services, Inpatient/Hospital, Outpatient Services; **Data Source**: Claims, Enrollment Data

NQF staff provided a brief description of the measure, as presented above. RTI International introduced the measure by noting portions of the measure specifications, the measure type, level of analysis, and the rationale for its use. The Standing Committee noted guidance from the American Society of Addiction Medicine (ASAM) and other evidence to focus on provider-level practice standards and approaches to ensure appropriate OUD treatment and further noted a general need for this sort of measure at this level of analysis. The developer was encouraged to include other populations beyond Medicaid beneficiaries captured in fee-for-service (FFS) and encounter data. The Standing Committee noted challenges associated with patients across the country having access to providers with buprenorphine waivers, noting that accountability for a systematic problem is unlikely to be solved by a provider-level measure. The Standing Committee noted the thorough review of the evidence provided by the developers and voiced no concerns with the evidence. For performance gap, the Standing Committee noted the large number of facilities and clinicians included. During the discussion on reliability, the Standing Committee noted that the developer included appropriate analyses with appropriate performance levels.

The Standing Committee also discussed the nuances associated with holding clinicians accountable for both appropriate prescribing and ensuring that patients engage around their medications and pick them up. The developer informed the Standing Committee that the word *ordered* was inappropriately included in the measure description and that it will be removed from the description.
The Standing Committee reviewed the measure testing submitted by the developer for validity and noted that the convergent validity testing for the measure was appropriate.
The Standing Committee discussed that the measure draws from claims data and agreed that it meets NQF's feasibility requirements. During the discussion on use, the Standing Committee stated that this measure is currently included in Shatterproof Atlas but only as a provider-facing metric.
The Standing Committee also discussed the potential impacts of having this measure serve as a patient-facing metric as well. The Standing Committee expressed no concerns related to usability. Ultimately, the Standing Committee recommended the measure for initial endorsement. No comments were received on the measure. The CSAC upheld the Standing Committee's recommendation and maintained endorsement of this measure.

#3590 Continuity of Care After Receiving Hospital or Residential Substance Use Disorder (SUD) Treatment (RTI International): Endorsed

Description: Percentage of Medicaid discharges, ages 18 to 64, being treated for a substance use disorder (SUD) from an inpatient or residential provider that received SUD follow-up treatment within seven or 30 days after discharge. SUD follow-up treatment includes outpatient, intensive outpatient, or partial hospitalization visits; telehealth encounters; SUD medication fills or administrations; or residential treatment (after an inpatient discharge). Two rates are reported: continuity within seven and 30 days after discharge; **Measure Type**: Process; **Level of Analysis**: Facility; **Setting of Care**: Inpatient/Hospital; **Data Source**: Claims, Enrollment Data

NQF staff provided a brief description of the measure, as presented above. RTI International introduced the measure by reviewing the measure specifications and the testing approach for the submission. During the discussion on evidence, the Standing Committee noted that the developer did not include a systematic review; instead, they provided a good number of articles that suggested follow-up as an effective means to improve outcomes for psychiatric discharges that were directionally

positive and of moderate quality. The Standing Committee expressed that they were unaware of any articles suggesting that follow-up is an ineffective intervention. The Standing Committee discussed the time frame for the follow-up to occur, the evidence to support it, and the inconsistency across measures. The developer conceded that there are inconsistencies in the time frame, which is a potential area for future work; however, they also suggested that earlier follow-up interventions may be a better option since the literature suggests that the period closest to discharge carries the most risk for poor outcomes for patients. The Standing Committee discussed outcomes associated with follow-up, including reductions in death, criminal justice involvement, substance use, and treatment justice. During the discussion on performance gap, the Standing Committee reviewed the developer's submission, noting significant variation between providers on follow-up. It was observed that males were less likely to receive follow-up care than females, and Black patients received fewer follow-ups than White patients. The Standing Committee expressed no concerns related to performance gap. During the discussion on reliability, the Standing Committee reviewed the measure specifications and the reliability testing approach provided in the developer's submission, noting that the developer used appropriate analytical approaches with results with moderate effect sizes. The Standing Committee emphasized the importance of the inclusion of telemedicine codes within the measure, especially in light of the COVID-19 pandemic. During the discussion on validity, the Standing Committee reviewed both the developer's submission and the staff analysis and concurred that the measure has moderate validity. They further noted the importance of having follow-up measures that match the acuity of the condition with the proposed follow-up. In addition, the Standing Committee reviewed the analytic approach taken by the developer and found the testing to be appropriately conducted with moderate results.
The Standing Committee also expressed that the data elements for the measure are generated as part of the routine delivery of care and meet the feasibility criterion.

The Standing Committee discussed this measure in the context of the Institutions for Mental Diseases (IMD) exclusion that prohibits the use of federal Medicaid funds to treat enrollees ages 21–64 in psychiatric residential treatment facilities that have more than 16 beds. In 2015, the Centers for Medicare & Medicaid Services (CMS) created a streamlined application pathway for state waivers of this rule to allow Medicaid coverage for SUD treatment in residential facilities. However,
the Standing Committee noted that not every state has a Medicaid waiver such as the one described, and there may be some limitations associated with the IMD exclusion. The Standing Committee also noted that the measure is currently being used for both external and internal benchmarking for some institutions. They expressed that the measure is conducive to continuous improvement and that the developer demonstrated the requirements for initial NQF endorsement related to use.
The Standing Committee did not note any concerns related to usability and ultimately recommended the measure for initial endorsement. No comments were received on the measure. The CSAC upheld the Standing Committee's recommendation and maintained endorsement of the measure.

Measure Gaps and Priorities

The Standing Committee discussed measurement gaps within NQF's portfolio of endorsed behavioral health measures. In particular, the Standing Committee noted that the 2020 Measures Under Consideration (MUC) list did not include any behavioral health measures for the 2020-21 Measure Applications Partnership (MAP) review cycle. The Standing Committee also suggested that one measure gap that warrants consideration is measures of engagement in behavioral health services, which ensures

that patients are not lost from care. The Standing Committee noted that certain process measures capture engagement; however, they expressed that early detection of relapse and risk for relapse are both potential areas to explore for certain conditions. The Standing Committee also noted that there continue to be measure gaps related to transitions in care for behavioral health patients.

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Appendix A: Details of Measure Evaluation

Rating Scale: H=High; **M**=Moderate; **L**=Low; **I**=Insufficient; **NA**=Not Applicable

Vote totals may differ between measure criteria and between measures as Standing Committee members often have to join calls late or leave calls early. NQF ensures that quorum is maintained for all live voting. All voting outcomes are calculated using the number of Standing Committee members present for that vote as the denominator. Quorum (a minimum of 16 out of 23 active Standing Committee members present) was reached and maintained for the duration of all measure evaluation meetings.

Measures Endorsed

#0576 Follow-Up After Hospitalization for Mental Illness

Measure Worksheet | Specifications

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

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

Numerator Statement: 30-Day Follow-Up: a follow-up visit with a mental health provider within 30 days after discharge.

7-Day Follow-Up: a follow-up visit with a mental health provider within 7 days after discharge.

Denominator Statement: Discharges from an acute inpatient setting with a principal diagnosis of mental illness or intentional self-harm on the discharge claim during the first 11 months of the measurement year (i.e., January 1 to December 1) for members 6 years and older.

Exclusions: Exclude from the denominator for both rates members who begin using hospice services anytime during the measurement year (Hospice Value Set).

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

Exclude discharges followed by readmission or direct transfer to a non-acute facility within the 30-day follow-up period regardless of principal diagnosis.

Exclude discharges followed by readmission or direct transfer to an acute facility within the 30-day follow-up period if the principal diagnosis was not for mental health or intentional self-harm.

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

Adjustment/Stratification: None

Level of Analysis: Health Plan

Setting of Care: Inpatient/Hospital, Outpatient Services

Type of Measure: Process

Data Source: Claims

Measure Steward: National Committee for Quality Assurance (NCQA)

STANDING COMMITTEE MEETING: February 8, 2021

1. Importance to Measure and Report: ***The measure meets the Importance criteria.***

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **Total Votes-20; H-1; M-18; L-0; I-1**; 1b. Performance Gap: **Total Votes-20; H-6; M-13; L-1; I-0**; Evidence Exception: **N/A**

Rationale:

- The Standing Committee noted that the updated evidence is directionally the same as the evidence from the June 2017 review.
- The Standing Committee noted updated evidence from the developer, specifically a new article that supported previously submitted evidence.
- The Standing Committee asked the developer for justification for the seven-day and 30-day rates, to which the developer responded by stating that the National Institute for Health and Care Excellence (NICE) guidelines cited support for this recommendation in their submission.
- The developer emphasized that deaths by suicide were lower for those who received a seven-day follow up, and readmissions were reduced for patients with mental health conditions when a follow-up occurred within 30 days.
- In the review of the performance gap analysis, the Standing Committee noted a persistent performance gap.
- The 2018 data on commercial health plans, Medicare, and Medicaid reflected the following:
    - Seven-day rates (mean) of 0.44, 0.28, and 0.36, respectively
    - 30-day rates (mean) of 0.6, 0.48, and 0.57, respectively
- The 2017 data on commercial health plans, Medicare, and Medicaid reflected the following:
    - Seven-day rates (mean) of 0.46, 0.32, and 0.37, respectively
    - 30-day rates (mean) of 0.68, 0.53, and 0.58, respectively

2. Scientific Acceptability of Measure Properties: *The measure meets the Scientific Acceptability criteria.*

(2a. Reliability precise specifications, testing; 2b. Validity testing, threats to validity)

2a. Reliability: **Total Votes-20; H-6; M-13; L-1; I-0**; 2b. Validity: **Total Votes-20; H-2; M-15; L-3; I-0**

Rationale:

- The developer tested reliability at the score level using the beta-binomial model that is used to measure the signal-to-noise ratio (SNR).
- Point estimates of mean SNR ratios for 7-day rates by health plan type provided the following:
    - Commercial plans = 0.884
    - Medicaid plans = 0.969
    - Medicare plans = 0.900
- Point estimates of mean SNR ratios for 30-day rates by health plan type provided the following:
    - Commercial plans = 0.883
    - Medicaid plans = 0.967
    - Medicare plans = 0.910
- The developer used Pearson correlation score-level results of construct validity testing measured against the *Follow-Up After Emergency Department Visit for Mental Illness (FUM)* measure.
- Pearson correlation score-level results were provided within the measure between seven-day and 30-day rates. Correlations were noted by the Standing Committee as positive and significant across health plan types.

3. Feasibility: Total Votes-20; H-14; M-5; L-1; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/ unintended consequences identified; 3d. Data collection strategy can be implemented)

Rationale:

- The measure was noted to draw on claims data and regarded as occurring as part of the routine delivery of care.

4. Usability and Use: *The maintenance measure meets the Use subcriterion.*

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

4a. Use**: Total Votes-19; Pass-19; No Pass-0**; 4b. Usability: **Total Votes-20; H-3; M-14; L-3; I-0**

Rationale:

- The Standing Committee acknowledged that the measure is currently used in several Centers for Medicare & Medicaid Services (CMS) programs, including the following:
  - Medicaid Child Core Set
  - Medicaid Adult Core Set
  - Care Compare
  - Qualified Health Plan (QHP) Quality Rating System (QRS)
  - Quality Payment Program (QPP)
- The measure is also used for NCQA's accreditation of commercial, Medicaid, and Medicare plans; Health Plan Ratings/Report Cards; and the State of Health Care Annual Report.
- Other programs in which the measure is in use include the Quality Compass and Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program.
- The Standing Committee expressed concern related to year-over-year performance for usability but noted that some of the improvement trends that were not increasing were doing so for years with anticipated drops due to changes in measure specifications.

5. **Related and Competing Measures**
   - The Standing Committee noted two related measures: NQF #2605 *Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence* and NQF #3489 *Follow-Up After Emergency Department Visit for Mental Illness*, with all three measures developed by NCQA.
   - The Standing Committee acknowledged that NQF #0576 differs from the other two measures in that it is related to inpatient stays rather than emergency department (ED) visits. However, they called upon NCQA to justify the continuance of NQF #2605 and NQF #3489, given the apparent overlap between the two measures.
6. **Standing Committee Recommendation for Endorsement: Total Votes-20; Yes-18; No-2**
7. **Public and Member Comment**
   - No comments were received.
8. **Consensus Standards Approval Committee (CSAC) Endorsement Decision: Yes-12; No-0; Abstain-0 (June 29, 2021): Endorsed**

The CSAC upheld the Standing Committee's decision to recommend the measure for continued endorsement.

9. **Appeals:** No appeals were received.

#3589 Prescription or Administration of Pharmacotherapy to Treat Opioid Use Disorder (OUD)

Measure Worksheet | Specifications

Description: This measure reports the percentage of a provider's patients who were Medicaid beneficiaries, ages 18 to 64, with an OUD diagnosis who filled a prescription for, or were administered or ordered, an FDA-approved medication to treat OUD within 30 days of the first attributable OUD treatment encounter with that provider.

Numerator Statement: Beneficiaries ages 18 to 64 with an OUD who filled a prescription for, or were administered or ordered, an FDA-approved medication for the treatment of OUD within 30 days of the first attributable encounter with an OUD diagnosis with the provider.

Denominator Statement: Number of Medicaid ages 18–64 beneficiaries with at least one medical claim for an encounter with an OUD diagnosis with that provider (where the provider is identified by a National Provider Identifier [NPI] code).

Exclusions: Dual-eligible Medicare/Medicaid beneficiaries are excluded.

Rationale: Individuals who are covered under Medicare would receive coverage for follow-up treatment medications (e.g., medication-assisted treatment) under Medicare Part D, and Medicare Part D claims are not captured in Medicaid claims databases. Therefore, follow-up would be missed.

Individuals under 18 are excluded.

Rationale: There is limited evidence regarding the efficacy of MOUD for this population.

Individuals over 64 are excluded.

Rationale: Most individuals over age 64 are covered under Medicare. Services covered by Medicare would not be captured in the Medicaid claims data and therefore follow-up treatment would be missed.

Adjustment/Stratification: None

Level of Analysis: Facility, Clinician: Individual

Setting of Care: Emergency Department and Services, Inpatient/Hospital, Outpatient Services

Type of Measure: Process

Data Source: Claims, Enrollment Data

Measure Steward: RTI International

STANDING COMMITTEE MEETING: February 11 and 22, 2021

1. **Importance to Measure and Report:** ***The measure meets the Importance criteria.***

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **Total Votes-19; H-15; M-3; L-1; I-0** 1b. Performance Gap: **Total Votes-19; H-14; M-5; L-0; I-0**; Evidence Exception: **N/A**

Rationale:

- The Standing Committee noted a detailed review of the literature provided by the developer:
  - A 2020 American Society of Addiction Medicine (ASAM) recommendation was provided; grades were not provided.
  - Additional systematic reviews were provided that supported the use of methadone and buprenorphine.
  - A Cochrane collaborate review was cited as well as meta-analysis of 31 trials of buprenorphine versus methadone or placebo, with high-moderate quality of evidence range.
  - A 2005 Substance Abuse and Mental Health Services Administration (SAMHSA) publication was provided; the recommendation is ungraded and notes that there is research to support the use of medications to treat OUD.
  - The 2020 SAMHSA Treatment Improvement Protocol for Medications for OUD was also provided. Statements were ungraded.
- The mean performance for clinicians was 44%; the mean performance for facilities was 31%.
- Disparities data were provided that indicated disparities in the use of medications to treat OUD.

2. **Scientific Acceptability of Measure Properties:** ***The measure meets the Scientific Acceptability criteria.***

(2a. Reliability precise specifications, testing; 2b. Validity testing, threats to validity)

2a. Reliability: **Total Votes-18; H-2; M-15; L-1; I-0**; 2b. Validity: **Total Votes-18; H-1; M-16; L-0; I-1**

Rationale:

- The developer provided test results for three reliability analyses:
  - Parametric analysis of variance (ANOVA) with effect size calculations provided:
    - F-statistic for clinicians: 71.17
    - F-statistic for facility: 84.84
  - Intra-unit reliability (IUR) – 0.99 for clinicians and facilities
  - Beta-binomial SNR analysis
    - Mean for clinicians: 0.95
    - Mean for facilities: 0.95

- The developer conducted score-level validity testing using Pearson product moment correlation coefficients:
    - SUD Follow-Up measure: r=0.39
    - Hospitalization or ED visit associated with SUD or overdose within 30-days after encounter with provider: r=0.39

3. Feasibility: Total Votes-18; H-1; M-17; L-0; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/ unintended consequences identified; 3d. Data collection strategy can be implemented)

Rationale:

- The Standing Committee noted that the measure draws from claims data and agreed that it meets NQF feasibility requirements.

4. Usability and Use:

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

4a. Use**: Total Votes-17; Pass-16; No Pass-1**; 4b. Usability: **Total Votes-17; H-4; M-12; L-1; I-0**

Rationale:

- During the discussion on use, the Standing Committee noted that this measure is currently included in the Shatterproof Atlas but only as a provider-facing metric.
- The Standing Committee discussed the potential impacts of having this measure serve as a patient-facing metric as well.
- The Standing Committee expressed no concerns related to usability.

5. Related and Competing Measures

- The Standing Committee compared NQF #3589 to NQF #3175 *Continuity of Pharmacotherapy for Opioid Use Disorder* and NQF #3400 *Use of Pharmacotherapy for Opioid Use* Disorder, with the same assessment demonstrating that they are related but not competing.
- The measure developer (RTI International) noted that these measures are harmonized to the extent possible.

6. Standing Committee Recommendation for Endorsement: Total Votes-17; Yes-17; No-0

7. Public and Member Comment

- No comments were received.

8. CSAC Endorsement Decision: Yes-12; No-0; Abstain-0 (June 29, 2021): Endorsed

The CSAC upheld the Standing Committee's decision to recommend the measure for endorsement.

9. Appeals: No appeals were received.

#3590 Continuity of Care After Receiving Hospital or Residential Substance Use Disorder (SUD) Treatment

Measure Worksheet | Specifications

Description: Percentage of Medicaid discharges, ages 18 to 64, being treated for a substance use disorder (SUD) from an inpatient or residential provider that received SUD follow-up treatment within 7 or 30 days after discharge. SUD follow-up treatment includes outpatient, intensive outpatient, or partial hospitalization visits; telehealth encounters; SUD medication fills or administrations; or residential treatment (after an inpatient discharge). Two rates are reported: continuity within 7 and 30 days after discharge.

Numerator Statement: Medicaid discharges, ages 18 to 64, with a principal/primary substance (SUD) diagnosis treated at an inpatient or residential provider that received SUD follow-up treatment within 7 or 30 days after discharge. SUD treatment includes outpatient, intensive outpatient, or partial

hospitalization visits; telehealth encounters; or SUD medication fills or administrations; or residential treatment (after an inpatient discharge). Two rates are reported: continuity within 7 and 30 days after discharge.

Denominator Statement: The denominator is Medicaid beneficiaries, ages 18-64, discharged from inpatient or residential provider with a principal diagnosis of SUD on the inpatient/residential treatment encounter claim.

Exclusions: Dual-eligible Medicare/Medicaid beneficiaries are excluded.

Rationale: Individuals who are covered under Medicare would receive coverage for follow-up treatment medications (e.g., OUD medications) under Medicare Part D and Medicare Part D claims are not captured in Medicaid claims databases. Therefore follow-up treatment would be missed.

Adjustment/Stratification: None

Level of Analysis: Facility

Setting of Care: Inpatient/Hospital

Type of Measure: Process

Data Source: Claims, Enrollment Data

Measure Steward: RTI International

STANDING COMMITTEE MEETING: February 22, 2021

1. Importance to Measure and Report: ***The measure meets the Importance criteria.***

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **Total Votes-17; M-17; L-0; I-0**; 1b. Performance Gap: **Total Votes-17; H-13; M-4; L-0; I-0**

Rationale:

- The Standing Committee reviewed the developer's evidence submission and noted that the existing follow-up literature indicates the following results:
    - Follow-up after discharge from inpatient or residential SUD stays is associated with better outcomes.
    - 12 studies were cited.
    - Associations are directionally consistent of moderate quantity and quality.
- The Standing Committee expressed that they were unaware of any articles suggesting that follow-up is an ineffective intervention.
- The Standing Committee noted a substantial performance gap.
    - The median seven-day follow-up rate was 11%.
    - The median 30-day follow-up rate was 24%.
    - There was significant variation across providers.
    - Disparities data were provided:
        - Males less likely than females to receive follow-up care (15% vs. 23%)
        - Blacks less likely than Whites to receive follow-up care (22% vs. 9%)

2. Scientific Acceptability of Measure Properties: ***The measure meets the Scientific Acceptability criteria.***

(2a. Reliability precise specifications, testing; 2b. Validity testing, threats to validity

2a. Reliability: **Total Votes-17; H-1; M-16; L-0; I-0** 2b. Validity: **Total Votes-17; H-0; M-17; L-0; I-0**

Rationale:

- The developer provided three tests for score-level reliability:
    - Parametric ANOVA with effect size calculations provided
        - F-statistic for 7-day follow-up: 63.9
        - F-statistic for facility: 56.6
    - Intra-unit reliability (IUR) – 0.94 for 7-day follow-up; 0.93 for 30-day follow-up
    - Beta-binomial SNR analysis
        - Mean for 7-day: 0.94

        - Mean for 30-day: 0.93
- The submission for score-level validity included an analysis using Pearson product moment correlation coefficients:
    - SUD Follow-Up measure at 7-days: r=0.39
    - SUD Follow-Up measure at 30-days: r=0.39
- The Standing Committee emphasized the importance of the inclusion of telemedicine codes within the measure, especially in light of the COVID-19 pandemic.
- They further noted the importance of having follow-up measures that match the acuity of the condition with the proposed follow-up.

3. Feasibility: Total Votes-16; H-5; M-10; L-1; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

- The Standing Committee noted that this measure is generated using data collected during the routine delivery of care.

4. Use and Usability

4a. Use; 4a1. Accountability and transparency; 4a2. Feedback on the measure by those being measured and others; 4b. Usability; 4b1. Improvement; 4b2. The benefits to patients outweigh evidence of unintended negative consequences to patients)

4a. Use: **Total Votes-16; Pass-16; No Pass-0** *4b. Usability:* **Total Votes-17; H-3; M-13; L-1; I-0**

Rationale:

- The Standing Committee noted that the measure is currently being used for both external and internal benchmarking for some institutions.
- The Standing Committee expressed that the measure is conducive to continuous improvement and that the developer demonstrated the requirements for initial NQF endorsement related to use.

5. Related and Competing Measures

- NQF #3590 had multiple measures that were considered during the related and competing measures discussion. These included four NCQA measures that were considered related but not competing and appropriately harmonized:
    - NQF #0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment
    - NQF #0576 Follow-Up After Hospitalization for Mental Illness
    - NQF #1937 Follow-Up After Hospitalization for Schizophrenia
    - NQF #2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence
- Mathematica's measure, NQF #3312 *Continuity of Care After Medically Managed Withdrawal From Alcohol and/or Drugs*, was noted to report seven- and 14-day rates, which differed from the seven- and 30-day follow-up rates from the other measures.
- NQF #3453 *Continuity of Care After Inpatient or Residential Treatment for Substance Use Disorder* was noted to be at a different level of analysis and otherwise harmonized with NQF #3590.

6. Standing Committee Recommendation for Endorsement: **Total Votes-17; Yes-17; No-0**

7. Public and Member Comment

- No comments were received.

8. CSAC Endorsement Decision: Yes-12; No-0; Abstain-0 (June 29, 2021): Endorsed

The CSAC upheld the Standing Committee's decision to recommend the measure for endorsement.

9. Appeals: No appeals were received.

Measures Not Endorsed

#3205 Medication Continuation Following Inpatient Psychiatric Discharge

Measure Worksheet

Description: This measure assesses whether patients discharged from an inpatient psychiatric facility (IPF) with major depressive disorder (MDD), schizophrenia, or bipolar disorder filled a prescription for evidence-based medication within 2 days prior to discharge and 30 days post-discharge. This measure evaluates admissions over a two-year period.

Numerator Statement: The numerator for the measure includes:

- Discharges with a principal diagnosis of MDD in the denominator population for which patients were dispensed evidence-based outpatient medication within 2 days prior to discharge through 30 days post-discharge
- Discharges with a principal diagnosis of schizophrenia in the denominator population for which patients were dispensed evidence-based outpatient medication within 2 days prior to discharge through 30 days post-discharge
- Discharges with a principal diagnosis of bipolar disorder in the denominator population for which patients were dispensed evidence-based outpatient medication within 2 days prior to discharge through 30 days post-discharge

Denominator Statement: The target population for this measure is Medicare FFS beneficiaries with Part D coverage aged 18 years and older discharged from an IPF with a principal diagnosis of MDD, schizophrenia, or bipolar disorder.

Exclusions: The denominator for this measure excludes discharged patients who:

- received electroconvulsive (ECT) during the inpatient stay or follow-up period
- received transcranial stimulation (TMS) during the inpatient stay or follow-up period
- were pregnant at discharge
- had a secondary diagnosis of delirium at discharge
- had a principal diagnosis of schizophrenia with a secondary diagnosis of dementia at discharge

Adjustment/Stratification: None

Level of Analysis: Facility

Setting of Care: Inpatient/Hospital

Type of Measure: Process

Data Source: Claims

Measure Steward/Developer: Centers for Medicare & Medicaid Services/Mathematica

STANDING COMMITTEE MEETING: February 8, 2021

1. Importance to Measure and Report: ***The measure meets the Importance criteria.***

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **Total Votes-18; H-1; M-16; L-1; I-0** 1b. Performance Gap: **Total Votes-18; H-5; M-13; L-0; I-0** Evidence Exception: **N/A**

Rationale:

- The Standing Committee noted that the developer provided updated evidence for medication continuation in patients with schizophrenia only.
- The evidence provided for major depressive disorder (MDD) and bipolar disorder was the same as the evidence from the previous submission.
- It was noted that the developer provided guidelines that emphasize the need for continued use of medications; however, the evidence described largely focuses on the efficacy or relative advantage of individual medications and not on the timeliness of their use (as is the focus of this measure).

- It was further noted that the U.S. Department of Veterans Affairs/Department of Defense (VA/DoD) guidelines provide some insight into the quality of the studies, but overall, the quality of the evidence has not been presented.
- The Standing Committee agreed that there is evidence to support that lack of adherence to medication leads to relapse and negative outcomes. They also noted that claims data related to medication adherence are directly correlated to outcomes.
- During the discussion on performance gap, the Standing Committee reviewed the performance data from Medicare FFS Part A and Part B claims provided from July 2017 through June 2019.
    - Medication continuation rate (mean) across all facilities: 75.0%
    - Medication continuation rate (mean) for facilities with at least 75 eligible cases in the denominator: 75.1%
    - Disparities data provided: data grouped by sex, SUD diagnosis, dual status, race, diagnosis, and age

2. Scientific Acceptability of Measure Properties: *The measure meets the Scientific Acceptability criteria.*

(2a. Reliability precise specifications, testing; 2b. Validity testing, threats to validity)

2a. Reliability: **Total Votes-19; H-0; M-19; L-0; I-0** 2b. Validity: **Total Votes-19; H-1; M-11; L-4; I-3**

Rationale:

- The developer used the beta-binomial model to measure the SNR.
- The mean reliability was 0.78 at the score level.
- Validity was tested using the known group method.
- The developer identified predefined patient subgroups known to have lower rates of medication continuation based on peer-reviewed literature.
- Spearman's rank correlation score-level results were measured against the Follow-Up After Hospitalization (FUH) Seven-Day, FUH 30-Day, and IPF All-Cause Unplanned Readmission measures.
    - FUH seven-day: 0.34
    - FUH 30-day: 0.43
    - IPF (observed): -0.26
- The Standing Committee expressed concerns related to validity threats.
    - The developer was encouraged to ensure that long-acting injectables administered within the facility are included in the measure since this allows for more control on the part of the facility.
    - This was concerning from a data-sourcing perspective, given that long-acting injectables would not be captured in Medicare Part D data.
    - The Standing Committee expressed concern that the measure is not keeping pace with practice, both pharmacologically and therapeutically, as long-acting injectables are increasingly used within inpatient settings to allow for an extended period of therapeutic coverage post-discharge.
    - The developer was encouraged to analyze their own measure to ensure that this element of care provision is appropriately captured within the measure to further ensure its validity.

3. Feasibility: Total Votes-19; H-2; M-13; L-4; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/ unintended consequences identified; 3d. Data collection strategy can be implemented)

Rationale:

- The Standing Committee did not identify any feasibility concerns.

4. **Usability and Use:** ***The maintenance measure meets the Use sub-criterion.***

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

4a. Use**: Total Votes-20; Pass-20; No Pass-0** 4b. Usability: **Total Votes-18; H-1; M-15; L-2; I-0**

Rationale:

- The developer noted that the IPFs have yet to receive scores, as the measure will be used in the IPFQR program for the first time for FY 2021.
- CMS plans to monitor stakeholder feedback going forward.

5. **Related and Competing Measures**
   - The Standing Committee regarded NQF #1879 *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* as related but not competing.
   - The measure developer (Mathematica) noted that these two measures are harmonized in the medication coding.

6. **Standing Committee Recommendation for Endorsement:** Not recommended

Initial vote during Measure Evaluation Meeting: Total Votes-19; Yes-11; No-8 (Consensus Not Reached)

Re-vote during Post-Comment Meeting: Total Votes-17; Yes-5; No-12

Rationale

- The Standing Committee expressed concerns about the quantity of LAIs administered outside of the hospital and who would be held accountable for this since there is no shared accountability between the hospital and outpatient setting.
- The Standing Committee was also concerned that the data source for this measure—claims data—does not capture all data of relevance.

7. **Public and Member Comment**
   - Two commenters stated that ensuring medication adherence is maintained during transitions of care is an important process to measure; however, they agreed with the Standing Committee's concerns regarding the threats to the measure's validity and supported discontinuing endorsement at this time.
8. **CSAC Endorsement Decision: Yes-11; No-1; Abstain-0 (June 29, 2021): Not Endorsed**

The CSAC upheld the Standing Committee's decision not to recommend the measure for endorsement.

9. **Appeals:** No appeals were received.

Appendix B: Behavioral Health and Substance Use Portfolio—Use in Federal Programs[a]

NQF #	Title	Federal Programs: Finalized or Implemented as of June 30, 2021
0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Marketplace Quality Rating System (QRS) (Implemented 2015) Medicaid (Implemented 2013)
0004e	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (eMeasure)	None
0027	Medical Assistance With Smoking and Tobacco Use Cessation	Medicaid (Implemented 2018) Marketplace Quality Rating System (QRS) (Implemented 2016)
0028	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	Physician Compare (Implemented 2018) Merit-Based Incentive Payment System (MIPS) (Implemented 2018) Medicare Shared Savings Program (MSSP) (Implemented 2012)
0028e	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (eMeasure)	Physician Compare (Implemented 2018) MIPS Program (Implemented 2018) Million Hearts (Implemented 2018) Medicaid Promoting Interoperability Program (Implemented 2019)
0104	Adult Major Depressive Disorder: Suicide Risk Assessment	None
0104e	Adult Major Depressive Disorder: Suicide Risk Assessment (eMeasure)	Physician Compare (Implemented 2018) MIPS Program (Implemented 2018) Medicaid Promoting Interoperability Program (Implemented 2019)
0105	Antidepressant Medication Management (AMM)	Healthcare Effectiveness Data and Information Set (HEDIS) Quality Measure Rating System (Implemented 1999) MIPS Program (Implemented 2018) Marketplace Quality Rating System (QRS) (Implemented 2016) Medicaid (Implemented 2013)
0105e	Antidepressant Medication Management (AMM) (eMeasure)	None
0108	Follow-Up Care for Children Prescribed ADHD Medication (ADD)	Medicaid (Implemented 2018)
0108e	Follow-Up Care for Children Prescribed ADHD Medication (ADD) (eMeasure)	None

[a] Per CMS Measures Inventory Tool as of 09/02/2021

NQF #	Title	Federal Programs: Finalized or Implemented as of June 30, 2021
0560	HBIPS-5 Patients Discharged on Multiple Antipsychotic Medications With Appropriate Justification	Inpatient Psychiatric Quality Reporting (Implemented 2013)
0576	Follow-Up After Hospitalization for Mental Illness (FUH)	Medicaid (Implemented 2013)
0640	HBIPS-2 Hours of Physical Restraint Use	Hospital Compare (Implemented 2013) Inpatient Psychiatric Facility Quality Reporting (Implemented 2013)
0641	HBIPS-3 Hours of Seclusion Use	Hospital Compare (Implemented 2013) Inpatient Psychiatric Facility Quality Reporting (Implemented 2013)
0710e	Depression Remission at 12 Months (eMeasure)	Physician Compare (Implemented 2018) MIPS Program (Implemented 2018) Medicaid Promoting Interoperability Program (Implemented 2019)
0711	Depression Remission at Six Months	None
0712e	Depression Utilization of the PHQ-9 Tool (eMeasure)	None
1365	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment	None
1365e	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment (eMeasure)	Physician Compare (Implemented 2018) MIPS Program (Implemented 2018)
1879	Adherence to Antipsychotic Medications for Individuals With Schizophrenia	MIPS Program (Implemented 2018) Medicaid (Implemented 2013)
1932	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	Medicaid (Implemented 2018)
2152	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	Physician Compare (Implemented 2018) MIPS Program (Implemented 2018)
2605	Follow-Up After Discharge From the Emergency Department for Mental Health or Alcohol or Other Drug Dependence	None
2607	Diabetes Care for People With Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	Medicaid (Implemented 2017)
3175	Continuity of Pharmacotherapy for Opioid Use Disorder	None
3589	Prescription or Administration of Pharmacotherapy to Treat Opioid Use Disorder (OUD)	None
3590	Continuity of Care After Receiving Hospital or Residential Substance Use Disorder (SUD) Treatment	None

Appendix C: Behavioral Health and Substance Use Standing Committee and NQF Staff

STANDING COMMITTEE

Harold Pincus, MD (Co-Chair)
Professor and Vice Chair of Psychiatry and Co-Director of the Irving Institute for Clinical and Translational Research at Columbia University
New York, New York

Michael Trangle, MD (Co-Chair)
Senior Fellow, HealthPartners Institute for Research and Education
Bloomington, Minnesota

Loretta (Ann) Bostic, DNP, MBA, APRN, CRNA, PMHNP-BC
Program Director, MedSurg Behavioral Health Services
Charleston, West Virginia

Caroline Carney, MD, MSc, FAMP, CPHQ
Chief Medical Officer, Magellan Rx Management, Magellan Health, Inc.
Phoenix, Arizona

Vitka Eisen, MSW, EdD
President and Chief Executive Officer, HealthRIGHT 360
San Francisco, California

Julie Goldstein Grumet, PhD
Director of Zero Suicide Institute/Senior Health Care Advisor to Suicide Prevention Resource Center
Education Development Center
Washington, District of Columbia

Benjamin Han, MD, MPH
Assistant Professor, University of California, San Diego
La Jolla, California

Morissa Henn, MPH, DrPH
Community Health Director, Intermountain Healthcare
Salt Lake City, Utah

Lisa Jensen, DNP, APRN
Director of Clinical Operations, Specialty Care Services, Veterans Health Administration
North Salt Lake, Utah

Caitlyn Kjolhede, BSN, MBA
Vice President of Clinical Performance, CHESS Health
East Rochester, New York

Kraig Knudsen, PhD *(inactive)*
Chief, Bureau of Research and Evaluation, Ohio Department of Mental Health and Addiction Services
Columbus, Ohio

Barbara Lang, LPC, LISAC
Deputy Chief of Standards and Compliance, Community Bridges, Inc.
Yuma, Arizona

Michael R. Lardieri, LCSW
Assistant Vice President Strategic Program Development, Northwell Health, Behavioral Health Services Line
Glen Oaks, New York

Raquel Mazon Jeffers, MPH, MIA
Senior Director, U.S. Initiatives, Community Health Acceleration Partnership
Hopewell, New Jersey

Brooke Parish, MD
Executive Medical Director, Health Care Service Corporation, Blue Cross Blue Shield of New Mexico
Albuquerque, New Mexico

David Pating, MD
Associate Clinical Professor, Addiction Psychiatry – Substance Use Services,
San Francisco Department of Public Health
San Francisco, California

Vanita Pindolia, PharmD
Vice President, Ambulatory Clinical Pharmacy Programs,
Henry Ford Health System (HFHS)/Health Alliance Plan (HAP)
Detroit, Michigan

Chantelle Rice Collins, OTD, OTR/L, CDCES
Associate Professor, University of Southern California
Los Angeles, California

Andrew Sperling, JD
Director of Federal Advocacy, National Alliance on Mental Illness
Arlington, Virginia

Jeffery Susman, MD
Dean and VPHA, Emeritus, Northeast Ohio Medical University
Rootstown, Ohio

Allen Tien, MD
President and Director of Applied Research, Medical Decision Logic, Inc.
Baltimore, Maryland

Patrick Triplett, MD
Clinical Director and Physician Advisor, Department of Psychiatry and Behavioral Sciences, Johns Hopkins University School of Medicine
Baltimore, MD

Heidi Waters, MBA, PhD
Director, Health Economics and Outcomes Research, Otsuka Pharmaceutical Development and Commercialization, Inc.
Rockville, Maryland

Bonnie Zima, MD, MPH
Professor in Residence, Child and Adolescent Psychiatry, Semel Institute for Neuroscience and Human Behavior, University of California, Los Angeles (UCLA)
Los Angeles, California

NQF STAFF

Kathleen Giblin, RN
Acting Senior Vice President, Quality Measurement

Tricia Elliott, MBA, CPHQ, FNAHQ
Senior Managing Director, Quality Measurement

Sheri Winsper, RN, MSN, MSHA
Senior Vice President, Quality Measurement

Michael Katherine Haynie
Senior Managing Director, Quality Measurement

Poonam Bal, MHSA
Director

Samuel Stolpe, PharmD, MPH
Senior Director

Mike DiVecchia, MBA, PMP
Senior Project Manager

Monika Harvey, MBA, PMP
Project Manager

Hannah Bui, MPH
Manager

Tamara Funk, MPH
Manager

Udobi Onyeuku, MSHA
Analyst

Gus Zimmerman, MPP
Coordinator

Appendix D: Measure Specifications

#0576 Follow-Up After Hospitalization for Mental Illness

STEWARD

National Committee for Quality Assurance

DESCRIPTION

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

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

TYPE

Process

DATA SOURCE

Claims This measure is based on administrative claims collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from Health Management Organizations and Preferred Provider Organizations via NCQA's online data submission system.

LEVEL

Health Plan

SETTING

Inpatient/Hospital, Outpatient Services

NUMERATOR STATEMENT

30-Day Follow-Up: A follow-up visit with a mental health provider within 30 days after discharge.

7-Day Follow-Up: A follow-up visit with a mental health provider within 7 days after discharge.

NUMERATOR DETAILS

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

- An outpatient visit (Visit Setting Unspecified Value Set) with (Outpatient POS Value Set) with a mental health provider.
- An outpatient visit (BH Outpatient Value Set) with a mental health provider.
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) with (Partial Hospitalization POS Value Set).
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set).

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

(See corresponding Excel document for the value sets referenced above).

Mental Health Provider Definition:

A provider who delivers 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).
- A physician assistant who is certified by the National Commission on Certification of Physician Assistants to practice psychiatry.

- A certified Community Mental Health Center (CMHC), or the comparable term (e.g. behavioral health organization, mental health agency, behavioral health agency) used within the state in which it is located, or a Certified Community Behavioral Health Clinic (CCBHC).
- Only authorized CMHCs are considered mental health providers. To be authorized as a CMHC, an entity must meet one of the following criteria:
- The entity has been certified by CMS to meet the conditions of participation (CoPs) that community mental health centers (CMHCs) must meet in order to participate in the Medicare program, as defined in the Code of Federal Regulations Title 42. CMS defines a CMHC as an entity that meets applicable licensing or certification requirements for CMHCs in the State in which it is located and provides the set of services specified in section 1913(c)(1) of the Public Health Service Act (PHS Act).
- The entity has been licensed, operated, authorized, or otherwise recognized as a CMHC by a state or county in which it is located.
- Only authorized CCBHCs are considered mental health providers. To be authorized as a CCBHC, an entity must meet one of the following criteria:

  o Has been certified by a State Medicaid agency as meeting criteria established by the Secretary for participation in the Medicaid CCBHC demonstration program pursuant to Protecting Access to Medicare Act § 223(a) (42 U.S.C. § 1396a note); or as meeting criteria within the State's Medicaid Plan to be considered a CCBHC.

  o Has been recognized by the Substance Abuse and Mental Health Services Administration, through the award of grant funds or otherwise, as a CCBHC that meets the certification criteria of a CCBHC.

DENOMINATOR STATEMENT

Discharges from an acute inpatient setting with a principal diagnosis of mental illness or intentional self-harm on the discharge claim during the first 11 months of the measurement year (i.e. January 1 to December 1) for members 6 years and older.

DENOMINATOR DETAILS

An acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm (Mental Illness Value Set; Intentional Self-Harm Value Set) on the discharge claim on or between January 1 and December 1 of the measurement year. To identify acute inpatient discharges:

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

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

Acute readmission or direct transfer

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

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

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

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

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

See corresponding Excel document for the Value Sets referenced above in S.2b.

EXCLUSIONS

Exclude from the denominator for both rates, members who begin using hospice services anytime during the measurement year (Hospice Value Set)

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

Exclude discharges followed by readmission or direct transfer to a nonacute facility within the 30-day follow-up period regardless of principal diagnosis.

Exclude discharges followed by readmission or direct transfer to an acute facility within the 30-day follow-up period if the principal diagnosis was not for mental health or intentional self harm.

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

EXCLUSION DETAILS

Members in hospice are excluded from the eligible population.

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

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

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

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

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

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

See corresponding Excel document for the Value Sets referenced above in S.2b.

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

N/A

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

Step 1. Determine the denominator. The denominator is all discharges that meet the specified denominator criteria (S7).

Step 2. Remove exclusions. Remove all discharges from the denominator that meet the specified exclusion criteria (S9).

Step 3. Identify numerator events: Search administrative systems to identify numerator events for all discharges in the denominator (S5).

Step 4. Calculate the rate by dividing the events in step 3 by the discharges in step 2. 123834|140881

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#3589 Prescription or Administration of Pharmacotherapy to Treat Opioid Use Disorder (OUD)

STEWARD

RTI International

DESCRIPTION

This measure reports the percentage of a provider's patients who were Medicaid beneficiaries ages 18 to 64 with an OUD diagnosis who filled a prescription for, or were administered or ordered, a FDA-approved medication to treat OUD within 30 days of the first attributable OUD treatment encounter with that provider.

TYPE

Process

DATA SOURCE

Claims, Enrollment Data The data source is Medicaid Analytic Extract (MAX) files, including person summary (PS), inpatient (IP), other services (OT), long-term care (LT) and drug (RX) files. The other services file contains facility and individual provider services data. The Medicaid Analytic Extract (MAX) files contain data from 32 states.

LEVEL

Facility, Clinician : Individual

SETTING

Emergency Department and Services, Inpatient/Hospital, Outpatient Services

NUMERATOR STATEMENT

Beneficiaries ages 18 to 64 with an OUD who filled a prescription for, or were administered or ordered, an FDA-approved medication for the treatment of OUD within 30 days of the first attributable encounter with an OUD diagnosis with the provider.

NUMERATOR DETAILS

The measure numerator is the number of beneficiaries ages 18 to 64 with an OUD diagnosis (see Appendix A in Data Dictionary) who filled a prescription for, or were administered or ordered, an FDA-approved medication to treat OUD (see Appendix B in Data Dictionary) within 30 days of the first attributable encounter with the provider.

Note that the OUD medication administration or prescription can be from any provider (e.g., office-based physician, hospital, OTP), it need not necessarily be the attributed provider. This justification is that all providers who treat patients with an OUD diagnosis should be held accountable for ensuring that they receive gold standard treatment.

DENOMINATOR STATEMENT

Number of Medicaid ages 18 – 64 beneficiaries with at least one medical claim for an encounter with an OUD diagnosis with that provider (where the provider is identified by a National Provider Identifier (NPI) code).

DENOMINATOR DETAILS

The target population for the denominator includes all Medicaid beneficiaries age 18 through 64 years with a diagnosis of OUD (primary or other) that had an encounter with the provider at least once during the measure time period which is defined as a calendar year. See Appendix A for ICD codes for identifying OUD. Age is calculated as of December 31st of the measurement year. Denominator exclusions are described below in 5.8.

EXCLUSIONS

Dual eligible Medicare/Medicaid beneficiaries are excluded. Rationale: Individuals who are covered under Medicare would receive coverage for follow up treatment medications (e.g. medication assisted treatment) under Medicare Part D and Medicare Part D claims are not captured in Medicaid claims databases. Therefore, follow-up would be missed.

Individuals under 18 are excluded. Rationale: There is limited evidence regarding the efficacy of MOUD for this population.

Individuals over 64 are excluded: Rationale: Most individuals over age 64 are covered under Medicare. Services covered by Medicare would not be capture in the Medicaid claims data and therefore follow-up treatment would be missed.

EXCLUSION DETAILS

Instructions for the analytic file build, including denominator exclusion detail are included below.

Measurement Year: Calendar year 2014

Ages:18 years and older as of December 31 of the measurement year. 64 or younger as of December 31 of the measurement year

Required Benefits:Medical, Chemical Dependency, and Pharmacy

Analytic File Inclusion Criteria Follow steps below.

1. Subset file to patients who had an OUD diagnosis. (Appendix A contains ICD codes for identifying OUD) in any diagnostic position from any provider during selected Calendar year.

2. Eliminate dual eligible (Medicare/Medicaid) beneficiaries.
3. Eliminate any patient IDs of patients younger than 18 as of December 31 of the measurement year, or older than 64 as of December 31 of the measurement year.
4. Pull all the claims/records from the enrollment, inpatient, outpatient, prescription drug files, and long-term claims files with these Member IDs into an analytic sample.

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

Not applicable.

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

Identify denominator

Identify Medicaid beneficiaries age 18 through 64 years with at least one encounter with a provider with an OUD diagnosis on the claim (primary or other secondary) during the measurement year. Must be continuously enrolled for at least 30 days after the attributable encounter . Age is calculated as of December 31st of the measurement year.

Step 1. Identify the attribution date, the first encounter between a member and a provider. The attribution date is as follows.

a. Outpatient Encounter Attribution Date: Attribution date is the date of the encounter with an outpatient provider that includes an OUD diagnosis (primary or secondary).
b. Inpatient/Residential Encounter Attribution Date. Attribution date is the discharge date from an inpatient/residential provider that includes an OUD diagnosis (any position).

Note: a member can be attributed to more than one provider at different times during the measurement period. However, if members have multiple attribution dates with a single provider, only the first is included in the denominator.

Step 2. Exclude a member from the denominator for a provider organization if the attribution date is after December 1 to allow for 30 days of time after the encounter.

Step 3. Only include members with continuous enrollment over the relevant 30 day time period.

Step 4. Exclude providers if their total number of attributable members is < 10.

Step 5. Count the number of patients in the denominator with a qualifying_medication_event_date (Appendix B) <= 30 days of the attribution_date (attribution_date <= qualifying_medication_event_date <= attribution_date + 30 days)

Step 6. Report measure metrics at the NPI level separately for individual clinicians and hospitals/agencies/facilities. 146353

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#3590 Continuity of Care After Receiving Hospital or Residential Substance Use Disorder (SUD) Treatment

STEWARD

RTI International

DESCRIPTION

Percentage of Medicaid discharges, ages 18 to 64, being treated for a substance use disorder (SUD) from an inpatient or residential provider that received SUD follow-up treatment within 7 or 30 days after discharge. SUD follow-up treatment includes outpatient, intensive outpatient, or partial hospitalization visits; telehealth encounters; SUD medication fills or administrations; or residential treatment (after an inpatient discharge). Two rates are reported: continuity within 7 and 30 days after discharge.

TYPE

Process

DATA SOURCE

Claims, Enrollment Data The Medicaid Analytic Extract (MAX) files were used to identify discharges from inpatient substance use disorder (SUD) or residential specialty SUD treatment programs with a principal/primary SUD diagnosis on the discharge record (denominator) and the receipt of SUD outpatient or prescription medication treatment within 7 and/or 30 days after discharge (numerator). The Medicaid MAX files used include the following types of files: personal summary (PS), inpatient (IP), other services (OT), long-term care (LT) and drug (RX) files. Data from the PS IP, LT and OT files were used to construct the measure denominator. We used the PS file to limit the analytic sample based on age and enrollment criteria, and then we used the IP, LT, and OT files to determine whether those beneficiaries met the criteria for the measure denominator. The OT and Rx files enabled us to identify the numerator events (e.g., receipt of SUD outpatient treatment within 7 and/or 30 days after discharge). The PS file contained additional demographic and enrollment information, such as beneficiaries' state, age, sex, and race or ethnicity.

LEVEL

Facility

SETTING

Inpatient/Hospital

NUMERATOR STATEMENT

Medicaid discharges, ages 18 to 64, with a principal/primary substance (SUD) diagnosis treated at an inpatient or residential provider that received SUD follow-up treatment within 7 or 30 days after discharge. SUD treatment includes outpatient, intensive outpatient, or partial hospitalization visits; telehealth encounters; or SUD medication fills or administrations; or residential treatment (after an inpatient discharge. Two rates are reported: continuity within 7 and 30 days after discharge.

NUMERATOR DETAILS

For this measure two numerators are calculated (follow-up within 7 days of discharge and follow-up within 30 days of discharge). For the 7-day follow up calculation, the numerator is the total discharges with an outpatient visit, intensive outpatient encounter or partial hospitalization OR telehealth visit with SUD diagnosis in principal position, or filled a prescription for or were administered a medication for SUD within 7 days after discharge. Set this variable equal to 1 if either of the following occur: (a) Follow-up visit or telehealth encounter after index discharge date and on or before index discharge date + 7. SUD diagnosis codes must be in principal position for the follow-up encounter. (b) SUD-related medication fill (see attached Appendix D) on or after index discharge date and on or before index discharge date + 7.

The same process above applies for the 30-day follow-up calculation, but within 30 days after discharge. Set the variable equal to 1 if either of the following occur: (a) Follow-up visit or telehealth encounter after index discharge date and on or before index discharge date + 30. SUD diagnosis codes must be in principal position for the follow-up encounter. (b) SUD-related medication fill (see attached Appendix D) on or after index discharge date and on or before index discharge date + 30.

The measure time period is a calendar year.

DENOMINATOR STATEMENT

The denominator are Medicaid beneficiaries, ages 18-64, discharged from inpatient or residential provider with a principal diagnosis of SUD on the inpatient/residential treatment encounter claim.

DENOMINATOR DETAILS

The target population for the denominator includes all Medicaid beneficiaries (non-dual eligible) age 18 through 64 years and who had a discharge from SUD inpatient or residential treatment provider with a principal/primary SUD diagnosis during the measurement year which is defined as a calendar year. Eligible discharges are identified based on discharge date.

EXCLUSIONS

Dual eligible Medicare/Medicaid beneficiaries are excluded. Rationale: Individuals who are covered under Medicare would receive coverage for follow-up treatment medications (e.g. opioid use disorder medications) under Medicare Part D and Medicare Part D claims are not captured in Medicaid claims databases. Therefore follow-up treatment would be missed.

EXCLUSION DETAILS

Dual eligible (Medicare/Medicaid) beneficiaries (as identified on Medicaid enrollment/beneficiary files)

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

Not applicable.

TYPE SCORE

Rate/proportion better quality = lower score

ALGORITHM

S.12. Type of score:

Rate/proportion

If other:

S.13. Interpretation of Score (Classifies interpretation of score according to whether higher quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)

Better quality = Higher score

S.14. Calculation Algorithm/Measure Logic (Diagram or describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; time period for data, aggregating data; risk adjustment; etc.)

Step 1: Identify denominator

Identify Medicaid- only beneficiaries age 18 through 64 years who had a discharge from SUD inpatient or residential treatment with a principal/primary SUD diagnosis during the measurement year. Age is calculated as of December 31st of the measurement year.

Step 1A. Exclude discharge if the date of discharge (for inpatient or residential levels of care) is after December 15 of the measurement year or if the date of discharge is missing.

Step 1B. Exclude discharge if the discharge date occurs on the same day as admission to another inpatient or residential facility. Consider this a transfer; the discharge date from the transfer facility would therefore define the index date.

Step 1C. Exclude any discharges that did not have continuous enrollment with both medical and pharmacy benefits on and within the 30 days of that index discharge date.

Step 2: Identify numerator

Step 2A. Use the Analytic Sample to Create the 7- and 30- day follow-up variables:

a. 7_day_follow-up: Identify discharges with an outpatient visit, intensive outpatient encounter or partial hospitalization OR telehealth visit with SUD diagnosis in principal position, or filled a prescription for or were administered medication for SUD within 7 days after discharge. Set this variable equal to 1 if either of the following occurs:

i. Follow-up visit or telehealth encounter (Appendix C) after index discharge date and on or before index discharge date + 7. SUD diagnosis codes must be in principal position for the follow-up encounter

ii. SUD-related medication fill (Appendix D) on or after index discharge date and on or before index discharge date + 7.

b. 30_day_follow-up: Identify discharges with an outpatient visit, intensive outpatient encounter, or partial hospitalization OR telehealth visit with SUD diagnosis in principal position or filled a prescription for or were administered medication for SUD within 30 days after discharge. Set this variable equal to 1 if either of the following occurs:

i. Follow-up visit or telehealth encounter (Appendix C) after index discharge date and on or before index discharge date + 30. SUD diagnosis codes must be in principal position for the follow-up encounter.

ii. SUD-related medication fill (Appendix D) on or after index discharge date and on or before index discharge date + 30. 146353

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Appendix E: Related and Competing Measures

Comparison of NQF #0576 with NQF #2605 and NQF #3489

#0576 Follow-Up After Hospitalization for Mental Illness
#2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence
#3489 Follow-Up After Emergency Department Visit for Mental Illness

Steward

#0576 Follow-Up After Hospitalization for Mental Illness

National Committee for Quality Assurance

#2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence

National Committee for Quality Assurance

#3489 Follow-Up After Emergency Department Visit for Mental Illness

National Committee for Quality Assurance

Description

#0576 Follow-Up After Hospitalization for Mental Illness

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

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

#2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence

The percentage of discharges for patients 18 years of age and older who had a visit to the emergency department with a primary diagnosis of mental health or alcohol or other drug dependence during the measurement year AND who had a follow-up visit with any provider with a corresponding primary diagnosis of mental health or alcohol or other drug dependence within 7- and 30-days of discharge.

Four rates are reported:

- The percentage of emergency department visits for mental health for which the patient received follow-up within 7 days of discharge.
- The percentage of emergency department visits for mental health for which the patient received follow-up within 30 days of discharge.
- The percentage of emergency department visits for alcohol or other drug dependence for which the patient received follow-up within 7 days of discharge.
- The percentage of emergency department visits for alcohol or other drug dependence for which the patient received follow-up within 30 days of discharge.

#3489 Follow-Up After Emergency Department Visit for Mental Illness

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

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

Type

#0576 Follow-Up After Hospitalization for Mental Illness

Process

#2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence

Process

#3489 Follow-Up After Emergency Department Visit for Mental Illness

Process

Data Source

#0576 Follow-Up After Hospitalization for Mental Illness

Claims This measure is based on administrative claims collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from Health Management Organizations and Preferred Provider Organizations via NCQA's online data submission system.

No data collection instrument provided Attachment 0576_FUH_Fall_2020_Value_Sets.xlsx

#2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence

Claims Both the numerator and the denominator for this measure are based on administrative claims data.

No data collection instrument provided Attachment 2605_Follow_Up_After_ED_Discharge_for_Mental_Health_Conditions_Value_Sets-636220757625866651.xlsx

#3489 Follow-Up After Emergency Department Visit for Mental Illness

Claims This measure is based on administrative claims collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from Health Management Organizations and Preferred Provider Organizations via NCQA's online data submission system.

No data collection instrument provided Attachment 3489_FUM_Value_Sets_Spring_2019.xlsx

Level

#0576 Follow-Up After Hospitalization for Mental Illness

Health Plan

#2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence

Health Plan, Population : Regional and State

#3489 Follow-Up After Emergency Department Visit for Mental Illness

Health Plan

Setting

#0576 Follow-Up After Hospitalization for Mental Illness

Inpatient/Hospital, Outpatient Services

#2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence

Inpatient/Hospital, Outpatient Services

#3489 Follow-Up After Emergency Department Visit for Mental Illness

Outpatient Services

Numerator Statement

#0576 Follow-Up After Hospitalization for Mental Illness

30-Day Follow-Up: A follow-up visit with a mental health provider within 30 days after discharge.

7-Day Follow-Up: A follow-up visit with a mental health provider within 7 days after discharge.

#2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence

The numerator for each denominator population consists of two rates:

Mental Health

- Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of mental health within 7 days after emergency department discharge
- Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of mental health within 30 days after emergency department discharge

Alcohol or Other Drug Dependence

- Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of alcohol or other drug dependence within 7 days after emergency department discharge
- Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of alcohol or other drug dependence within 30 days after emergency department discharge

#3489 Follow-Up After Emergency Department Visit for Mental Illness

The numerator consists of two rates:

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

Numerator Details

#0576 Follow-Up After Hospitalization for Mental Illness

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

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

(See corresponding Excel document for the value sets referenced above).

Mental Health Provider Definition:

A provider who delivers 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).
- A physician assistant who is certified by the National Commission on Certification of Physician Assistants to practice psychiatry.
- A certified Community Mental Health Center (CMHC), or the comparable term (e.g., behavioral health organization, mental health agency, behavioral health agency) used within the state in which it is located, or a Certified Community Behavioral Health Clinic (CCBHC).
- Only authorized CMHCs are considered mental health providers. To be authorized as a CMHC, an entity must meet one of the following criteria:
- The entity has been certified by CMS to meet the conditions of participation (CoPs) that community mental health centers (CMHCs) must meet in order to participate in the Medicare program, as defined in the Code of Federal Regulations Title 42. CMS defines a CMHC as an entity that meets applicable licensing or certification requirements for CMHCs in the State in which it is located and provides the set of services specified in section 1913(c)(1) of the Public Health Service Act (PHS Act).
- The entity has been licensed, operated, authorized, or otherwise recognized as a CMHC by a state or county in which it is located.
- Only authorized CCBHCs are considered mental health providers. To be authorized as a CCBHC, an entity must meet one of the following criteria:
  - Has been certified by a State Medicaid agency as meeting criteria established by the Secretary for participation in the Medicaid CCBHC demonstration program pursuant to Protecting Access to Medicare Act § 223(a) (42 U.S.C. § 1396a note); or as meeting criteria within the State's Medicaid Plan to be considered a CCBHC.
  - Has been recognized by the Substance Abuse and Mental Health Services Administration, through the award of grant funds or otherwise, as a CCBHC that meets the certification criteria of a CCBHC.

#2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence

Mental Health

Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of mental health within 7 days after emergency department discharge

- A visit (FUH Stand Alone Visits Value Set) with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).
- A visit (FUH Visits Group 1 Value Set and FUH POS Group 1 Value Set) with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).

- A visit (FUH Visits Group 2 Value Set and FUH POS Group 2 Value Set) with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).
- A visit to a behavioral healthcare facility (FUH RevCodes Group 1 Value Set).
- A visit to a non-behavioral healthcare facility (FUH RevCodes Group 2 Value Set) with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).
- A visit to a non-behavioral healthcare facility (FUH RevCodes Group 2 Value Set) with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).
- Transitional care management services (TCM 7 Day Value Set) where the date of service on the claim is 29 days after the date the patient was discharged from the emergency department with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).

  Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of mental health within 30 days after emergency department discharge
- A visit (FUH Stand Alone Visits Value Set) with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).
- A visit (FUH Visits Group 1 Value Set and FUH POS Group 1 Value Set) with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).
- A visit (FUH Visits Group 2 Value Set and FUH POS Group 2 Value Set) with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).
- A visit to a behavioral healthcare facility (FUH RevCodes Group 1 Value Set).
- A visit to a non-behavioral healthcare facility (FUH RevCodes Group 2 Value Set) with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).
- A visit to a non-behavioral healthcare facility (FUH RevCodes Group 2 Value Set) with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).
- Transitional care management services (TCM 7 Day Value Set) where the date of service on the claim is 29 days after the date the patient was discharged from the emergency department with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).
- Transitional care management services (TCM 14 Day Value Set) where the date of service on the claim is 29 days after the date the patient was discharged from the emergency department with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).
- Note: Transitional care management is a 30-day period that begins on the date of discharge and continues for the next 29 days. The date of service on the claim is 29 days after discharge and not the date of the face-to-face visit.

  Alcohol or Other Drug Dependence

  Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of alcohol or other drug dependence within 7 days after emergency department discharge. Any of the following code combinations meet criteria:
- IET Stand Alone Visits Value Set with a primary diagnosis of AOD (AOD Dependence Value Set).
- IET Visits Group 1 Value Set with IET POS Group 1 Value Set and a primary diagnosis of AOD (AOD Dependence Value Set).
- IET Visits Group 2 Value Set with IET POS Group 2 Value Set and a primary diagnosis of AOD (AOD Dependence Value Set).

Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis alcohol or other drug dependence within 30 days after emergency department discharge. Any of the following code combinations meet criteria:

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

#3489 Follow-Up After Emergency Department Visit for Mental Illness

30-day follow-up: The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days). Any of the following meet criteria for a follow-up visit:

- An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).
- An outpatient visit (BH Outpatient Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set), with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization/Intensive Outpatient Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set), with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) with (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set), with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).
- An observation visit (Observation Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).
- An outpatient visit (BH Outpatient Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set), with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization/Intensive Outpatient Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set), with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) with (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set), with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).
- An observation visit (Observation Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

7-day follow-up: The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days). Any of the following meet criteria for a follow-up visit:

- An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).
- An outpatient visit (BH Outpatient Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set), with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization/Intensive Outpatient Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set), with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) with (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial

Hospitalization POS Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

- A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set), with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).
- An observation visit (Observation Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).
- An outpatient visit (BH Outpatient Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set), with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization/Intensive Outpatient Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set), with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) with (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set), with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).
- An observation visit (Observation Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

Denominator Statement

#0576 Follow-Up After Hospitalization for Mental Illness

Discharges from an acute inpatient setting with a principal diagnosis of mental illness or intentional self-harm on the discharge claim during the first 11 months of the measurement year (i.e., January 1 to December 1) for members 6 years and older.

#2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence

Patients who were treated and discharged from an emergency department with a primary diagnosis of mental health or alcohol or other drug dependence on or between January 1 and December 1 of the measurement year.

#3489 Follow-Up After Emergency Department Visit for Mental Illness

Emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm on or between January 1 and December 1 of the measurement year.

Denominator Details

#0576 Follow-Up After Hospitalization for Mental Illness

An acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm (Mental Illness Value Set; Intentional Self-Harm Value Set) on the discharge claim on or between January 1 and December 1 of the measurement year. To identify acute inpatient discharges:

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

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

Acute readmission or direct transfer

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

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

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

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

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

See corresponding Excel document for the Value Sets referenced above in S.2b.

#2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence

Age: 18 years and older as of the date of discharge

Benefit: Medical and Behavioral Health

Continuous Enrollment: Date of emergency department visit through 30 days after discharge

Diagnosis criteria: Patients who were treated and discharged from an emergency department with a primary diagnosis of mental health (see Mental Health Diagnosis Value Set) or alcohol or other drug dependence (see AOD Dependence Value Set) on or between January 1 and December 1 of the measurement year. The denominator for this measure is based on discharges, not individuals. If a person has more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year. Use only facility claims to identify denominator events (including admissions or direct transfers). Do not use professional claims.

#3489 Follow-Up After Emergency Department Visit for Mental Illness

Age: 6 years and older as of the date of the ED visit

Benefit: Medical and mental health.

Continuous Enrollment: Date of emergency department visit through 30 days the ED visit

Event/diagnosis criteria: An ED visit (ED Value Set) with a principal diagnosis of mental illness or intentional self-harm (Mental Illness Value Set; Intentional Self-Harm Value Set) on or between January 1 and December 1 of the measurement year where the member was 6 years or older on the date of the visit.

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

If a member has more than one ED visit in a 31-day period, include only the first eligible ED visit. For example, if a member has an ED visit on January 1 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. Note: Removal of multiple visits in a 31-day period is based on eligible visits. Assess each ED visit for exclusions before removing multiple visits in a 31-day period.

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

Exclusions

#0576 Follow-Up After Hospitalization for Mental Illness

Exclude from the denominator for both rates, members who begin using hospice services anytime during the measurement year (Hospice Value Set)

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

Exclude discharges followed by readmission or direct transfer to a nonacute facility within the 30-day follow-up period regardless of principal diagnosis.

Exclude discharges followed by readmission or direct transfer to an acute facility within the 30-day follow-up period if the principal diagnosis was not for mental health or intentional self-harm.

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

#2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence

The following are exclusions from the denominator:

- If the discharge is followed by readmission or direct transfer to an emergency department for a principal diagnosis of mental health or alchohol or other drug dependence within the 30-day follow-up period, count only the readmission discharge or the discharge from the emegenecy department to which the patient was transferred.
- Exclude discharges followed by admission or direct transfer to an acute or nonacute facility within the 30-day follow-up period, regardless of primary diagnosis for the admission.

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

#3489 Follow-Up After Emergency Department Visit for Mental Illness

Patients in hospice.

Exclusion Details

#0576 Follow-Up After Hospitalization for Mental Illness

Members in hospice are excluded from the eligible population.

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

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

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

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

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

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

  See corresponding Excel document for the Value Sets referenced above in S.2b.

#2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence

See Section S.10 for exclusion details

#3489 Follow-Up After Emergency Department Visit for Mental Illness

Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. These patients may be identified using various methods, which may include but are not limited to enrollment data, medical record or claims/encounter data (Hospice Value Set).

Risk Adjustment

#0576 Follow-Up After Hospitalization for Mental Illness

No risk adjustment or risk stratification

#2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence

No risk adjustment or risk stratification

123834| 140881| 135810

123834| 140881| 135810

#3489 Follow-Up After Emergency Department Visit for Mental Illness

No risk adjustment or risk stratification

123834| 140881| 135810| 110874

123834| 140881| 135810| 110874

Stratification

#0576 Follow-Up After Hospitalization for Mental Illness

N/A

#2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence

Not applicable.

#3489 Follow-Up After Emergency Department Visit for Mental Illness

Not applicable.

Type Score

#0576 Follow-Up After Hospitalization for Mental Illness

Rate/proportion better quality = higher score

#2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence

Rate/proportion better quality = higher score

#3489 Follow-Up After Emergency Department Visit for Mental Illness

Rate/proportion better quality = higher score

Algorithm

#0576 Follow-Up After Hospitalization for Mental Illness

Step 1. Determine the denominator. The denominator is all discharges that meet the specified denominator criteria (S7).

Step 2. Remove exclusions. Remove all discharges from the denominator that meet the specified exclusion criteria (S9).

Step 3. Identify numerator events: Search administrative systems to identify numerator events for all discharges in the denominator (S5).

Step 4. Calculate the rate by dividing the events in step 3 by the discharges in step 2. 123834| 140881

#2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence

Mental Health

Step 1: Determine the eligible population.

Step 1A: Identify patients with who were treated and discharged from an emergency department with a primary diagnosis of mental health.

Step 1B: Exclude patients who meet the exclusion criteria as specified in the "Denominator Exclusion Details" section.

Step 2: Identify the numerator.

Step 2A: Identify those who had a qualifying follow-up visit within 7 days.

Step 2B: Identify those who had a qualifying follow-up visit within 30 days.

Step 3: Calculate the rates.

Step 3A: Calculate the 7-day rate by dividing the number of patients with qualifying follow-up visit within 7 days (Step 2A) by the denominator (after exclusions) (Step 1B).

Step 3B: Calculate the 30-day rate by dividing the number of patients with qualifying follow-up visit within 30 days (Step 2B) by the denominator (after exclusions) (Step 1B).

Alcohol or Other Drug Dependence

Step 1: Determine the eligible population.

Step 1A: Identify patients with who were treated and discharged from an emergency department with a primary diagnosis of alcohol or other drug dependence.

Step 1B: Exclude patients who meet the exclusion criteria as specified in the "Denominator Exclusion Details" section.

Step 2: Identify the numerator.

Step 2A: Identify those who had a qualifying follow-up visit within 7 days.

Step 2B: Identify those who had a qualifying follow-up visit within 30 days.

Step 3: Calculate the rates.

Step 3A: Calculate the 7-day rate by dividing the number of patients with qualifying follow-up visit within 7 days (Step 2A) by the denominator (after exclusions) (Step 1B).

Step 3B: Calculate the 30-day rate by dividing the number of patients with qualifying follow-up visit within 30 days (Step 2B) by the denominator (after exclusions) (Step 1B). 123834| 140881| 135810

#3489 Follow-Up After Emergency Department Visit for Mental Illness

Step 1: Determine the eligible population.

Step 1A: Identify patients with who were treated and discharged from an emergency department with a primary diagnosis of mental health. Do not include ED visits that result in an inpatient stay,

or are 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.

Step 2: Identify the numerator.

Step 2A: Identify those who had a qualifying follow-up visit within 7 days.

Step 2B: Identify those who had a qualifying follow-up visit within 30 days.

Step 3: Calculate the rates.

Step 3A: Calculate the 7-day rate by dividing the number of ED visits with qualifying follow-up visit within 7 days (Step 2A) by the denominator (Step 1A).

Step 3B: Calculate the 30-day rate by dividing the number of ED visits with qualifying follow-up visit within 30 days (Step 2B) by the denominator (Step 1A). 123834| 140881| 135810| 110874

Submission Items

#0576 Follow-Up After Hospitalization for Mental Illness

5.1 Identified measures:

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: N/A

5b.1 If competing, why superior or rationale for additive value: N/A

#2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence

5.1 Identified measures: 0576 : Follow-Up After Hospitalization for Mental Illness (FUH)

1937 : Follow-Up After Hospitalization for Schizophrenia (7- and 30-day)

3312 : Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact: Portions of the specifications for this measure have been adapted from the existing health plan measures (Follow-up After Hospitalization for Mental Illness NQF #0576 and Follow-up After Hospitalization for Schizophrenia NQF#1937). The proposed measure is harmonized with the two existing NQF-endorsed measures. The following highlights the differences between the measures: -Population focus (denominator): The proposed measure targets patients discharged from the emergency department (not inpatient) and also focuses on patients with alcohol or other drug dependence disorders.-Numerator: The proposed measure captures follow-up with a primary mental health or alcohol or other drug dependence diagnosis (regardless of the type of provider).

5b.1 If competing, why superior or rationale for additive value: Not applicable.

#3489 Follow-Up After Emergency Department Visit for Mental Illness

5.1 Identified measures: 0576 : Follow-Up After Hospitalization for Mental Illness (FUH)

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact: The measure is harmonized with the existing NQF-endorsed measure. The following highlights the differences between the measures: Population focus (denominator): The measure targets patients discharged from the emergency department (not inpatient). Numerator: The measure captures follow-up with a primary mental health diagnosis (regardless of the type of provider).

5b.1 If competing, why superior or rationale for additive value: Not applicable.

Comparison of NQF #3205 with NQF #1879

#3205 Medication Continuation Following Inpatient Psychiatric Discharge
#1879 Adherence to Antipsychotic Medications for Individuals With Schizophrenia

Steward

#3205 Medication Continuation Following Inpatient Psychiatric Discharge

Centers for Medicare & Medicaid Services/Mathematica

#1879 Adherence to Antipsychotic Medications for Individuals With Schizophrenia

Centers for Medicare & Medicaid Services

Description

#3205 Medication Continuation Following Inpatient Psychiatric Discharge

This measure assesses whether patients discharged from an inpatient psychiatric facility (IPF) with major depressive disorder (MDD), schizophrenia, or bipolar disorder filled a prescription for evidence-based medication within 2 days prior to discharge and 30 days post-discharge. This measure evaluates admissions over a two-year period.

#1879 Adherence to Antipsychotic Medications for Individuals With Schizophrenia

Percentage of individuals at least 18 years of age as of the beginning of the measurement period with schizophrenia or schizoaffective disorder who had at least two prescription drug claims for antipsychotic medications and had a Proportion of Days Covered (PDC) of at least 0.8 for antipsychotic medications during the measurement period (12 consecutive months).

Type

#3205 Medication Continuation Following Inpatient Psychiatric Discharge

Process

#1879 Adherence to Antipsychotic Medications for Individuals With Schizophrenia

Process

Data Source

#3205 Medication Continuation Following Inpatient Psychiatric Discharge

Claims Medicare administrative data from Parts A, B, and D claims.

No data collection instrument provided Attachment Med_Cont_Data_Dictionary_FY2021.xlsx

#1879 Adherence to Antipsychotic Medications for Individuals With Schizophrenia

Claims The data source for the measure calculation required the following Medicare files depending on the level of accountability where the measure is being used:

- Denominator tables to determine individual enrollment
- Prescription drug benefit (Part D) coverage tables
- Beneficiary file
- Institutional claims (Part A)
- Non-institutional claims (Part B)—physician carrier/non-DME (durable medical equipment)

- Prescription drug benefit (Part D) claims
- Centers for Medicare and Medicaid Services (CMS) physician and physician specialty tables
- National Plan and Provider Enumeration System (NPPES) database

No data collection instrument provided Attachment NQF_1879_Code_Tables_2018_Final.xlsx

Level

#3205 Medication Continuation Following Inpatient Psychiatric Discharge

Facility

#1879 Adherence to Antipsychotic Medications for Individuals With Schizophrenia

Clinician : Group/Practice, Health Plan, Population : Regional and State

Setting

#3205 Medication Continuation Following Inpatient Psychiatric Discharge

Inpatient/Hospital

#1879 Adherence to Antipsychotic Medications for Individuals With Schizophrenia

Outpatient Services

Numerator Statement

#3205 Medication Continuation Following Inpatient Psychiatric Discharge

The numerator for the measure includes:

- Discharges with a principal diagnosis of MDD in the denominator population for which patients were dispensed evidence-based outpatient medication within 2 days prior to discharge through 30 days post-discharge
- Discharges with a principal diagnosis of schizophrenia in the denominator population for which patients were dispensed evidence-based outpatient medication within 2 days prior to discharge through 30 days post-discharge
- Discharges with a principal diagnosis of bipolar disorder in the denominator population for which patients were dispensed evidence-based outpatient medication within 2 days prior to discharge through 30 days post-discharge

#1879 Adherence to Antipsychotic Medications for Individuals With Schizophrenia

Individuals with schizophrenia or schizoaffective disorder who had at least two prescription drug claims for antipsychotic medications and have a PDC of at least 0.8 for antipsychotic medications.

Numerator Details

#3205 Medication Continuation Following Inpatient Psychiatric Discharge

The following are lists of evidence-based medications for the treatment of MDD, schizophrenia, and bipolar disorder:

Medications for MDD

- Monoamine Oxidase Inhibitors: isocarboxazid, phenelzine, selegiline (transdermal patch), tranylcypromine
- Selective Serotonin Reuptake Inhibitors (SSRI): citalopram, escitalopram, fluoxetine, fluvoxamine, paroxetine, sertraline
- Serotonin Modulators: nefazodone, trazodone, vilazodone, vortioxetine

- Serotonin Norepinephrine Reuptake Inhibitors (SNRI): desvenlafaxine, duloxetine, levomilnacipran, venlafaxine
- Tricyclic and Tetracyclic Antidepressants: amitriptyline, amoxapine, clomipramine, desipramine, doxepin, imipramine, maprotiline, nortriptyline, protriptyline, trimipramine
- Other Antidepressants: bupropion, mirtazapine
- Psychotherapeutic Combinations: amitriptyline-chlordiazepoxide, amitriptyline-perphenazine, fluoxetine-olanzapine

Medications for Schizophrenia

- First-generation Antipsychotics: chlorpromazine, fluphenazine, haloperidol, haloperidol lactate, loxapine succinate, molindone, perphenazine, pimozide, prochlorperazine, thioridazine, thiothixene, trifluoperazine
- Second-generation (Atypical) Antipsychotics: aripiprazole, asenapine, brexpiprazole, cariprazine, clozapine, iloperidone, lurasidone, olanzapine, paliperidone, quetiapine, risperidone, ziprasidone
- Psychotherapeutic Combinations: amitriptyline-perphenazine, fluoxetine-olanzapine
- Long-Acting (Depot) Injectable Antipsychotics: fluphenazine decanoate, haloperidol decanoate, aripiprazole, aripiprazole lauroxil, olanzapine pamoate, paliperidone palmitate (1-month extended-release injection, risperidone microspheres

Medications for Bipolar Disorder

- Anticonvulsants: carbamazepine, divalproex sodium, lamotrigine, valproic acid
- First-generation Antipsychotics: chlorpromazine, haloperidol, haloperidol lactate, loxapine succinate
- Second-generation (Atypical) Antipsychotics: aripiprazole, asenapine, cariprazine, clozapine, lurasidone, olanzapine, quetiapine, risperidone, ziprasidone
- Lithium Salts: lithium, lithium carbonate, lithium citrate
- Psychotherapeutic Combinations: fluoxetine-olanzapine
- Long-acting (depot) Injectable Antipsychotics: haloperidol decanoate, aripiprazole, aripiprazole lauroxil, olanzapine pamoate, risperidone microspheres

#1879 Adherence to Antipsychotic Medications for Individuals With Schizophrenia

The numerator is defined as individuals with a PDC of 0.8 or greater.

The PDC is calculated as follows:

PDC NUMERATOR

The PDC numerator is the sum of the days covered by the days' supply of all prescription drug claims for all antipsychotic medications. The period covered by the PDC starts on the day the first prescription is filled (index date) and lasts through the end of the measurement period, or death, whichever comes first. For prescription drug claims with a days' supply that extends beyond the end of the measurement period, count only the days for which the drug was available to the individual during the measurement period. If there are claims for the same drug (generic name) on the same date of service, keep the claim with the largest days' supply. If claims for the same drug (generic name) overlap, then adjust the prescription start date to be the day after the previous fill has ended.

PDC DENOMINATOR

The PDC denominator is the number of days from the first prescription drug claim date through the end of the measurement period, or death date, whichever comes first.

Denominator Statement

#3205 Medication Continuation Following Inpatient Psychiatric Discharge

The target population for this measure is Medicare fee-for-service (FFS) beneficiaries with Part D coverage aged 18 years and older discharged from an inpatient psychiatric facility with a principal diagnosis of MDD, schizophrenia, or bipolar disorder.

#1879 Adherence to Antipsychotic Medications for Individuals With Schizophrenia

Individuals at least 18 years of age as of the beginning of the measurement period with schizophrenia or schizoaffective disorder and at least two prescription drug claims for antipsychotic medications during the measurement period (12 consecutive months).

Denominator Details

#3205 Medication Continuation Following Inpatient Psychiatric Discharge

The denominator for this measure includes patients discharged from an IPF:

- With a principal diagnosis of MDD, schizophrenia, or bipolar disorder.
- 18 years of age or older at admission.
- Enrolled in Medicare fee-for-service Part A and Part B during the index admission and Parts A, B, and D at least 30-days post-discharge.
- Alive at discharge and alive during the follow-up period.
- With a discharge status code indicating that they were discharged to home or home health care.

The following are ICD-10-CM (clinical modification) diagnosis codes used to identify MDD, schizophrenia, or bipolar disorder:

MDD: F32.0, F32.1, F32.2, F32.3, F32.4, F32.9, F33.0, F33.1, F33.2, F33.3, F33.40, F33.41, F33.8, F33.9

Schizophrenia: F20.0, F20.1, F20.2, F20.3, F20.5, F20.81, F20.89, F20.9, F25.0, F25.1, F25.8, F25.9

Bipolar disorder: F30.10, F30.11, F30.12, F30.13, F30.2, F30.3, F30.4, F30.8, F30.9, F31.0, F31.10, F31.11, F31.12, F31.13, F31.2, F31.30, F31.31, F31.32, F31.4, F31.5, F31.60, F31.61, F31.62, F31.63, F31.64, F31.70, F31.71, F31.72, F31.73, F31.74, F31.75, F31.76, F31.77, F31.78, F31.81, F31.89, F31.9, F32.81, F32.89

#1879 Adherence to Antipsychotic Medications for Individuals With Schizophrenia

Target population meets the following conditions:

1. Continuously enrolled in Medicare Part D with no more than a one-month gap in enrollment during the measurement period;
2. Continuously enrolled in Medicare Part A and Part B with no more than a one-month gap in Part A enrollment and no more than a one-month gap in Part B enrollment during the measurement period; and,
3. No more than one month of HMO (Health Maintenance Organization) enrollment during the measurement period.

IDENTIFICATION OF SCHIZOPHRENIA

Individuals with schizophrenia or schizoaffective disorder are identified by having a diagnosis of schizophrenia within the inpatient or outpatient claims data. Individuals must have:

At least two encounters with a diagnosis of schizophrenia or schizoaffective disorder with different dates of service in an outpatient setting, emergency department setting, or non-acute inpatient setting during the measurement period;

OR

At least one encounter with a diagnosis of schizophrenia or schizoaffective disorder in an acute inpatient setting during the measurement period.

CODES USED TO IDENTIFY SCHIZOPHRENIA OR SCHIZOAFFECTIVE DISORDER DIAGNOSIS

Codes used to identify schizophrenia or schizoaffective disorder are included in the attached excel worksheet of codes (NQF_1879_Code Tables_2018_Final.xlsx) under the tab NQF_1879_Schizophrenia.

Table 1: Schizophrenia or Schizoaffective Disorder Diagnosis

ICD-9-CM: 295.xx

ICD-10-CM: F20.0, F20.1, F20.2, F20.3, F20.5, F20.81, F20.89, F20.9, F25.0, F25.1, F25.8, F25.9

CODES USED TO IDENTIFY ENCOUNTER TYPE:

Codes used to identify encounters are under tab NQF_1879_Encounter_types.

Table 2.1: Outpatient Setting

Current Procedural Terminology (CPT): 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99385-99387, 99395-99397, 99401-99404, 99411, 99412, 99429, 99510

HCPCS: G0155, G0176, G0177, G0409-G0411, G0463, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485, T1015

UB-92 revenue: 0510, 0511, 0513, 0516-0517, 0519-0523, 0526-0529, 0770, 0771, 0779, 0900-0905, 0907, 0911-0917, 0919, 0982, 0983

OR

CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 90880, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291

WITH

Place of Service (POS): 03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 24, 33, 49, 50, 52, 53, 71, 72

Table 2.2: Emergency Department Setting

CPT: 99281-99285

UB-92 revenue: 0450, 0451, 0452, 0456, 0459, 0981

OR

CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 99291

WITH

POS: 23

Table 2.3: Non-Acute Inpatient Setting

CPT: 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337

HCPCS: H0017-H0019, T2048

UB-92 revenue: 0118, 0128, 0138, 0148, 0158, 0190-0194, 0199, 0524, 0525, 0550-0552, 0559, 0660-0663, 0669, 1000, 1001, 1003-1005

OR

CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 99291

WITH

POS: 31, 32, 56

Table 2.4: Acute Inpatient Setting

UB-92 revenue: 0100, 0101, 0110-0114, 0119-0124, 0129-0134, 0139-0144, 0149-0154, 0159, 0160, 0164, 0167, 0169, 0200-0204, 0206-0209, 0210-0214, 0219, 0720-0724, 0729, 0987

OR

CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291

WITH

POS: 21, 51

IDENTIFICATION OF PRESCRIPTION DRUG CLAIMS FOR ANTIPSYCHOTIC MEDICATION:

Individuals with at least two prescription drug claims for any of the following oral antipsychotic medications (Table 3: Oral Antipsychotic Medications) or long-acting injectable antipsychotic medications (see Table 4: Long-acting injectable antipsychotic medications). The National Drug Center (NDC) identifier for medications included in the measure denominator are listed in tab NQF_1879_ Antipsychotics of the attached excel workbook. Obsolete drug products are excluded from National Drug Codes (NDCs) with an inactive date more than six years prior to the beginning of the measurement period or look-back period.

TABLE 3: ORAL ANTIPSYCHOTIC MEDICATIONS

The following are oral formulations only.

Typical Antipsychotic Medications:

chlorpromazine

fluphenazine

haloperidol

loxapine

molindone

perphenazine

prochlorperazine

thioridazine

thiothixene

trifluoperazine

Atypical Antipsychotic Medications:

aripiprazole

asenapine

brexpiprazole

cariprazine

clozapine

iloperidone

lurasidone

olanzapine

paliperidone

quetiapine

quetiapine fumarate (Seroquel)

risperidone

ziprasidone

Antipsychotic Combinations:

perphenazine-amitriptyline

TABLE 4: LONG-ACTING INJECTABLE ANTIPSYCHOTIC MEDICATIONS

The following are the long-acting (depot) injectable antipsychotic medications by class for the denominator. The route of administration includes all injectable and intramuscular formulations of the medications listed below.

Typical Antipsychotic Medications:

fluphenazine decanoate (J2680)

haloperidol decanoate (J1631)

Atypical Antipsychotic Medications:

aripiprazole (J0401)

aripiprazole lauroxil (Aristada)

olanzapine pamoate (J2358)

paliperidone palmitate (J2426)

risperidone microspheres (J2794)

Note: Since the days' supply variable is not reliable for long-acting injections in administrative data, the days' supply is imputed as listed below for the long-acting (depot) injectable antipsychotic medications billed under Medicare Part D and Part B:

fluphenazine decanoate (J2680) – 28 days' supply

haloperidol decanoate (J1631) – 28 days' supply

aripiprazole (J0401) – 28 days' supply

aripiprazole lauroxil (Aristada) - 28 days' supply

olanzapine pamoate (J2358) – 28 days' supply

paliperidone palmitate (J2426) – 28 days' supply

risperidone microspheres (J2794) – 14 days' supply

Exclusions

#3205 Medication Continuation Following Inpatient Psychiatric Discharge

The denominator for this measure excludes discharged patients who:

- Received electroconvulsive (ECT) during the inpatient stay or follow-up period
- Received transcranial stimulation (TMS) during the inpatient stay or follow-up period
- Were pregnant at discharge
- Had a secondary diagnosis of delirium at discharge

- Had a principal diagnosis of schizophrenia with a secondary diagnosis of dementia at discharge

#1879 Adherence to Antipsychotic Medications for Individuals With Schizophrenia

Individuals with any diagnosis of dementia during the measurement period.

Exclusion Details

#3205 Medication Continuation Following Inpatient Psychiatric Discharge

See Exclusions tab of attached codebook for list of codes used to define exclusions.

#1879 Adherence to Antipsychotic Medications for Individuals With Schizophrenia

Individuals with any diagnosis of dementia are identified with the diagnosis codes listed below tab NQF_1879_Dementia

Table 5: Codes Used to Identify Dementia

ICD-9-CM: 290.0, 290.10, 290.11, 290.12, 290.13, 290.20, 290.21, 290.3, 290.40, 290.41, 290.42, 290.43, 290.8, 290.9, 291.2, 292.82, 294.10, 294.11, 294.20, 294.21, 330.1, 331.0, 331.19, 331.82

ICD-10-CM: E75.00, E75.01, E75.02, E75.09, E75.10, E75.11, E75.19, E75.4, F01.50, F01.51, F02.80, F02.81, F03.90, F03.91, F05, F10.27, F11.122, F13.27, F13.97, F18.17, F18.27, F18.97, F19.17, F19.27, F19.97, G30.0, G30.1, G30.8, G30.9, G31.09, G31.83

Risk Adjustment

#3205 Medication Continuation Following Inpatient Psychiatric Discharge

No risk adjustment or risk stratification

147129| 138817

147129| 138817

#1879 Adherence to Antipsychotic Medications for Individuals With Schizophrenia

No risk adjustment or risk stratification

119011| 120823| 140881| 123834| 141015| 142428| 147517

119011| 120823| 140881| 123834| 141015| 142428| 147517

Stratification

#3205 Medication Continuation Following Inpatient Psychiatric Discharge

Not applicable. The measure is not stratified.

#1879 Adherence to Antipsychotic Medications for Individuals With Schizophrenia

Depending on the operational use of the measure, measure results can be stratified by:

- State
- Physician Group*
- Age – Divided into six categories: 18-24, 25-44, 45-64, 65-74, 75-84, and 85+ years
- Race/Ethnicity
- Dual Eligibility

*See Calculation Algorithm/Measure Logic S.14 below for physician group attribution methodology used for this measure.

Type Score

#3205 Medication Continuation Following Inpatient Psychiatric Discharge

Rate/proportion better quality = higher score

#1879 Adherence to Antipsychotic Medications for Individuals With Schizophrenia

Rate/proportion better quality = higher score

Algorithm

#3205 Medication Continuation Following Inpatient Psychiatric Discharge

Denominator:

1. Pull all IPF discharges from the Part A data.
2. Include IPF discharges for patients who were at least 18 years of age at admission.
3. Identify interim claims having the same beneficiary, provider, admission dates or having an admission date within one day of the discharge date of the previous claim and having a discharge status code of "Still patient." Collapse or combine the interim claims into one hospital stay using the admission date from the earliest claim and the discharge date from the latest claim. The data values from the latest claim are used for the newly combined hospital stay.
4. De-duplicate the IPF inpatient discharges dataset by Patient ID, Sex, Provider ID, Admission Date, and Discharge Date.
5. Remove the IPF inpatient discharges for patients who do not have Part A and Part B coverage at admission, during the entire stay, at discharge, and during the 30 days post-discharge.
6. Remove the IPF inpatient discharges who do not have a principal diagnosis of MDD, bipolar disorder, or schizophrenia using value sets containing ICD-10 codes for each of the disease conditions.
7. Remove the IPF inpatient discharges for patients who expired during the hospital stay or within 30 days of discharge.
8. Remove the IPF inpatient discharges for patients who do not have Part D coverage during the 30 days post-discharge.
9. Remove the IPF inpatient discharges for patients who were not discharged to home or home health.
10. Exclude IPF inpatient discharges who have a secondary diagnosis of pregnancy or delirium.
11. Exclude IPF inpatient discharges who have schizophrenia as the principal diagnosis with a secondary diagnosis of dementia.
12. Exclude IPF inpatient discharges who have ECT or TMS during the hospital stay or within 30 days post-discharge.

Numerator:

1. Pull all Part D claims for the evidence-based medications used for the treatment of MDD, schizophrenia, and bipolar disorder.
2. Pull all Part A and Part B claims for antipsychotic long-acting injectables (LAIs) and add them to the Part D medication claims for schizophrenia and bipolar disorder.
3. Compare the medication claims to the denominator file of eligible IPF inpatient discharges and remove any claims that occur more than two days prior to the discharge date.

4. Determine which claims occur within the follow-up period (two days prior to discharge through 30 days post-discharge) for each of the three disease conditions.
5. Total the denominator cases having at least one medication claim corresponding to the disease condition during the follow-up period. 147129| 138817

#1879 Adherence to Antipsychotic Medications for Individuals With Schizophrenia

Target Population: Individuals at least 18 years of age as of the beginning of the measurement period who have met the enrollment criteria for Medicare Parts A, B, and D.

Denominator: Individuals at least 18 years of age as of the beginning of the measurement period with schizophrenia or schizoaffective disorder and at least two prescription drug claims for antipsychotic medications during the measurement period (12 consecutive months).

CREATE DENOMINATOR:

1. Pull individuals who are 18 years of age or older as of the beginning of the measurement period.
2. Include individuals who were continuously enrolled in Medicare Part D coverage during the measurement period, with no more than a one-month gap in enrollment during the measurement period, or up until their death date if they died during the measurement period.
3. Include individuals who had no more than a one-month gap in Medicare Part A enrollment, no more than a one-month gap in Part B enrollment, and no more than one month of HMO (Health Maintenance Organization) enrollment during the current measurement period (fee-for-service [FFS] individuals only).
4. Of those individuals identified in Step 3, keep individuals who had:

   At least two encounters with a diagnosis of schizophrenia of schizoaffective disorder with different dates of service in an outpatient setting, emergency department setting, or non-acute inpatient setting during the measurement period;

   OR

   Individuals who had at least one encounter with a diagnosis of schizophrenia or schizoaffective disorder in an acute inpatient setting during the measurement period.
5. For the individuals identified in Step 4, extract Medicare Part D claims for any antipsychotic medication during the measurement period. Attach the generic name and the drug ID to the dataset.
6. Of the individuals identified in Step 5, exclude those who did not have at least two prescription drug claims for any antipsychotic medication on different dates of service (identified by having at least two Medicare Part D claims with the specific codes) during the measurement period.
7. Exclude those individuals with a diagnosis of dementia during the measurement period.

Numerator: Individuals with schizophrenia or schizoaffective disorder who had at least two prescription drug claims for antipsychotic medications and have a PDC of at least 0.8 for antipsychotic medications.

CREATE NUMERATOR:

For the individuals in the denominator, calculate the PDC for each individual according to the following methods:

1. Determine the individual's medication therapy period, defined as the number of days from the index prescription date through the end of the measurement period, or death, whichever comes first. The index date is the service date (fill date) of the first prescription drug claim for an antipsychotic medication in the measurement period.

2. Within the medication therapy period, count the days the individual was covered by at least one drug in the antipsychotic medication class based on the prescription drug claim service date and days of supply.

a. Sort and de-duplicate Medicare Part D antipsychotic medication claims by beneficiary ID, service date, generic name, and descending days' supply. If prescriptions for the same drug (generic name) are dispensed on the same date of service for an individual, keep the dispensing with the largest days' supply.

b. Calculate the number of days covered by antipsychotic drug therapy per individual.

i. For prescription drug claims with a days' supply that extends beyond the end of the measurement period, count only the days for which the drug was available to the individual during the measurement period.

ii. If claims for the same drug (generic name) overlap, then adjust the prescription start date to be the day after the previous fill has ended.

iii. If claims for different drugs (different generic names) overlap, do not adjust the prescription start date.

3. Calculate the PDC for each individual. Divide the number of covered days found in Step 2 by the number of days in the individual's medication therapy period found in Step 1.

An example of SAS code for Steps 1-3 was adapted from Pharmacy Quality Alliance (PQA) and is available at the URL: http://www2.sas.com/proceedings/forum2007/043-2007.pdf.

4. Of the individuals identified in Step 3, count the number of individuals with a calculated PDC of at least 0.8 for the antipsychotic medications. This is the numerator.

PHYSICIAN GROUP ATTRIBUTION:

Physician group attribution was adapted from Generating Medicare Physician Quality Performance Measurement Results (GEM) Project: Physician and Other Provider Grouping and Patient Attribution Methodologies (http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/GEM/downloads/GEMMethodologies.pdf). The following is intended as guidance and reflects only one of many methodologies for assigning individuals to a medical group. Please note that the physician group attribution methodology excludes patients who died, even though the overall measure does not.

I. Identify Physician and Medical Groups

1. Identify all Tax Identification Numbers (TINs)/National Provider Identification (NPIs) combinations from all Medicare Part B claims in the measurement year and the prior year. Keep records with valid NPI. Valid NPIs have 10 numeric characters (no alpha characters).

2. For valid NPIs, pull credentials and specialty code(s) from the CMS provider tables.

3. Create one record per NPI with all credentials and all specialties. A provider may have more than one specialty.

4. Attach TIN to NPI, keeping only those records with credentials indicating a physician (MD or DO), physician assistant (PA), or nurse practitioner (NP).

5. Identify medical group TINs: Medical group TINs are defined as TINs that had physician, physician assistant, or nurse practitioner provider specialty codes on at least 50% of Medicare Part B carrier claim line items billed by the TIN during the measurement year or prior year. (The provider specialty codes are listed after Patient Attribution.)

a. Pull Part B records billed by TINS identified in Step 4 during the measurement year and prior year.

b. Identify claims that had the performing NPI (npi_prfrmg) in the list of eligible physicians/TINs, keeping those that match by TIN, performing NPI, and provider state code.

c. Calculate the percentage of Part B claims that match by TIN, npi_prfrmg, and provider state code for each TIN, keeping those TINs with percentages greater than or equal to 50%.

d. Delete invalid TINs. Examples of invalid TINs are defined as having the same value for all nine digits or values of 012345678, 012345678, 123456789, 987654321, or 87654321.

6. Identify TINs that are not solo practices.

a. Pull Part B records billed by physicians identified in Step 4 for the measurement year and/or prior year.

b. Count unique NPIs per TIN.

c. Keep only those TINs having two or more providers.

d. Delete invalid TINs. Examples of invalid TINs are defined as having the same value for all nine digits or values of 012345678, 012345678, 123456789, 987654321, or 87654321.

7. Create final group of TINs from Step 5 and Step 6 (TINs that are medical groups and are not solo practices).

8. Create file of TINs and NPIs associated with those TINs. These are now referred to as the medical group TINs.

9. Determine the specialty of the medical group (TIN) to be used in determining the specialty of nurse practitioners and physician assistants. The plurality of physician providers in the medical group determines the specialty of care for nurse practitioners and physician assistants.

a. From the TIN/NPI list created in Step 8, count the NPIs per TIN/specialty.

b. The specialty with the maximum count is assigned to the medical group.

II. Identify Individual Sample and Claims

10. Create individual sample.

a. Pull individuals with 11+ months of Medicare Parts A, B, and D during the measurement year.

b. Verify the individual did not have any months with Medicare as secondary payer. Remove individuals with BENE_PRMRY_PYR_CD not equal to one of the following:

- A = working-age individual/spouse with an employer group health plan (EGHP)
- B = End Stage Renal Disease (ESRD) in the 18-month coordination period with an EGHP
- G = working disabled for any month of the year

c. Verify the individual resides in the U.S., Puerto Rico, Virgin Islands, or Washington D.C.

d. Exclude individuals who enter the Medicare hospice at any point during the measurement year.

e. Exclude individuals who died during the measurement year.

11. For individuals identified in Step 10, pull office visit claims that occurred during the measurement year and in the six months prior to the measurement year.

a. Office visit claims have CPT codes of 99201-99205, 99211-99215, and 99241-99245.

b. Exclude claims with no npi_prfrmg.

12. Attach medical group TIN to claims by NPI.

III. Patient Attribution

13. Pull all Medicare Part B office claims from Step 12 with specialties indicating primary care or psychiatry (see list of provider specialties and specialty codes below). Attribute each individual to at most one medical group TIN for each measure.

a. Evaluate specialty on claim (HSE_B_HCFA_PRVDR_SPCLTY_CD) first. If specialty on claim does not match any of the measure-specific specialties, then check additional specialty fields.
b. If the provider specialty indicates nurse practitioners or physician assistants (code 50 or code 97), then assign the medical group specialty determined in Step 9.

14. For each individual, count claims per medical group TIN. Keep only individuals with two or more E&M claims.
15. Attribute individual to the medical group TIN with the most claims. If a tie occurs between medical group TINs, attribute the TIN with the most recent claim.
16. Attach the medical group TIN to the denominator and numerator files by individual.

Provider Specialties and Specialty Codes

Provider specialties and specialty codes include only physicians, physician assistants, and nurse practitioners for physician grouping, TIN selection, and patient attribution. The provider specialty codes and the associated provider specialty are shown below:

01—General practice*
02—General surgery
03—Allergy/immunology
04—Otolaryngology
05—Anesthesiology
06—Cardiology
07—Dermatology
08—Family practice*
09—Interventional pain management
10—Gastroenterology
11—Internal medicine*
12—Osteopathic manipulative therapy
13—Neurology
14—Neurosurgery
16—Obstetrics/gynecology*
18—Ophthalmology
20—Orthopedic surgery
22—Pathology
24—Plastic and reconstructive surgery
25—Physical medicine and rehabilitation
26—Psychiatry*
28—Colorectal surgery
29—Pulmonary disease
30—Diagnostic radiology
33—Thoracic surgery
34—Urology
37—Nuclear medicine

38—Geriatric medicine*

39—Nephrology

39—Pediatric medicine

40—Hand surgery

44—Infectious disease

46—Endocrinology

50—Nurse practitioner*

66—Rheumatology

70—Multi-specialty clinic or group practice*

72—Pain management

76—Peripheral vascular disease

77—Vascular surgery

78—Cardiac surgery

79—Addiction medicine

81—Critical care (intensivists)

82—Hematology

83—Hematology/oncology

84—Preventive medicine*

85—Maxillofacial surgery

86—Neuropsychiatry*

90—Medical oncology

91—Surgical oncology

92—Radiation oncology

93—Emergency medicine

94—Interventional radiology

97—Physician assistant*

98—Gynecologist/oncologist

99—Unknown physician specialty

Other—NA

*Provider specialty codes specific to this measure 119011| 120823| 140881| 123834| 141015| 142428| 147517

Submission Items

#3205 Medication Continuation Following Inpatient Psychiatric Discharge

5.1 Identified measures: 1879 : Adherence to Antipsychotic Medications for Individuals with Schizophrenia

1880 : Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact: The numerator for the Medication Continuation measure has been harmonized with these measures when possible

because the measure populations of the three related measures overlap with the patient population targeted by this measure and the measures share a similar clinical focus on medication use. We compared the medications included in the related measures with medications included in the Medication Continuation measure.

5b.1 If competing, why superior or rationale for additive value: The related measures that we identified are not competing measures because the Medication Continuation measure is for those with diagnoses of bipolar disorder, MDD, or schizophrenia.

#1879 Adherence to Antipsychotic Medications for Individuals With Schizophrenia

5.1 Identified measures: 0544 : Use and Adherence to Antipsychotics among members with Schizophrenia

0543 : Adherence to Statin Therapy for Individuals with Cardiovascular Disease

0542 : Adherence to Chronic Medications

0545 : Adherence to Statins for Individuals with Diabetes Mellitus

0541 : Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

0569 : ADHERENCE TO STATINS

1880 : Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact: The measure specifications are harmonized with the related measure, Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder (NQF #1880), where possible. The methodology used to calculate adherence in these measures is proportion of days covered (PDC) which is calculated the same in both measures. The methodology used to identify the denominator population is also calculated the same in both measures with the exception of the clinical conditions which is the target of the measure. The medications included in both measures are specific to the clinical condition targeted in the measure.

5b.1 If competing, why superior or rationale for additive value: The Adherence to Antipsychotic Medications for Individuals with Schizophrenia (NCQA) measure is used for HEDIS reporting and is harmonized with the NQF #1879 in condition, target population, methodology, and medications. The HEDIS measure is only used in Medicaid health plans and therefore is restricted to adults age 18-64.

During development the measure developers identified another competing measure which eventually lost NQF endorsement. The section below is from the original submission of the measures for initial endorsement and compares this measure (#1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia) to a previously NQF-endorsed measure (#0544 Use and Adherence to Antipsychotics among Members with Schizophrenia).

Measure 1879 (Adherence to Antipsychotic Medications for Individuals with Schizophrenia) has both the same measure focus and essentially the same target population as Measure 0544 (Use and Adherence to Antipsychotics among Members with Schizophrenia), which is no longer endorsed after the measure's time-limited endorsement (TLE) status expired. Measure 1879 is superior to the existing Measure 0544 because it represents a more valid and efficient approach to measuring medication adherence to antipsychotic medications. In addition, as discussed above in Section 5a.2, Measure 1879 is harmonized with several other adherence measures in the NQF portfolio. Key differences in measure validity and efficiency are addressed in the sections below.

VALIDITY

The Proportion of Days Covered (PDC), which is the method used to calculate adherence in Measure 1879, has several advantages over the Medication Possession Ratio (MPR), which is used in Measure 0544. First, the PDC was found to be more conservative compared to the Medication Possession Ratio (MPR) and was preferred in clinical scenarios in which there is the potential for more than one drug to be used within a drug class concomitantly (e.g., antipsychotics). This clinical situation applies directly to Measure 1879. Martin et al. (2009) demonstrated this in a study published in the Annals of Pharmacotherapy by comparing the methodology for drugs that are commonly switched, where the MPR was 0.690, truncated MPR was 0.624, and PDC was 0.562 and found significant differences between the values for adherence ($p < 0.001$). Martin et al (2009) also compared drugs with therapeutic duplication where the PDC was 0.669, truncated MPR was 0.774, and MPR was 1.238, and again obtained significant differences ($p < 0.001$). These findings were partially replicated by testing results from FMQAI (now HSAG) of Measure 1879 where MPR produced a higher measure rate (as compared to PDC) as shown below.

Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Method Measure Rate

Comparison of MPR and PDC

Method Measure Rate

MPR 74.4%

PDC 70.0%

Based on initial draft measure specifications and data from a 100% sample of Medicare fee-for-service beneficiaries

with Part D coverage in Florida and Rhode Island, using 2008 Medicare Parts A, B, and D data.

Additional differences between Measure 1879 and TLE 0544 related to validity include the following concerns:

Denominator: The measure denominator requires at least two antipsychotic medication prescriptions; whereas, the NQF TLE measure (NQF# 0544) does not require any antipsychotic medication prescriptions in the measure denominator. In 0544, an MPR of “0” is assigned to those without any antipsychotic medication prescriptions, which may falsely lower measure rates, specifically in scenarios where the prescriber has made the decision not to prescribe antipsychotic medications for an individual diagnosed with schizophrenia.

Exclusion related to a diagnosis of dementia: Measure 1879 excludes individuals with a diagnosis of dementia during the measurement year which is not considered in Measure 0544. Antipsychotic medications are currently labeled with a Food and Drug Administration (FDA) Black Box warning that states, “Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Analyses of seventeen placebo-controlled trials (modal duration of 10 weeks), largely in patients taking atypical antipsychotic drugs, revealed a risk of death in drug-treated patients of between 1.6 to 1.7 times the risk of death in placebo-treated patients.” The Technical Expert Panel, which reviewed the measure, recommended excluding these individuals from the measure denominator, since continued adherence to antipsychotic medications in this subpopulation may increase mortality and not represent quality of care. (Please see Section 2b3.2 that provides descriptive results of testing related to exclusions.)

EFFICIENCY

Measure 1879 requires only one year of administrative claims data, rather than two years of data which is required for TLE 0544. The Technical Expert Panel that reviewed Measure 1879 indicated that the burden of requiring two years of administrative claims data would not meaningfully

modify measure rates and would potentially result in the unnecessary exclusion of individuals for which adherence should be assessed but for which only 1 year of claims data were available. Additional rationale for this TEP recommendation was related to an increased length of the continuous enrollment criteria to specify the measure use with two years of data. FMQAI's (now HSAG) empirical analysis of a related adherence measure (NQF 0542 – Adherence to Chronic Medications) using 2007 and 2008 Medicare Part D data for beneficiaries in Florida and Rhode Island validated this concern and indicated that approximately 10% of the eligible population would be excluded from the measure if the enrollment criteria required two years of administrative claims data as opposed to one year.

Comparison of NQF #3589 with NQF #3175 and NQF #3400

#3589 Prescription or Administration of Pharmacotherapy to Treat Opioid Use Disorder (OUD)
#3175 Continuity of Pharmacotherapy for Opioid Use Disorder
#3400 Use of Pharmacotherapy for Opioid Use Disorder (OUD)

Steward

#3589 Prescription or Administration of Pharmacotherapy to Treat Opioid Use Disorder (OUD)

RTI International

#3175 Continuity of Pharmacotherapy for Opioid Use Disorder

University of Southern California

#3400 Use of Pharmacotherapy for Opioid Use Disorder (OUD)

Centers for Medicare & Medicaid Services

Description

#3589 Prescription or Administration of Pharmacotherapy to Treat Opioid Use Disorder (OUD)

This measure reports the percentage of a provider's patients who were Medicaid beneficiaries ages 18 to 64 with an OUD diagnosis who filled a prescription for, or were administered or ordered, a FDA-approved medication to treat OUD within 30 days of the first attributable OUD treatment encounter with that provider.

#3175 Continuity of Pharmacotherapy for Opioid Use Disorder

Percentage of adults of at least 18 years of age with pharmacotherapy for opioid use disorder (OUD) who have at least 180 days of continuous treatment

#3400 Use of Pharmacotherapy for Opioid Use Disorder (OUD)

The percentage of Medicaid beneficiaries ages 18–64 with an OUD who filled a prescription for or were administered or dispensed an FDA-approved medication for the disorder during the measure year. The measure will report any medications used in medication-assisted treatment of opioid dependence and addiction and four separate rates representing the following types of FDA-approved drug products: buprenorphine; oral naltrexone; long-acting, injectable naltrexone; and methadone.

Type

#3589 Prescription or Administration of Pharmacotherapy to Treat Opioid Use Disorder (OUD)

Process

#3175 Continuity of Pharmacotherapy for Opioid Use Disorder

Process

#3400 Use of Pharmacotherapy for Opioid Use Disorder (OUD)

Process

Data Source

#3589 Prescription or Administration of Pharmacotherapy to Treat Opioid Use Disorder (OUD)

Claims, Enrollment Data The data source is Medicaid Analytic Extract (MAX) files, including person summary (PS), inpatient (IP), other services (OT), long-term care (LT) and drug (RX) files. The other services file contains facility and individual provider services data. The Medicaid Analytic Extract (MAX) files contain data from 32 states.

No data collection instrument provided Attachment Data_Dictionary_for_MAT_Receipt_Measure__7-9-20.xlsx

#3175 Continuity of Pharmacotherapy for Opioid Use Disorder

Claims For measure calculation, the following files from the Truven MarketScan® Commercial Database and the Medicare 100% Research Identifiable Files (RIF) were used:

- Enrollment data
- Drug claims/prescription drug events
- Medical claims

We used data from these files for calendar years 2010-2016. The MarketScan database has long been a commonly used data source to study patterns of commercially insured patients. The Medicare RIF files contain all claims for beneficiaries in traditional Medicare. Both databases contain fully adjudicated, patient-level claims. All records in these files were used as input to identify individuals that met the measure's eligibility criteria.

No data collection instrument provided Attachment NQF_3175_OUD_Code_Lists_2021_version.xlsx

#3400 Use of Pharmacotherapy for Opioid Use Disorder (OUD)

Claims Medicaid Alpha-MAX 2014 data: eligible (EL), inpatient (IP), other services (OT), long-term care (LT) and drug (RX) files. The other services file contains facility and individual provider services data. Most notably, it may contain both residential and other stayover service claims data as claims are assigned to MAX claims file types based upon the category of service provided.

No data collection instrument provided Attachment NQF3400_ValueSets_2020Update.xlsx

Level

#3589 Prescription or Administration of Pharmacotherapy to Treat Opioid Use Disorder (OUD)

Facility, Clinician : Individual

#3175 Continuity of Pharmacotherapy for Opioid Use Disorder

Clinician : Group/Practice, Health Plan, Clinician : Individual, Population : Regional and State

#3400 Use of Pharmacotherapy for Opioid Use Disorder (OUD)

Population : Regional and State

Setting

#3589 Prescription or Administration of Pharmacotherapy to Treat Opioid Use Disorder (OUD)

Emergency Department and Services, Inpatient/Hospital, Outpatient Services

#3175 Continuity of Pharmacotherapy for Opioid Use Disorder

Outpatient Services

#3400 Use of Pharmacotherapy for Opioid Use Disorder (OUD)

Emergency Department and Services, Inpatient/Hospital, Outpatient Services

Numerator Statement

#3589 Prescription or Administration of Pharmacotherapy to Treat Opioid Use Disorder (OUD)

Beneficiaries ages 18 to 64 with an OUD who filled a prescription for, or were administered or ordered, an FDA-approved medication for the treatment of OUD within 30 days of the first attributable encounter with an OUD diagnosis with the provider.

#3175 Continuity of Pharmacotherapy for Opioid Use Disorder

Individuals in the denominator who have at least 180 days of continuous pharmacotherapy with a medication prescribed for OUD without a gap of more than seven days

#3400 Use of Pharmacotherapy for Opioid Use Disorder (OUD)

Medicaid beneficiaries with evidence of at least one prescription filled, or were administered or dispensed an FDA-approved medication for OUD during the measurement year (see NQF 3400—worksheet tab 2 of attached value sets).

Numerator Details

#3589 Prescription or Administration of Pharmacotherapy to Treat Opioid Use Disorder (OUD)

The measure numerator is the number of beneficiaries ages 18 to 64 with an OUD diagnosis (see Appendix A in Data Dictionary) who filled a prescription for, or were administered or ordered, an FDA-approved medication to treat OUD (see Appendix B in Data Dictionary) within 30 days of the first attributable encounter with the provider.

Note that the OUD medication administration or prescription can be from any provider (e.g., office-based physician, hospital, OTP), it need not necessarily be the attributed provider. This justification is that all providers who treat patients with an OUD diagnosis should be held accountable for ensuring that they receive gold standard treatment.

#3175 Continuity of Pharmacotherapy for Opioid Use Disorder

The measure numerator is calculated based on claims data for rolling two-year periods. The measure numerator is defined as individuals in the denominator with at least 180 days of "continuous pharmacotherapy" with an OUD medication.

Continuous pharmacotherapy for OUD is identified on the basis of the days covered by the days' supply of all prescription claims for any OUD medication (see list below) or number of days for which the drug was dispensed in a physician office or treatment center with the exceptions noted in this paragraph. The period of continuous pharmacotherapy starts on the day the first claim for an OUD medication is filled/supplied (index date) and lasts through the days' supply of the last claim for an OUD medication. To meet the 180-day requirement and be eligible for the measure, the date on the first claim for an OUD medication must fall at least 180 days before the end of the measurement period. For claims with a days' supply that extends beyond the end of the

measurement period, count only the days for which the drug was available to the individual during the measurement period. If two or more prescription claims occur on the same day or overlap, the surplus based on the days' supplies accumulates over all prescriptions. However, if another claim is submitted after a claim for an injectable/implantable OUD medication or an oral OUD medication that is dispensed in an office or treatment center, the surplus from the day's supply for the injectable/implantable or office-dispensed medication is not retained.

An individual is considered to have continuous pharmacotherapy with OUD medication if there is no treatment gap of more than seven days. A gap is defined as a period during which the individual does not have oral OUD medication available based on the days' supply, or is more than 7 days overdue for having an injection of an extended-release OUD medication.

OUD medications were identified using National Drug Codes (NDCs) for the following:

- Buprenorphine
- Naltrexone (oral)
- Buprenorphine and Naloxone

And HCPCS codes for the following:

- Buprenorphine or Buprenorphine/naloxone, oral

  Buprenorphine (extended-release injectable or implant)
- Methadone administration
- Naltrexone (extended-release injectable)

The National Drug Codes (NDCs) for the oral medications and the HCPCS codes for the injectable medications and office-dispensed oral medications (methadone and buprenorphine/naloxone) are contained in the sheets called "NDCs" and "HCPCS Codes", respectively, in the Excel file called "NQF 3175 OUD Code Lists" which is attached to this form under Item S.2b. Note that the NDC code list DOES NOT include NDC codes for methadone, as it can legally only be dispensed as OUD pharmacotherapy in licensed treatment centers. Buprenorphine can be dispensed through a pharmacy or in an office and is therefore identified based on either NDC or HCPCS codes.

Justification of Measure Definition: We define treatment continuity as (1) receiving at least 180 days of treatment and (2) no gaps in medication use of more than 7 days.

Our definition of minimum duration is based on the fact that the FDA registration trials for OUD drugs studied the effect of treatment over three to six months (US FDAa, undated; US FDAb, undated), and we have no evidence for effectiveness of shorter durations. In addition, several recommendations support a minimum six-month treatment period as the risk of relapse is the highest in the first 6-12 months after start of opioid abstinence (US FDAa, undated; US FDAb, undated; US DHHS, 2015). Longer treatment duration is associated with better outcomes compared to shorter treatments and the best outcomes have been observed among patients in long-term methadone maintenance programs ("Effective medical treatment of opiate addiction", 1998; Gruber et al., 2008; Moos et al., 1999; NIDA, 1999; Ouimette et al., 1998; Peles et al., 2013). Studies with long-term follow-up suggest that ongoing pharmacotherapy is associated with improved odds of opioid abstinence (Hser et al., 2015; Weiss et al., 2015). We did not specify a maximum duration of treatment, as no upper limit for duration of treatment has been empirically established (US DHHS, 2015).

We opted for using a treatment gap of more than seven days in our definition, given that the measure includes three active ingredients with different pharmacological profiles. There is substantial evidence for an elevated mortality risk immediately after treatment cessation (Cornish et al., 2010; Cousins et al., 2016; Davoli et al, 2007; Degenhardt et al., 2009; Gibson & Degenhardt,

2007; Pierce et al., 2016). Research suggests that methadone tolerance is lost after three days and this three-day threshold has been used in other observational methadone studies and in developing a United Kingdom treatment guideline which recommends revaluating patients for intoxication and withdrawal after a three-day methadone treatment gap (Cousins et al., 2016; Cousins et al., 2011; "Drug Misuse and Dependence—Guidelines on Clinical Management", 1999). Across all the medications, the mortality risk is highest in the first four weeks out of treatment, with many studies showing an increase in mortality in days 1-14 after treatment cessation.

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#3400 Use of Pharmacotherapy for Opioid Use Disorder (OUD)

Medicaid beneficiaries with evidence of at least one prescription filled, or were administered or dispensed an FDA-approved medication for OUD during the measurement year through use of pharmacy claims (relevant NDC code) or through relevant HCPCS coding of medical service (see NQF 3400—worksheet tab 2 of attached value sets).

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

The measure will be calculated both overall and stratified by four medications/mode of administration: buprenorphine; oral naltrexone; long-acting, injectable naltrexone; and methadone. The total is not a sum of the four medication cohorts. Count beneficiaries in the total denominator rate if they had at least one of the four FDA-approved medications for OUD during the measurement year. Report beneficiaries with multiple medications only once for the total rate for the denominator.

Denominator Statement

#3589 Prescription or Administration of Pharmacotherapy to Treat Opioid Use Disorder (OUD)

Number of Medicaid ages 18 – 64 beneficiaries with at least one medical claim for an encounter with an OUD diagnosis with that provider (where the provider is identified by a National Provider Identifier (NPI) code).

#3175 Continuity of Pharmacotherapy for Opioid Use Disorder

Individuals at least 18 years of age who had a diagnosis of OUD and at least one claim for an OUD medication

#3400 Use of Pharmacotherapy for Opioid Use Disorder (OUD)

Medicaid beneficiaries with at least one encounter with a diagnosis of opioid abuse, dependence, or remission (primary or other) at any time during the measurement year.

Denominator Details

#3589 Prescription or Administration of Pharmacotherapy to Treat Opioid Use Disorder (OUD)

The target population for the denominator includes all Medicaid beneficiaries age 18 through 64 years with a diagnosis of OUD (primary or other) that had an encounter with the provider at least

once during the measure time period which is defined as a calendar year. See Appendix A for ICD codes for identifying OUD. Age is calculated as of December 31st of the measurement year. Denominator exclusions are described below in 5.8.

#3175 Continuity of Pharmacotherapy for Opioid Use Disorder

The measure denominator is calculated for rolling two-year periods. The denominator includes individuals of at least 18 years of age during their treatment period who had a diagnosis code of OUD during an inpatient, intensive outpatient, partial hospitalization, outpatient, detoxification or emergency department encounter at any time during the measurement period. To meet the 180-day requirement and be eligible for the measure, the date on the first claim for an OUD medication must fall at least 180 days before the end of the measurement period.

The diagnosis codes used to identify individuals with OUD included:

- ICD-9: 304.0x, 305.5x
- ICD-10: F11.xxx

These codes and descriptions are contained in the sheets called “ICD-9 Diagnosis Codes” and “ICD-10 Diagnosis Codes” in the Excel file called “NQF 3175 OUD Code Lists” which is attached to this form under Item S.2b.

OUD medications were identified using National Drug Codes (NDCs) for the following:

- Buprenorphine
- Naltrexone (oral)
- Buprenorphine and Naloxone

And HCPCS codes for the following:

- Buprenorphine or Buprenorphine/naloxone, oral
- Buprenorphine (extended release injectable or implant)
- Methadone administration
- Naltrexone (extended-release injectable)

The National Drug Codes (NDCs) for the oral medications and the HCPCS codes for the injectable medications and office-or treatment-center dispensed oral medications (methadone and buprenorphine) are contained in the sheets called “NDCs” and “HCPCS Codes”, respectively, in the Excel file called “NQF 3175 OUD Code Lists” which is attached to this form under Item S.2b. Note that the NDC code list DOES NOT include NDC codes for methadone, as it can legally only be dispensed as OUD pharmacotherapy in licensed treatment centers. Buprenorphine can be dispensed through a pharmacy or in an office/treatment center and is therefore identified based on either NDC or HCPCS codes.

#3400 Use of Pharmacotherapy for Opioid Use Disorder (OUD)

Medicaid beneficiaries age 18–64, enrolled for full 12 months of measurement year, and had at least one encounter with a diagnosis of opioid abuse, dependence, or remission (primary or other diagnosis) at any time during the measurement year. ICD-10 codes for OUD are provided in worksheet tab 1 of the attached value set Excel file.

Exclusions

#3589 Prescription or Administration of Pharmacotherapy to Treat Opioid Use Disorder (OUD)

Dual eligible Medicare/Medicaid beneficiaries are excluded. Rationale: Individuals who are covered under Medicare would receive coverage for follow up treatment medications (e.g. medication

assisted treatment) under Medicare Part D and Medicare Part D claims are not captured in Medicaid claims databases. Therefore, follow-up would be missed.

Individuals under 18 are excluded. Rationale: There is limited evidence regarding the efficacy of MOUD for this population.

Individuals over 64 are excluded: Rationale: Most individuals over age 64 are covered under Medicare. Services covered by Medicare would not be capture in the Medicaid claims data and therefore follow-up treatment would be missed.

#3175 Continuity of Pharmacotherapy for Opioid Use Disorder

There are no denominator exclusions.

#3400 Use of Pharmacotherapy for Opioid Use Disorder (OUD)

Not applicable: the measure does not have denominator exclusions.

Exclusion Details

#3589 Prescription or Administration of Pharmacotherapy to Treat Opioid Use Disorder (OUD)

Instructions for the analytic file build, including denominator exclusion detail are included below.

Measurement Year: Calendar year 2014

Ages:18 years and older as of December 31 of the measurement year. 64 or younger as of December 31 of the measurement year

Required Benefits:Medical, Chemical Dependency, and Pharmacy

Analytic File Inclusion Criteria Follow steps below.

1. Subset file to patients who had an OUD diagnosis. (Appendix A contains ICD codes for identifying OUD) in any diagnostic position from any provider during selected Calendar year.
2. Eliminate dual eligible (Medicare/Medicaid) beneficiaries.
3. Eliminate any patient IDs of patients younger than 18 as of December 31 of the measurement year, or older than 64 as of December 31 of the measurement year.
4. Pull all the claims/records from the enrollment, inpatient, outpatient, prescription drug files, and long-term claims files with these Member IDs into an analytic sample.

#3175 Continuity of Pharmacotherapy for Opioid Use Disorder

There are no denominator exclusions.

#3400 Use of Pharmacotherapy for Opioid Use Disorder (OUD)

Not applicable: the measure does not have denominator exclusions.

Risk Adjustment

#3589 Prescription or Administration of Pharmacotherapy to Treat Opioid Use Disorder (OUD)

No risk adjustment or risk stratification

146353

146353

#3175 Continuity of Pharmacotherapy for Opioid Use Disorder

No risk adjustment or risk stratification

123001| 148777| 141015| 150289

123001| 148777| 141015| 150289

#3400 Use of Pharmacotherapy for Opioid Use Disorder (OUD)

No risk adjustment or risk stratification

120752| 141015| 113612

120752| 141015| 113612

Stratification

#3589 Prescription or Administration of Pharmacotherapy to Treat Opioid Use Disorder (OUD)

Not applicable.

#3175 Continuity of Pharmacotherapy for Opioid Use Disorder

Measure results may be stratified by:

- Age
- Gender
- Race/ethnicity
- Dual eligibility status

#3400 Use of Pharmacotherapy for Opioid Use Disorder (OUD)

The measure is calculated both overall and stratified by four medications/mode of administration: buprenorphine; oral naltrexone; long-acting, injectable naltrexone; and methadone. The NDC pharmacy codes used to identify the FDA-approved medications for OUD are listed in the attached value sets.

Type Score

#3589 Prescription or Administration of Pharmacotherapy to Treat Opioid Use Disorder (OUD)

Rate/proportion better quality = higher score

#3175 Continuity of Pharmacotherapy for Opioid Use Disorder

Rate/proportion better quality = higher score

#3400 Use of Pharmacotherapy for Opioid Use Disorder (OUD)

Rate/proportion better quality = higher score

Algorithm

#3589 Prescription or Administration of Pharmacotherapy to Treat Opioid Use Disorder (OUD)

Identify denominator

Identify Medicaid beneficiaries age 18 through 64 years with at least one encounter with a provider with an OUD diagnosis on the claim (primary or other secondary) during the measurement year. Must be continuously enrolled for at least 30 days after the attributable encounter . Age is calculated as of December 31st of the measurement year.

Step 1. Identify the attribution date, the first encounter between a member and a provider. The attribution date is as follows.

a. Outpatient Encounter Attribution Date: Attribution date is the date of the encounter with an outpatient provider that includes an OUD diagnosis (primary or secondary).
b. Inpatient/Residential Encounter Attribution Date. Attribution date is the discharge date from an inpatient/residential provider that includes an OUD diagnosis (any position).

Note: a member can be attributed to more than one provider at different times during the measurement period. However, if members have multiple attribution dates with a single provider, only the first is included in the denominator.

Step 2. Exclude a member from the denominator for a provider organization if the attribution date is after December 1 to allow for 30 days of time after the encounter.

Step 3. Only include members with continuous enrollment over the relevant 30 day time period.

Step 4. Exclude providers if their total number of attributable members is < 10.

Step 5. Count the number of patients in the denominator with a qualifying_medication_event_date (Appendix B) <= 30 days of the attribution_date (attribution_date <= qualifying_medication_event_date <= attribution_date + 30 days)

Step 6. Report measure metrics at the NPI level separately for individual clinicians and hospitals/agencies/facilities. 146353

#3175 Continuity of Pharmacotherapy for Opioid Use Disorder

The measure score is calculated for rolling two-year periods.

DENOMINATOR: Individuals of at least 18 years of age who had a diagnosis of OUD and at least one claim for an OUD medication

CREATE DENOMINATOR:

1. For each two-year period, identify individuals who are at least 18 years of age for the duration of the first year during which they appear in the period.
2. Of individuals identified in Step 1, keep those who had at least one encounter with any diagnosis (primary or secondary) of OUD in an outpatient setting, acute inpatient setting, or emergency department setting at any time during the two-year measurement period. The OUD diagnosis codes with descriptions are contained in the sheets called “ICD-9 Diagnosis Codes” and “ICD-10 Diagnosis Codes” in the Excel file called “NQF 3175 OUD Code Lists”, which is attached to this form under Item S.2b.
3. Of individuals identified in Step 2, keep those who have at least one claim with a National Drug Code (NDC) for any of the following oral OUD medications during the two-year period with a date at least 180 days before the end of the final calendar year of the measurement period:

- Buprenorphine
- Naltrexone (oral)
- Buprenorphine and Naloxone

Or a HCPCS code for any of the following OUD medications:

- Buprenorphine or Buprenorphine/naloxone, oral
- Buprenorphine (extended release injectable or implant)
- Methadone administration
- Naltrexone (extended-release injectable)

Claims for oral medications with negative, missing, or zero days’ supply were not included. The NDCs for the oral medications and the HCPCS codes for the injectable and office- or treatment center-dispensed medications are contained in the sheets called “NDCs” and “HCPCS Codes”, respectively, in the Excel file called “NQF 3175 OUD Code Lists,” which is attached to this form under Item S.2b.

4. Of individuals identified in Step 3, keep individuals who were continuously enrolled in a commercial health plan captured by our data for at least 6 months after the month with the first

OUD medication claim in the measurement period, with no gap in enrollment. Individuals who are not enrolled for 6 months, including those who die during the period, are not eligible and are not included in the analysis. This is the denominator.

NUMERATOR: Individuals in the denominator who have at least 180 days of continuous pharmacotherapy with a medication prescribed for OUD without a gap of more than seven days

CREATE NUMERATOR:

For the individuals in the denominator, identify those who have at least 180 days of continuous pharmacotherapy with an OUD medication without a gap of more than seven days using the following method:

1. Determine the number of days for the PDC denominator. The start date is the service date (fill date) of the first prescription or injection/dispensing claim for an OUD medication in the two-year measurement period. The end date is defined as the earliest of:

- The date on which the individual exhausts their days' supply, including any pre-existing surplus, following their final claim (assuming daily use).
- The individual's death date.
- December 31st of the second year in the two-year period.

2. For each individual: Count the days during the observation period for which the individual was covered by at least one OUD medication based on the prescription drug or injection/dispensing claim service dates and days' supply.

   2a. Sort OUD medication claims by individual's ID and service date. Scan the claims in order, calculating a rolling surplus which accumulates any remaining days' supply from other prior or same-day fills.

   2b. Naltrexone and buprenorphine injections contribute 30 days' supply and a buprenorphine implant 180 days unless another claim is found sooner, in which case the injection or implant covers only the days up to the next claim.

   2c. Methadone and buprenorphine/naloxone supply is determined by the start and end dates on the outpatient claims with the codes for in-office/treatment center dispensation of methadone (H0020) and buprenorphine/naloxone (J0571-J0575).

   2d. Claims for injections/implants and for licensed treatment center-dispensed methadone and office-dispensed buprenorphine/naloxone are not added to the surplus supply and only one such claim per day is counted.

   2e. For claims with a days' supply that extends beyond the end of the measurement period, count only the days for which the drug was available to the individual during the measurement period.

3. Determine treatment gaps as periods, in which the individual has exhausted his/her available supply, defined as the days' supply from the most recent previous fill/dispensing and any pre-existing surplus available before that fill/dispensing.

4. Of the individuals in Step 2, count the number of individuals who have a period of 180 days or greater from the start date of the first claim for OUD medication to the end date of the last claim for OUD medication within the two-year period and who do not have a gap of more than seven days without OUD medication available. This is the numerator.

   CALCULATE MEASURE SCORE:

1. Calculate the measure score by dividing the numerator by the denominator.

2. Calculate the measure score for each state. The state code on the claim record is used to identify individuals in each state. The measure score is then reported for each state that has at least 20 individuals in the denominator.
3. Calculate the measure score for each health plan. Health plan membership is approximated based on a combination of two variables found on the claim record, industry type and Metropolitan Statistical Area (MSA). A health plan identifier is assigned based on each unique combination of industry and MSA. The health plan identifier is used to group individuals into health plans. The measure score is then reported for each health plan that has at least 20 individuals in the denominator.
4. Calculate the measure score for each clinician and clinician-group/practice level. Attribute individuals to clinicians and clinician-groups/practices based on the plurality of treatment days covered. Clinicians are identified based on their National Provider Identifier and clinician-groups/practices based on their Tax Identification Number. The measure score is reported for clinicians and clinician-group/practices with at least 25 denominator-eligible patients attributed to them. Details of the attribution method and its empirical justification are described in the attached Attribution Analysis document 123001| 148777| 141015| 150289

#3400 Use of Pharmacotherapy for Opioid Use Disorder (OUD)

Step 1: Identify the Eligible Population (Denominator)

- Eligible population:

— Identify Medicaid beneficiaries ages 18–64, enrolled for a full 12 months of the measurement year, and had at least one encounter with a diagnosis of opioid abuse, dependence, or remission (primary or other) at any time during the measurement year. ICD-10 codes for OUD are provided in NQF 3400 —worksheet tab 1 of the attached value sets.

Step 2: Identify the Numerator

- Step 2A: Overall: Identify the numerator as beneficiaries with evidence of at least one prescription filled, or were administered or dispensed an FDA-approved medication for OUD during the measurement year through use of pharmacy claims (relevant NDC code) or through relevant HCPCS coding of medical service (see NQF 3400—worksheet tab 2 of attached value sets).

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

  A list of value sets for the measure is attached in the Excel workbook. NDC codes are listed in NQF 3400—worksheet tab 2. NDC codes are subject to frequent changes so measure users should update these codes.
- Step 2B: Identify beneficiaries with evidence of at least one prescription for buprenorphine at any point during the measurement year (see NQF 3400—worksheet tab 2 of attached value sets).
- Step 2C: Identify beneficiaries with evidence of at least one prescription for oral naltrexone at any point during the measurement year (see NQF 3400—worksheet tab 2 of attached value sets).
- Step 2D: Identify beneficiaries with evidence of at least one prescription for long-acting, injectable naltrexone at any point during the measurement year (see NQF 3400worksheet tab 2 of attached value sets).
- Step 2E: Identify beneficiaries with evidence of at least one dose of methadone at any point during the measurement year (see NQF 3400—worksheet tab 2 of attached value sets).

  Note: Pharmacotherapy for opioid abuse, dependence, or remission (prescriptions, procedures, and dispensing) might occur in several files. Similarly, a diagnosis of opioid abuse, dependence, or

remission might occur in several files. For example, one claims file may contain injectables while another claims file may contain oral medications. Consequently, pharmacotherapy and opioid abuse, dependence, or remission variables are created separately in each source and then merged by beneficiary ID.

Step 3: Calculate the Rates

- Step 3A. Calculate the overall rate by dividing the number of beneficiaries with evidence of at least one prescription (Step 2) by the number of beneficiaries with at least one encounter associated with a diagnosis of opioid abuse, dependence, or remission (Step 1).

Then, calculate rates separately for each of the four medications:

- Step 3B: Calculate the buprenorphine prescription rate by dividing the number of beneficiaries with evidence of at least one prescription for buprenorphine during the measurement year (Step 2B) by the number of beneficiaries with at least one encounter associated with a diagnosis of opioid abuse, dependence, or remission (Step 1).
- Step 3C: Calculate the oral naltrexone prescription rate by dividing the number of beneficiaries with evidence of at least one prescription for oral naltrexone during the measurement year (Step 2C) by the number of beneficiaries with at least one encounter associated with a diagnosis of opioid abuse, dependence, or remission (Step 1).
- Step 3D: Calculate the long-acting, injectable naltrexone prescription rate by dividing the number of beneficiaries with evidence of at least one claim for administration of injectable naltrexone during the measurement year (Step 2D) by the number of beneficiaries with at least one encounter associated with a diagnosis of opioid abuse, dependence, or remission (Step 1).
- Step 3E: Calculate the methadone dispensing rate by dividing the number of beneficiaries with evidence of at least one dose of methadone during the measurement year (Step 2E) by the number of beneficiaries with at least one encounter associated with a diagnosis of opioid abuse, dependence, or remission (Step 1). 120752| 141015| 113612

Submission Items

#3589 Prescription or Administration of Pharmacotherapy to Treat Opioid Use Disorder (OUD)

5.1 Identified measures: 3175 : Continuity of Pharmacotherapy for Opioid Use Disorder

3400 : Use of Pharmacotherapy for Opioid Use Disorder (OUD)

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact: The measure is harmonized with NQF#3400 Use of Pharmacotherapy for Opioid Use Disorder (OUD). The same OUD code and pharmacotherapy codes are included in both. The differences between NQF 3400 and this measure (Prescription or administration of pharmacotherapy to treat OUD), is that this measure is meant to be used at the provider level. Therefore, this measure has processes to identify providers and attribute patients with OUD to them.

5b.1 If competing, why superior or rationale for additive value: Not applicable.

#3175 Continuity of Pharmacotherapy for Opioid Use Disorder

5.1 Identified measures: 0004 : Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

1664 : SUB-3 Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol & Other Drug Use Disorder Treatment at Discharge

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: The target population of the proposed measure is related to the two measures listed above (NQF 0004 and NQF 1664). Differences among the three measures, along with the rationale and impact, are discussed below in the text box for Item 5b.1. The text box for this item (5a.2) would not accommodate the length of our response.

5b.1 If competing, why superior or rationale for additive value: There are no competing measures that address both the same measure focus and the same target population as the proposed measure.

RESPONSE TO ITEM 5A.2

The information below is the response to Item 5a.2, describing the differences, rationale, and impact on interpretability and data collection burden for the two NQF-endorsed RELATED measures which were identified. (We have inserted it here because the text box under Item 5a.2 would not accept this volume of formatted text.)

The target population of the proposed measure is related to the two NQF-endorsed measures listed above (NQF 0004 and NQF 1664). The proposed measure focuses on continuity of pharmacotherapy for patients with OUD. NQF 0004 focuses on treatment initiation and engagement of patients with a new episode of OUD or other substance use disorders, including alcohol use disorder (AUD). NQF 1664 focuses on 0UD and other drug use disorders among hospital discharges. Differences among the three measures, along with the rationale and impact are discussed below.

Diagnoses Included in Denominator Definition

- Proposed measure: Diagnosis of OUD
- NQF #0004 Diagnosis of alcohol or other drug dependence
- NQF #1664: Diagnosis of AUD or another substance use disorder
- Rationale and impact of focusing on only OUD: There are different medications for treatment of OUD and AUD, and there are no FDA-approved medications for treatment of other substance use disorders. In addition, the conceptual issues related to continuity of pharmacotherapy differ between OUD and AUD, so developing separate measures for the two disorders is required. The impact of this is a more narrowly focused measure that provides information specific to individuals with OUD.

Age Range

- Proposed measure: Patients at least 18 years of age
- NQF #0004 Patients aged 13 years of age and older
- NQF #1664: Patients 18 years of age and older
- Rationale and impact of limiting to individuals 18 years of age and older: Medications for treatment of OUD have not been approved by the FDA for adolescent patients 13-17 years of age; therefore, the proposed measure is restricted to adults of at least 18 years of age.

Data Source

- Proposed measure: Electronic claims data
- NQF #0004 Administrative claims, electronic clinical data
- NQF #1664: Electronic clinical data, paper medical records
- Rationale and impact of using electronic claims data: Electronic claims data are timely, accessible, and relatively inexpensive to use for analyses of a large number of patients. Using a single source of data expedites the calculation of the measure, and will provide feedback to providers sooner.

Inpatient vs. Outpatient

- Proposed measure: Inpatient and outpatient
- NQF #0004 Inpatient and outpatient
- NQF #1664: Inpatient discharges
- Rationale and impact of using inpatient and outpatient records to identify patients: A large majority of patients with OUD are not admitted to a hospital, so using inpatient and outpatient data leads to more complete identification of the population eligible for treatment.

Process of Care Included in Numerator Definition

- Proposed measure: Continuity of pharmacotherapy for OUD
- NQF #0004 Inpatient admission, outpatient visit, intensive outpatient encounter, or partial hospitalization for adults with a new episode of AUD, OUD, or other substance use disorders
- NQF #1664: Medication for treatment of alcohol or drug use disorder OR a referral for addictions treatment
- Rationale and impact of the process of care included in the numerator definition: Successful pharmacotherapy of OUD requires continuity over at least a 180-day period. Therefore, providing feedback to providers about continuity of OUD pharmacotherapy has the potential to improve continuity rates by increasing provider awareness, and motivating health plans and insurers to develop educational material and programs about pharmacotherapy for OUD for both providers and patients.

#3400 Use of Pharmacotherapy for Opioid Use Disorder (OUD)

5.1 Identified measures: 3175 : Continuity of Pharmacotherapy for Opioid Use Disorder

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact: Not Applicable.

5b.1 If competing, why superior or rationale for additive value: Not Applicable.

Comparison of NQF #3590 with NQF #0004, NQF #0576, NQF #2605, NQF #3312, and NQF #3453

#3590 Continuity of Care After Receiving Hospital or Residential Substance Use Disorder (SUD) Treatment
#0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment
#0576 Follow-Up After Hospitalization for Mental Illness
#2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence
#3312 Continuity of Care After Medically Managed Withdrawal From Alcohol and/or Drugs
#3453 Continuity of Care After Inpatient or Residential Treatment for Substance Use Disorder (SUD)

Steward

#3590 Continuity of Care After Receiving Hospital or Residential Substance Use Disorder (SUD) Treatment

RTI International

#0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

National Committee for Quality Assurance

#0576 Follow-Up After Hospitalization for Mental Illness

National Committee for Quality Assurance

#2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence

National Committee for Quality Assurance

#3312 Continuity of Care After Medically Managed Withdrawal From Alcohol and/or Drugs

Centers for Medicare & Medicaid Services

#3453 Continuity of Care After Inpatient or Residential Treatment for Substance Use Disorder (SUD)

Centers for Medicare & Medicaid Services

Description

#3590 Continuity of Care After Receiving Hospital or Residential Substance Use Disorder (SUD) Treatment

Percentage of Medicaid discharges, ages 18 to 64, being treated for a substance use disorder (SUD) from an inpatient or residential provider that received SUD follow-up treatment within 7 or 30 days after discharge. SUD follow-up treatment includes outpatient, intensive outpatient, or partial hospitalization visits; telehealth encounters; SUD medication fills or administrations; or residential treatment (after an inpatient discharge). Two rates are reported: continuity within 7 and 30 days after discharge.

#0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

This measure assesses the degree to which the organization initiates and engages members identified with a need for alcohol and other drug (AOD) abuse and dependence services and the degree to which members initiate and continue treatment once the need has been identified. Two rates are reported:

- Initiation of AOD Treatment. The percentage of adolescent and adult members with a new episode of AOD abuse or dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth or medication assisted treatment (MAT) within 14 days of the diagnosis.
- Engagement of AOD Treatment. The percentage of adolescent and adult members with a new episode of AOD abuse or dependence who initiated treatment and who had two or more additional AOD services or MAT within 34 days of the initiation visit.

#0576 Follow-Up After Hospitalization for Mental Illness

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

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

#2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence

The percentage of discharges for patients 18 years of age and older who had a visit to the emergency department with a primary diagnosis of mental health or alcohol or other drug dependence during the measurement year AND who had a follow-up visit with any provider with a corresponding primary diagnosis of mental health or alcohol or other drug dependence within 7- and 30-days of discharge.

Four rates are reported:

- The percentage of emergency department visits for mental health for which the patient received follow-up within 7 days of discharge.
- The percentage of emergency department visits for mental health for which the patient received follow-up within 30 days of discharge.
- The percentage of emergency department visits for alcohol or other drug dependence for which the patient received follow-up within 7 days of discharge.
- The percentage of emergency department visits for alcohol or other drug dependence for which the patient received follow-up within 30 days of discharge.

#3312 Continuity of Care After Medically Managed Withdrawal From Alcohol and/or Drugs

Percentage of discharges from a medically managed withdrawal episode for adult Medicaid beneficiaries, ages 18–64, that were followed by a treatment service for substance use disorder (including the prescription or receipt of a medication to treat a substance use disorder [pharmacotherapy]) within 7 or 14 days after discharge.

#3453 Continuity of Care After Inpatient or Residential Treatment for Substance Use Disorder (SUD)

Percentage of discharges from inpatient or residential treatment for substance use disorder (SUD) for Medicaid beneficiaries, ages 18–64, which were followed by a treatment service for SUD. SUD treatment services include having an outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth encounter, or filling a prescription or being administered or dispensed a medication for SUD. (After an inpatient discharge only, residential treatment also counts as continuity of care.) Two rates are reported, continuity within 7 and 14 days after discharge.

Type

#3590 Continuity of Care After Receiving Hospital or Residential Substance Use Disorder (SUD) Treatment

Process

#0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

Process

#0576 Follow-Up After Hospitalization for Mental Illness

Process

#2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence

Process

#3312 Continuity of Care After Medically Managed Withdrawal From Alcohol and/or Drugs

Process

#3453 Continuity of Care After Inpatient or Residential Treatment for Substance Use Disorder (SUD)

Process

Data Source

#3590 Continuity of Care After Receiving Hospital or Residential Substance Use Disorder (SUD) Treatment

Claims, Enrollment Data The Medicaid Analytic Extract (MAX) files were used to identify discharges from inpatient substance use disorder (SUD) or residential specialty SUD treatment programs with a principal/primary SUD diagnosis on the discharge record (denominator) and the receipt of SUD outpatient or prescription medication treatment within 7 and/or 30 days after discharge (numerator). The Medicaid MAX files used include the following types of files: personal summary (PS), inpatient (IP), other services (OT), long-term care (LT) and drug (RX) files. Data from the PS IP, LT and OT files were used to construct the measure denominator. We used the PS file to limit the analytic sample based on age and enrollment criteria, and then we used the IP, LT, and OT files to determine whether those beneficiaries met the criteria for the measure denominator. The OT and Rx files enabled us to identify the numerator events (e.g., receipt of SUD outpatient treatment within 7 and/or 30 days after discharge). The PS file contained additional demographic and enrollment information, such as beneficiaries' state, age, sex, and race or ethnicity.

No data collection instrument provided Attachment Data_Dictionary_for_SUD_Follow_up_Measure.xlsx

#0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

Claims NCQA collects HEDIS data directly from Health Management Organizations and Preferred Provider Organizations via a data submission portal - the Interactive Data Submission System (IDSS).

No data collection instrument provided Attachment 0004_IET_Value_Sets.xlsx

#0576 Follow-Up After Hospitalization for Mental Illness

Claims This measure is based on administrative claims collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from Health Management Organizations and Preferred Provider Organizations via NCQA's online data submission system.

No data collection instrument provided Attachment 0576_FUH_Fall_2020_Value_Sets.xlsx

#2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence

Claims Both the numerator and the denominator for this measure are based on administrative claims data.

No data collection instrument provided Attachment 2605_Follow_Up_After_ED_Discharge_for_Mental_Health_Conditions_Value_Sets-636220757625866651.xlsx

#3312 Continuity of Care After Medically Managed Withdrawal From Alcohol and/or Drugs

Claims Medicaid Analytic eXtract (MAX) 2013 and 2014 eligible (EL), inpatient (IP), other services (OT), long-term care (LT) and drug (RX) files. The other services file contains facility and individual provider services data. Most notably, it may contain both residential and other stayover service claims data as claims are assigned to MAX claims file types based upon the category of service

provided. The inpatient file only contains inpatient hospital, sterilization, abortion and religious non-medical health care institution claims.

No data collection instrument provided Attachment NQF3312_ValueSets_2020Update.xlsx

#3453 Continuity of Care After Inpatient or Residential Treatment for Substance Use Disorder (SUD)

Claims Medicaid Alpha-MAX 2014 data: eligible (EL), inpatient (IP), other services (OT), long-term care (LT) and drug (RX) files. The other services (OT) file contains facility and individual provider services data. Most notably, it may contain both residential and other stayover service claims data as claims are assigned to MAX claims file types based upon the category of service provided.

No data collection instrument provided Attachment NQF3453_ValueSets_2020Update.xlsx

Level

#3590 Continuity of Care After Receiving Hospital or Residential Substance Use Disorder (SUD) Treatment

Facility

#0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

Health Plan

#0576 Follow-Up After Hospitalization for Mental Illness

Health Plan

#2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence

Health Plan, Population : Regional and State

#3312 Continuity of Care After Medically Managed Withdrawal From Alcohol and/or Drugs

Population : Regional and State

#3453 Continuity of Care After Inpatient or Residential Treatment for Substance Use Disorder (SUD)

Population : Regional and State

Setting

#3590 Continuity of Care After Receiving Hospital or Residential Substance Use Disorder (SUD) Treatment

Inpatient/Hospital

#0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

Emergency Department and Services, Inpatient/Hospital, Outpatient Services

#0576 Follow-Up After Hospitalization for Mental Illness

Inpatient/Hospital, Outpatient Services

#2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence

Inpatient/Hospital, Outpatient Services

#3312 Continuity of Care After Medically Managed Withdrawal From Alcohol and/or Drugs

Inpatient/Hospital, Outpatient Services

#3453 Continuity of Care After Inpatient or Residential Treatment for Substance Use Disorder (SUD)

Emergency Department and Services, Home Care, Inpatient/Hospital, Outpatient Services

Numerator Statement

#3590 Continuity of Care After Receiving Hospital or Residential Substance Use Disorder (SUD) Treatment

Medicaid discharges, ages 18 to 64, with a principal/primary substance (SUD) diagnosis treated at an inpatient or residential provider that received SUD follow-up treatment within 7 or 30 days after discharge. SUD treatment includes outpatient, intensive outpatient, or partial hospitalization visits; telehealth encounters; or SUD medication fills or administrations; or residential treatment (after an inpatient discharge. Two rates are reported: continuity within 7 and 30 days after discharge.

#0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

Initiation of AOD Treatment:

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

Engagement of AOD Treatment:

Initiation of AOD treatment and two or more additional AOD services or medication treatment within 34 days of the initiation visit.

#0576 Follow-Up After Hospitalization for Mental Illness

30-Day Follow-Up: A follow-up visit with a mental health provider within 30 days after discharge.

7-Day Follow-Up: A follow-up visit with a mental health provider within 7 days after discharge.

#2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence

The numerator for each denominator population consists of two rates:

Mental Health

- Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of mental health within 7 days after emergency department discharge
- Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of mental health within 30 days after emergency department discharge

Alcohol or Other Drug Dependence

- Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of alcohol or other drug dependence within 7 days after emergency department discharge
- Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of alcohol or other drug dependence within 30 days after emergency department discharge

#3312 Continuity of Care After Medically Managed Withdrawal From Alcohol and/or Drugs

Discharges in the denominator who have an inpatient, intensive outpatient, partial hospitalization, outpatient visit, residential, or drug prescription or procedure within 7 or 14 days after discharge from an inpatient hospital, residential addiction program, or ambulatory medically managed withdrawal.

#3453 Continuity of Care After Inpatient or Residential Treatment for Substance Use Disorder (SUD)

Discharges in the denominator with an outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or filled a prescription for or were administered or ordered a medication for SUD. (After an inpatient discharge only, residential treatment also counts as continuity of care.) Two rates are reported, continuity within 7 and 14 days after discharge.

Numerator Details

#3590 Continuity of Care After Receiving Hospital or Residential Substance Use Disorder (SUD) Treatment

For this measure two numerators are calculated (follow-up within 7 days of discharge and follow-up within 30 days of discharge). For the 7-day follow up calculation, the numerator is the total discharges with an outpatient visit, intensive outpatient encounter or partial hospitalization OR telehealth visit with SUD diagnosis in principal position, or filled a prescription for or were administered a medication for SUD within 7 days after discharge. Set this variable equal to 1 if either of the following occur: (a) Follow-up visit or telehealth encounter after index discharge date and on or before index discharge date + 7. SUD diagnosis codes must be in principal position for the follow-up encounter. (b) SUD-related medication fill (see attached Appendix D) on or after index discharge date and on or before index discharge date + 7.

The same process above applies for the 30-day follow-up calculation, but within 30 days after discharge. Set the variable equal to 1 if either of the following occur: (a) Follow-up visit or telehealth encounter after index discharge date and on or before index discharge date + 30. SUD diagnosis codes must be in principal position for the follow-up encounter. (b) SUD-related medication fill (see attached Appendix D) on or after index discharge date and on or before index discharge date + 30.

The measure time period is a calendar year.

#0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

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

- For an outpatient, intensive outpatient, partial hospitalization, observation, telehealth, detoxification or ED visit (not resulting in an inpatient stay), the IESD is the date of service.
- For an inpatient stay, the IESD is the date of discharge.
- For an ED and observation visits that results in an inpatient stay, the IESD is the date of the inpatient discharge (an AOD diagnosis is not required for the inpatient stay; use the diagnosis from the ED or observation visit to determine the diagnosis cohort).
- For direct transfers, the IESD is the discharge date from the last admission (an AOD diagnosis is not required for the transfer; use the diagnosis from the initial admission to determine the diagnosis cohort).

INITIATION OF AOD TREATMENT

Initiation of AOD treatment within 14 days of the IESD.

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

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

- An acute or nonacute inpatient admission with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute and nonacute inpatient admissions:
- Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
- Identify the admission date for the stay.
- IET Stand Alone Visits Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set).
- Observation Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- IET Visits Group 1 Value Set with IET POS Group 1 Value Set and a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set with or without a telehealth modifier (Telehealth Modifier Value Set).
- IET Visits Group 2 Value Set with IET POS Group 2 Value Set and a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set with or without a telehealth modifier (Telehealth Modifier Value Set).
- A telephone visit (Telephone Visit Value Set) with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An online assessment (Online Assessment Value) set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- If the Index Episode was for a diagnosis of alcohol abuse or dependence (Alcohol Abuse and Dependence Value Set) a medication treatment dispensing event (Medication Treatment for Alcohol Abuse or Dependence Medications List) or medication treatment during a visit (AOD Medication Treatment Value Set).
- If the Index Episode was for a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set) a medication treatment dispensing event (Medication Treatment for Opioid Abuse or Dependence Medications List) or medication treatment during a visit (AOD Medication Treatment Value Set).

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

- If a member is compliant for the Initiation numerator for any diagnosis cohort (i.e., alcohol, opioid, other drug) or for multiple cohorts, count the member only once in the Total Initiation numerator. The "Total" column is not the sum of the diagnosis columns.
- Exclude the member from the denominator for both indicators (Initiation of AOD Treatment and Engagement of AOD Treatment) if the initiation of treatment event is an inpatient stay with a discharge date after November 27 of the measurement year.

ENGAGEMENT OF AOD TREATMENT

1) Numerator compliant for the Initiation of AOD Treatment numerator and
2) Members whose initiation of AOD treatment was a medication treatment event (Medication Treatment for Alcohol Abuse or Dependence Medications List; Medication Treatment for Opioid Abuse or Dependence Medications List; AOD Medication Treatment Value Set).

   These members are numerator compliant if they have two or more engagement events where only one can be an engagement medication treatment event.
3) Remaining members whose initiation of AOD treatment was not a medication treatment event (members not identified in step 2).

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

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

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

  Engagement visits:

  Any of the following meet criteria for an engagement visit:

- An acute or nonacute inpatient admission with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute or nonacute inpatient admissions:

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

- IET Stand Alone Visits Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set).
- Observation Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- IET Visits Group 1 Value Set with IET POS Group 1 Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set).

- IET Visits Group 2 Value Set with IET POS Group 2 Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set).
- A telephone visit (Telephone Visits Value Set) with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An online assessment (Online Assessments Value Set) with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.

Engagement Medication Treatment Events:

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

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

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

#0576 Follow-Up After Hospitalization for Mental Illness

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

- An outpatient visit (Visit Setting Unspecified Value Set) with (Outpatient POS Value Set) with a mental health provider.
- An outpatient visit (BH Outpatient Value Set) with a mental health provider.
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) with (Partial Hospitalization POS Value Set).
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set).
- A community mental health center visit (Visit Setting Unspecified Value Set; BH Outpatient Value Set; Observation Value Set; Transitional Care Management Services Value Set) with (Community Mental Health Center POS Value Set).
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) with (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set).
- A telehealth visit: (Visit Setting Unspecified Value Set) with (Telehealth POS Value Set) with a mental health provider.
- An observation visit (Observation Value Set) with a mental health provider.

- Transitional care management services (Transitional Care Management Services Value Set), with a mental health provider.
- A visit in a behavioral healthcare setting (Behavioral Healthcare Setting Value Set).
- A telephone visit (Telephone Visits Value Set) with a mental health provider.

(See corresponding Excel document for the value sets referenced above).

Mental Health Provider Definition:

A provider who delivers 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).
- A physician assistant who is certified by the National Commission on Certification of Physician Assistants to practice psychiatry.
- A certified Community Mental Health Center (CMHC), or the comparable term (e.g. behavioral health organization, mental health agency, behavioral health agency) used within the state in which it is located, or a Certified Community Behavioral Health Clinic (CCBHC).
- Only authorized CMHCs are considered mental health providers. To be authorized as a CMHC, an entity must meet one of the following criteria:
- The entity has been certified by CMS to meet the conditions of participation (CoPs) that community mental health centers (CMHCs) must meet in order to participate in the Medicare program, as defined in the Code of Federal Regulations Title 42. CMS defines a CMHC as an entity that meets applicable licensing or certification requirements for CMHCs in the State in which it is

located and provides the set of services specified in section 1913(c)(1) of the Public Health Service Act (PHS Act).

- The entity has been licensed, operated, authorized, or otherwise recognized as a CMHC by a state or county in which it is located.
- Only authorized CCBHCs are considered mental health providers. To be authorized as a CCBHC, an entity must meet one of the following criteria:
  - Has been certified by a State Medicaid agency as meeting criteria established by the Secretary for participation in the Medicaid CCBHC demonstration program pursuant to Protecting Access to Medicare Act § 223(a) (42 U.S.C. § 1396a note); or as meeting criteria within the State's Medicaid Plan to be considered a CCBHC.
  - Has been recognized by the Substance Abuse and Mental Health Services Administration, through the award of grant funds or otherwise, as a CCBHC that meets the certification criteria of a CCBHC.

#2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence

Mental Health

Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of mental health within 7 days after emergency department discharge

- A visit (FUH Stand Alone Visits Value Set) with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).
- A visit (FUH Visits Group 1 Value Set and FUH POS Group 1 Value Set) with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).
- A visit (FUH Visits Group 2 Value Set and FUH POS Group 2 Value Set) with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).
- A visit to a behavioral healthcare facility (FUH RevCodes Group 1 Value Set).
- A visit to a non-behavioral healthcare facility (FUH RevCodes Group 2 Value Set) with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).
- A visit to a non-behavioral healthcare facility (FUH RevCodes Group 2 Value Set) with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).
- Transitional care management services (TCM 7 Day Value Set) where the date of service on the claim is 29 days after the date the patient was discharged from the emergency department with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).

Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of mental health within 30 days after emergency department discharge

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

- A visit to a non-behavioral healthcare facility (FUH RevCodes Group 2 Value Set) with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).
- A visit to a non-behavioral healthcare facility (FUH RevCodes Group 2 Value Set) with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).
- Transitional care management services (TCM 7 Day Value Set) where the date of service on the claim is 29 days after the date the patient was discharged from the emergency department with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).
- Transitional care management services (TCM 14 Day Value Set) where the date of service on the claim is 29 days after the date the patient was discharged from the emergency department with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).
- Note: Transitional care management is a 30-day period that begins on the date of discharge and continues for the next 29 days. The date of service on the claim is 29 days after discharge and not the date of the face-to-face visit.

Alcohol or Other Drug Dependence

Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of alcohol or other drug dependence within 7 days after emergency department discharge. Any of the following code combinations meet criteria:

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

Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis alcohol or other drug dependence within 30 days after emergency department discharge. Any of the following code combinations meet criteria:

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

#3312 Continuity of Care After Medically Managed Withdrawal From Alcohol and/or Drugs

The numerator includes individuals with any of the following within 14 days after discharge from medically managed withdrawal:

- Pharmacotherapy on day of discharge through day 7 or 14.
- Outpatient, intensive outpatient, partial hospitalization, or residential treatment procedure with a diagnosis of SUD on the day after discharge through day 7 or 14.
- Outpatient, intensive outpatient, partial hospitalization, or residential treatment with standalone SUD procedure on the day after discharge through day 7 or 14.
- Inpatient admission with an SUD diagnosis or procedure code on day after discharge through day 7 or 14.
- Long-term care institutional claims with an SUD diagnosis on day after discharge through day 7 or 14.

If an overdose diagnosis code appears on the same outpatient or inpatient claim that is being viewed as follow-up, that claim does not qualify as follow-up.

SUD diagnoses are used to identify procedures connected to SUD diagnoses. SUD diagnoses are identified through ICD-10 codes (see attached value set: NQF 3312—worksheet tab 3). Procedures are defined using a combination of Healthcare Common Procedure Coding System (HCPCS) codes, Uniform Billing (UB) Revenue Codes and ICD-10 procedure codes (see attached value sets: NQF 3312—worksheet tabs 4–8).

Pharmacotherapy includes naltrexone (short or long acting), acamprosate, or disulfiram for alcohol dependence treatment and buprenorphine for opioid dependence treatment, as well HCPCS codes to identify procedures related to injecting drugs (e.g., long-acting injectable naltrexone) (see attached value sets: NQF 3312—worksheet tabs 9–10).

Code lists for this measure are in the attached value sets. States may need to adapt the list of codes to include state-specific codes.

#3453 Continuity of Care After Inpatient or Residential Treatment for Substance Use Disorder (SUD)

The measure will report two rates, continuity of care within 7 days and within 14 days after discharge.

The numerator includes discharges with any of the following after inpatient or residential treatment:

- Outpatient visit, intensive outpatient encounter or partial hospitalization with a primary or secondary SUD diagnosis on the day after discharge through day 7 or 14.
- Telehealth encounter for SUD on the day after discharge through day 7 or 14
- Pharmacotherapy (filling a prescription or being administered or ordered a medication) on day of discharge through day 7 or 14
- For inpatient discharges only, residential admissions on day 3 through day 7 or day 14

If an overdose diagnosis code appears on the same outpatient or inpatient claim that is being viewed as follow up, that claim does not qualify as follow-up care.

Denominator Statement

#3590 Continuity of Care After Receiving Hospital or Residential Substance Use Disorder (SUD) Treatment

The denominator are Medicaid beneficiaries, ages 18-64, discharged from inpatient or residential provider with a principal diagnosis of SUD on the inpatient/residential treatment encounter claim.

#0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

Patients age 13 years of age and older as of December 31 of the measurement year who were diagnosed with a new episode of alcohol or other drug dependency (AOD) during the first 10 and ½ months of the measurement year (e.g., January 1-November 15).

#0576 Follow-Up After Hospitalization for Mental Illness

Discharges from an acute inpatient setting with a principal diagnosis of mental illness or intentional self-harm on the discharge claim during the first 11 months of the measurement year (i.e. January 1 to December 1) for members 6 years and older.

#2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence

Patients who were treated and discharged from an emergency department with a primary diagnosis of mental health or alcohol or other drug dependence on or between January 1 and December 1 of the measurement year.

#3312 Continuity of Care After Medically Managed Withdrawal From Alcohol and/or Drugs

Adult Medicaid beneficiary discharges from medically managed withdrawal from January 1 to December 15 of the measurement year.

#3453 Continuity of Care After Inpatient or Residential Treatment for Substance Use Disorder (SUD)

Adult Medicaid beneficiary discharges from inpatient or residential treatment for SUD with a principal diagnosis of SUD during from January 1 to December 15 of the measurement year.

Denominator Details

#3590 Continuity of Care After Receiving Hospital or Residential Substance Use Disorder (SUD) Treatment

The target population for the denominator includes all Medicaid beneficiaries (non-dual eligible) age 18 through 64 years and who had a discharge from SUD inpatient or residential treatment provider with a principal/primary SUD diagnosis during the measurement year which is defined as a calendar year. Eligible discharges are identified based on discharge date.

#0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

Identify the Index Episode. Identify all members 13 years and older as of December 31 of the measurement year who during the Intake Period had one of the following:

- An outpatient visit, telehealth, intensive outpatient visit or partial hospitalization with a diagnosis of AOD abuse or dependence. Any of the following code combinations meet criteria:
  - IET Stand Alone Visits Value Set with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set).
  - IET Visits Group 1 Value Set with IET POS Group 1 Value Set and with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set).
  - IET Visits Group 2 Value Set with IET POS Group 2 Value Set and with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set).
- A detoxification visit (Detoxification Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An ED visit (ED Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An observation visit (Observation Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.

- An acute or nonacute inpatient discharge with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute and nonacute inpatient discharges:

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

– Identify the discharge date for the stay.

- A telephone visit (Telephone Visits Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An online assessment (Online Assessments Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.

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

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

Select the Index Episode Start Date.

#0576 Follow-Up After Hospitalization for Mental Illness

An acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm (Mental Illness Value Set; Intentional Self-Harm Value Set) on the discharge claim on or between January 1 and December 1 of the measurement year. To identify acute inpatient discharges:

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

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

Acute readmission or direct transfer

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

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

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

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

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

See corresponding Excel document for the Value Sets referenced above in S.2b.

#2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence

Age: 18 years and older as of the date of discharge

Benefit: Medical and Behavioral Health

Continuous Enrollment: Date of emergency department visit through 30 days after discharge

Diagnosis criteria: Patients who were treated and discharged from an emergency department with a primary diagnosis of mental health (see Mental Health Diagnosis Value Set) or alcohol or other drug dependence (see AOD Dependence Value Set) on or between January 1 and December 1 of the measurement year. The denominator for this measure is based on discharges, not individuals. If a person has more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year. Use only facility claims to identify denominator events (including admissions or direct transfers). Do not use professional claims.

#3312 Continuity of Care After Medically Managed Withdrawal From Alcohol and/or Drugs

Measure data is reported annually (12 months). To account for the 14-day time period after discharge from medically managed withdrawal, the denominator period starts January 1 and ends December 15 of the measurement year.

Eligible population meets the following conditions:

- Medicaid beneficiaries aged 18-64 with at least one discharge from medically managed withdrawal during the year January 1 to December 15.
- Enrolled in Medicaid during the month of discharge medically managed withdrawal and the following month.
- The denominator is based on discharges, not individuals. A beneficiary may have more than one qualifying medically managed withdrawal episode.
- Medically managed withdrawal is identified using a combination of HCPCS codes, UB Revenue Codes, and ICD-10 procedure codes. A list of codes to identify medically managed withdrawal is posted in the value sets: Table NQF 3312—worksheet tabs 1–2. States will likely need to modify the specifications to include their state-specific codes.

#3453 Continuity of Care After Inpatient or Residential Treatment for Substance Use Disorder (SUD)

Eligible population meets the following conditions:

Population: Medicaid beneficiaries age 18 through 64 as of January 1 of the measurement year.

Benefit: Medical and Behavioral Health Services.

Continuous Enrollment: Date of the inpatient or residential SUD treatment discharge through end of the following month. The enrollment requirement is to ensure that beneficiaries are enrolled for sufficient time to allow for the continuity activities, particularly for a discharge that occurs near the end of a month.

Diagnosis Criteria: Discharges from inpatient or residential treatment with a primary diagnosis of SUD on any claim during the stay. Residential treatment is identified using the value sets in worksheet tabs 1–3 of the attached Excel file. SUD diagnoses are identified using the value sets in worksheet tabs 1 and 2.

The denominator is based on discharges, not individuals. If a beneficiary has more than one discharge, include all discharges on or between January 1 and December 15 of the measurement year.

Inpatient and residential treatment is identified using a combination of HCPCS codes, UB Revenue codes and ICD-10 procedure codes. A list of codes is in the value sets: SUD Residential Treatment value set—worksheet tab 3. States will likely need to modify the specifications to include their state-specific codes.

Exclusions

#3590 Continuity of Care After Receiving Hospital or Residential Substance Use Disorder (SUD) Treatment

Dual eligible Medicare/Medicaid beneficiaries are excluded. Rationale: Individuals who are covered under Medicare would receive coverage for follow-up treatment medications (e.g. opioid use disorder medications) under Medicare Part D and Medicare Part D claims are not captured in Medicaid claims databases. Therefore follow-up treatment would be missed.

#0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

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

Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.

#0576 Follow-Up After Hospitalization for Mental Illness

Exclude from the denominator for both rates, members who begin using hospice services anytime during the measurement year (Hospice Value Set)

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

Exclude discharges followed by readmission or direct transfer to a nonacute facility within the 30-day follow-up period regardless of principal diagnosis.

Exclude discharges followed by readmission or direct transfer to an acute facility within the 30-day follow-up period if the principal diagnosis was not for mental health or intentional self harm.

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

#2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence

The following are exclusions from the denominator:

- If the discharge is followed by readmission or direct transfer to an emergency department for a principal diagnosis of mental health or alchohol or other drug dependence within the 30-day follow-up period, count only the readmission discharge or the discharge from the emegenecy department to which the patient was transferred.
- Exclude discharges followed by admission or direct transfer to an acute or nonacute facility within the 30-day follow-up period, regardless of primary diagnosis for the admission.

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

#3312 Continuity of Care After Medically Managed Withdrawal From Alcohol and/or Drugs

Not applicable: the measure does not have denominator exclusions.

#3453 Continuity of Care After Inpatient or Residential Treatment for Substance Use Disorder (SUD)

Exclude from the denominator for both rates:

- Discharges with hospice services during the measurement year
- Both the initial discharge and the admission/direct transfer discharge if the admission/direct transfer discharge occurs after December 15 of the measurement year.
- Discharges followed by admission or direct transfer to inpatient or SUD residential treatment setting within 7- or 14-day continuity of care period. These discharges are excluded from the measure because transfer, hospitalization or admission to residential treatment within 7 or 14 days may prevent a continuity of care visit from taking place. An exception is admission to residential treatment following discharge from inpatient treatment; we do not exclude these admissions, because continuity into residential treatment after inpatient treatment is considered appropriate treatment.

Exclusion Details

#3590 Continuity of Care After Receiving Hospital or Residential Substance Use Disorder (SUD) Treatment

Dual eligible (Medicare/Medicaid) beneficiaries (as identified on Medicaid enrollment/beneficiary files)

#0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

Exclude patients who had a claim/encounter with a diagnosis of AOD during the 60 days (2 months) before the Index Episode Start Date. (See corresponding Excel document for the AOD Dependence Value Set)

- For an inpatient Index Episode Start Date, use the admission date to determine if the patient had a period of 60 days prior to the Index Episode Start Date with no claims with a diagnosis of AOD dependence.
- For an ED visit that results in an inpatient event, use the ED date of service to determine if the patient had a period of 60 days prior to the Index Episode Start Date with no claims with a diagnosis of AOD dependence.
- For direct transfers, use the first admission to determine if the patient had a period of 60 days prior to the Index Episode Start Date with no claims with a diagnosis of AOD dependence.

Exclude from the denominator for both indicators (Initiation of AOD Treatment and Engagement of AOD Treatment) patients whose initiation of treatment event is an inpatient stay with a discharge date after December 1 of the measurement year.

#0576 Follow-Up After Hospitalization for Mental Illness

Members in hospice are excluded from the eligible population.

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

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

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

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

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

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

See corresponding Excel document for the Value Sets referenced above in S.2b.

#2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence

See Section S.10 for exclusion details

#3312 Continuity of Care After Medically Managed Withdrawal From Alcohol and/or Drugs

Not applicable: the measure does not have denominator exclusions.

#3453 Continuity of Care After Inpatient or Residential Treatment for Substance Use Disorder (SUD)

Codes reflecting exclusions are included in the attached value sets. Residential treatment is identified using the value sets in worksheet tabs 1–3 of the attached Excel file. SUD diagnoses are identified using the value sets in worksheet tabs 1 and 2.

Risk Adjustment

#3590 Continuity of Care After Receiving Hospital or Residential Substance Use Disorder (SUD) Treatment

No risk adjustment or risk stratification

146353

146353

#0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

No risk adjustment or risk stratification

123834| 140881| 135810| 141015| 110874| 130488

123834| 140881| 135810| 141015| 110874| 130488

#0576 Follow-Up After Hospitalization for Mental Illness

No risk adjustment or risk stratification

123834| 140881

123834| 140881

#2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence

No risk adjustment or risk stratification

123834| 140881| 135810

123834| 140881| 135810

#3312 Continuity of Care After Medically Managed Withdrawal From Alcohol and/or Drugs

No risk adjustment or risk stratification

120752| 141015| 113612

120752| 141015| 113612

#3453 Continuity of Care After Inpatient or Residential Treatment for Substance Use Disorder (SUD)

No risk adjustment or risk stratification

120752| 141015| 110874| 113612

120752| 141015| 110874| 113612

Stratification

#3590 Continuity of Care After Receiving Hospital or Residential Substance Use Disorder (SUD) Treatment

Not applicable.

#0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

The total population is stratified by age: 13-17 and 18+ years of age.

- Report two age stratifications and a total rate.
- The total is the sum of the age stratifications.

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

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

#0576 Follow-Up After Hospitalization for Mental Illness

N/A

#2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence

Not applicable.

#3312 Continuity of Care After Medically Managed Withdrawal From Alcohol and/or Drugs

Some states may want to calculate continuity rates by medically managed withdrawal location. To identify medically managed withdrawal location, please refer to Step 1C in the measure calculation logic. Briefly, location of medically managed withdrawal can include hospital inpatient, inpatient residential addiction, other stayover treatment, and ambulatory medically managed withdrawal.

States may also be interested in calculating continuity rates when pharmacotherapy is the type of continuity received. To identify the extent to which continuity is established through pharmacotherapy, identify episodes that have a pharmacotherapy flag (Step 2A.2 in the measure calculation logic) only, but not a continuity service (Step 2A.1) within 7 or 14 days.

#3453 Continuity of Care After Inpatient or Residential Treatment for Substance Use Disorder (SUD)

States have the option to stratify by location of the inpatient or residential discharge. To do this stratification:

Calculate the inpatient continuity of care rate by dividing the number of discharges with evidence of a qualifying continuity of care visit or pharmacotherapy event (Step 2A) by the denominator (after exclusions) (Step 1D), only including discharges with a treatment location assigned as residential (Step 1C).

Calculate the inpatient continuity rates separately for 7 and 14 days after discharge.

Calculate the residential continuity of care rate by dividing the number of discharges with evidence of a qualifying continuity of care visit or pharmacotherapy event (Step 2A) by the denominator (after exclusions) (Step 1D), only including discharges with a treatment location assigned as residential (Step 1C).

Calculate the residential continuity rates separately for 7 and 14 days after discharge. For episodes assigned to a mix of both settings, for the purposes of stratification, assign the episode to one setting based on the last setting of the episode.

Type Score

#3590 Continuity of Care After Receiving Hospital or Residential Substance Use Disorder (SUD) Treatment

Rate/proportion better quality = lower score

#0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

Rate/proportion better quality = higher score

#0576 Follow-Up After Hospitalization for Mental Illness

Rate/proportion better quality = higher score

#2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence

Rate/proportion better quality = higher score

#3312 Continuity of Care After Medically Managed Withdrawal From Alcohol and/or Drugs

Rate/proportion better quality = higher score

#3453 Continuity of Care After Inpatient or Residential Treatment for Substance Use Disorder (SUD)

Rate/proportion better quality = higher score

Algorithm

#3590 Continuity of Care After Receiving Hospital or Residential Substance Use Disorder (SUD) Treatment

S.12. Type of score:

Rate/proportion

If other:

S.13. Interpretation of Score (Classifies interpretation of score according to whether higher quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)

Better quality = Higher score

S.14. Calculation Algorithm/Measure Logic (Diagram or describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases

meeting the target process, condition, event, or outcome; time period for data, aggregating data; risk adjustment; etc.)

Step 1: Identify denominator

Identify Medicaid- only beneficiaries age 18 through 64 years who had a discharge from SUD inpatient or residential treatment with a principal/primary SUD diagnosis during the measurement year. Age is calculated as of December 31st of the measurement year.

Step 1A. Exclude discharge if the date of discharge (for inpatient or residential levels of care) is after December 15 of the measurement year or if the date of discharge is missing.

Step 1B. Exclude discharge if the discharge date occurs on the same day as admission to another inpatient or residential facility. Consider this a transfer; the discharge date from the transfer facility would therefore define the index date.

Step 1C. Exclude any discharges that did not have continuous enrollment with both medical and pharmacy benefits on and within the 30 days of that index discharge date.

Step 2: Identify numerator

Step 2A. Use the Analytic Sample to Create the 7- and 30- day follow-up variables:

a. 7_day_follow-up: Identify discharges with an outpatient visit, intensive outpatient encounter or partial hospitalization OR telehealth visit with SUD diagnosis in principal position, or filled a prescription for or were administered medication for SUD within 7 days after discharge. Set this variable equal to 1 if either of the following occurs:

i. Follow-up visit or telehealth encounter (Appendix C) after index discharge date and on or before index discharge date + 7. SUD diagnosis codes must be in principal position for the follow-up encounter

ii. SUD-related medication fill (Appendix D) on or after index discharge date and on or before index discharge date + 7.

b. 30_day_follow-up: Identify discharges with an outpatient visit, intensive outpatient encounter, or partial hospitalization OR telehealth visit with SUD diagnosis in principal position or filled a prescription for or were administered medication for SUD within 30 days after discharge. Set this variable equal to 1 if either of the following occurs:

i. Follow-up visit or telehealth encounter (Appendix C) after index discharge date and on or before index discharge date + 30. SUD diagnosis codes must be in principal position for the follow-up encounter.

ii. SUD-related medication fill (Appendix D) on or after index discharge date and on or before index discharge date + 30. 146353

#0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

Step 1. Determine the eligible population. The eligible population is all patients who satisfy all specified denominator criteria (S7-S9).

Step 2. Search administrative systems to identify numerator events for all patients in the eligible population (S6).

Step 3. Calculate the rate of numerator events in the eligible population. 123834| 140881| 135810| 141015| 110874| 130488

#0576 Follow-Up After Hospitalization for Mental Illness

Step 1. Determine the denominator. The denominator is all discharges that meet the specified denominator criteria (S7).

Step 2. Remove exclusions. Remove all discharges from the denominator that meet the specified exclusion criteria (S9).

Step 3. Identify numerator events: Search administrative systems to identify numerator events for all discharges in the denominator (S5).

Step 4. Calculate the rate by dividing the events in step 3 by the discharges in step 2. 123834| 140881

#2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence

Mental Health

Step 1: Determine the eligible population.

Step 1A: Identify patients with who were treated and discharged from an emergency department with a primary diagnosis of mental health.

Step 1B: Exclude patients who meet the exclusion criteria as specified in the "Denominator Exclusion Details" section.

Step 2: Identify the numerator.

Step 2A: Identify those who had a qualifying follow-up visit within 7 days.

Step 2B: Identify those who had a qualifying follow-up visit within 30 days.

Step 3: Calculate the rates.

Step 3A: Calculate the 7-day rate by dividing the number of patients with qualifying follow-up visit within 7 days (Step 2A) by the denominator (after exclusions) (Step 1B).

Step 3B: Calculate the 30-day rate by dividing the number of patients with qualifying follow-up visit within 30 days (Step 2B) by the denominator (after exclusions) (Step 1B).

Alcohol or Other Drug Dependence

Step 1: Determine the eligible population.

Step 1A: Identify patients with who were treated and discharged from an emergency department with a primary diagnosis of alcohol or other drug dependence.

Step 1B: Exclude patients who meet the exclusion criteria as specified in the "Denominator Exclusion Details" section.

Step 2: Identify the numerator.

Step 2A: Identify those who had a qualifying follow-up visit within 7 days.

Step 2B: Identify those who had a qualifying follow-up visit within 30 days.

Step 3: Calculate the rates.

Step 3A: Calculate the 7-day rate by dividing the number of patients with qualifying follow-up visit within 7 days (Step 2A) by the denominator (after exclusions) (Step 1B).

Step 3B: Calculate the 30-day rate by dividing the number of patients with qualifying follow-up visit within 30 days (Step 2B) by the denominator (after exclusions) (Step 1B). 123834| 140881| 135810

#3312 Continuity of Care After Medically Managed Withdrawal From Alcohol and/or Drugs

The following step are used to identify the denominator, numerator, and calculation of the measure rate:

Step 1: Identify denominator

- Step 1A: Eligible population: Identify Medicaid beneficiaries ages 18–64 who have any medically managed withdrawal in inpatient hospital, residential addiction treatment program, or ambulatory medically managed withdrawal from January 1 to December 15 of the measurement year and are enrolled the month of medically managed withdrawal and the following month. Age is calculated as of January 1 of the measurement year.
- Step 1B: Among the Medicaid beneficiaries in Step 1A, identify all discharges from medically managed withdrawal using all inpatient, outpatient, and ambulatory claims files or tables that contain HCPCS or ICD-10 procedure codes and UB revenue codes (see NQF 3312 – Tab 1-2 for code lists). If more than one discharge from medically managed withdrawal in a year, treat each discharge from medically managed withdrawal as a separate episode, e.g., an inpatient hospital medically managed withdrawal in January and an ambulatory medically managed withdrawal in July counts as two episodes.

— Step 1B.1: Multiple medically managed withdrawal claims that are up to 2 days apart are combined into a single episode. Sort the inpatient, outpatient, and ambulatory discharge from medically managed withdrawals by Beneficiary ID and service dates to ensure the discharges from these multiple data sources are in chronological order. Then combine claims that are up to 2 days apart while retaining all clinical fields from each episode.

- Step 1C: Identify appropriate location of medically managed withdrawal services: hospital inpatient, inpatient residential addiction, outpatient residential outpatient addiction, other stayover treatment, and ambulatory medically managed withdrawal. Use HCPCS medically managed withdrawal procedure codes to assign medically managed withdrawal location whenever possible; revenue center medically managed withdrawal will map to the hospital inpatient location when the revenue codes appear on an inpatient claim or table (see attached value set: NQF 3312 – Tab 2). Revenue center medically managed withdrawal will map to other stayover treatment when the revenue codes appear on a non-inpatient claim. If there is more than 1 medically managed withdrawal location when episodes are combined, assign the location using the first claim´s location. If there is a tie between a medically managed withdrawal episode being identified via revenue center codes and a more specific category using HCPCS on the same claim, the HCPCS location prevails.

Step 2: Identify numerator

- Step 2A: From the denominator in Step 1B, identify those discharges from medically managed withdrawal in any setting with a qualifying continuity service within 7 or 14 days after discharge.

— Step 2A.1: Identify SUD continuity services: Continuity services are assigned using clinical claims billing information (e.g., diagnosis, procedure, revenue codes; see attached value sets NQF 3312 – Tab 2-8). The measure includes all claims files or data tables that contain clinical fields (e.g., inpatient hospital, outpatient, other ambulatory, and long-term care). SUD diagnoses can be in any position – primary or secondary – for continuity services. Since multiple claims files or tables could each contain a continuity claim, this calls for creating continuity variables separately within each file type or table, sorting the files or tables by beneficiary ID and service dates, then putting them together in order to assign the set of variables that are “First” to occur relative to the medically managed withdrawal episode discharge date. Continuity services have to occur the day after discharge through day 7 or 14.

— Step 2A.2: Identify pharmacotherapy which may occur in multiple files or tables (see attached value sets: NQF 3312 – Tab 9-10). For example, one claims file or data source may contain injectables, another claims file or table data source may contain oral medications. Consequently, pharmacotherapy variables are created separately in each source, the data sources are then sorted

by beneficiary ID and service dates, then multiple pharmacotherapy data sources are put together so they will be in chronological order to assign "First" variables. Pharmacotherapy services could be provided on the same day as the discharge from medically managed withdrawal through day 7 or 14. NDC codes are subject to frequent changes so measure users should update these codes.

— Step 2A.3: Co-occurring events: Emergency department visits, even with an SUD diagnosis, do not count as continuity. Also, other continuity services, e.g., an outpatient visit that occur on the same day as an emergency department visit with an SUD diagnosis do not count as continuity. If an overdose diagnosis code appears on the same claim as the continuity service, then the service does not count as continuity. If an inpatient continuity claim has an emergency department visit meaning that the beneficiary was admitted through the emergency department, it is allowed to remain a continuity service.

Step 3: Calculate rate

- Step 3A: Calculate the overall 7- or 14-day continuity rates by dividing the number of discharges with a qualifying continuity service (Step 2A) by the denominator (Step 1B).
- Step 3B: Calculate the rates separately for each medically managed withdrawal location by dividing the respective number of discharges by each location with a qualifying continuity service (Step 2A) by the denominator (Step 1C). 120752| 141015| 113612

#3453 Continuity of Care After Inpatient or Residential Treatment for Substance Use Disorder (SUD)

Value sets referenced in this section can be found in the attached excel spreadsheet included in S.2b.

Step 1: Identify denominator

- Step 1A: Eligible population: Identify non-dual eligible beneficiaries ages 18–64. Keep beneficiaries with any discharges from inpatient or residential treatment with a primary diagnosis of SUD on or between January 1 and December 15 of the measurement year. Beneficiaries must meet enrollment criteria, defined as Medicaid as the first payer and enrolled in the month of discharge and the following month. Age is calculated as of January 1 of the measurement year. Throughout Steps 1 and 2, diagnoses of SUD are identified using a primary diagnosis from the "HEDIS AOD Dependence" value set (worksheet tab 1) or any procedure code from the "HEDIS AOD Procedures" value set (worksheet tab 2).
- Step 1B: Flag claims as inpatient or as residential treatment with a primary diagnosis of SUD:

  Among the Medicaid beneficiaries in Step 1A, flag claims as being either in an inpatient or residential setting using all inpatient, outpatient, and ambulatory claims files or tables that contain HCPCS, ICD-10 procedure or diagnosis codes, place of service, or UB revenue codes. Residential treatment is identified using the codes in the SUD Residential Treatment value set (worksheet tab 3). If a beneficiary has more than one discharge in a year, treat each discharge as a separate episode, e.g., an inpatient hospital discharge in January and a residential treatment discharge in July count as two episodes.
- Step 1B.1: Consolidate episodes: Multiple inpatient or residential treatment claims that are up to 2 days apart should be combined into a single episode. Use all inpatient and residential treatment claims, regardless of diagnosis, to create episodes.
- Step 1C: Assign treatment location to episodes: Use HCPCS, ICD-10 procedure or diagnosis codes, place of service, or UB revenue codes in the SUD Residential Treatment value set (worksheet tab 3) and the SUD diagnosis value sets as noted in Step 1A to assign each episode as inpatient, residential treatment, or a mix of both (also indicating the first setting of each episode and the last setting of each episode).

- Step 1D: Exclusions: Exclude discharges that meet the exclusion criteria as specified in the "Denominator Exclusion Details" section.

— Exclude discharges for patients who receive hospice services during the measurement year.

— Exclude discharges after December 15 of the measurement year.

— Exclude discharges followed by admission or direct transfer to an inpatient or SUD residential treatment setting within the 7- or 14-day continuity of care period regardless of the primary diagnosis (with 13 exception of admission to residential treatment following discharge from inpatient treatment).

— Exclude episodes that do not include at least one claim with primary diagnosis of SUD.

The denominator for the 7- and 14-day continuity of care rates will differ because of the different exclusions based on transfer or admission to a hospital or residential treatment for 7 versus 14 days. For example, a beneficiary admitted to a residential setting on day 10 after discharge will be excluded from the 7-day rate but not from the 14-day rate.

Step 2: Identify numerator

- Step 2A: From the denominator defined above, identify discharges with qualifying continuity of care for SUD (primary or secondary diagnosis) within 7 or 14 days after discharge.
- Step 2A.1: Visits: Identify visits meeting continuity of care criteria using outpatient claims files or tables that contain diagnosis, procedure, or revenue codes, procedure code modifiers, or place of service codes. For visits to count as continuity there must be an SUD diagnosis in any position – primary or secondary. Visits have to occur the day after discharge through day 7 or 14. We identify visits as:

1. Any procedure code or UB revenue code from "HEDIS IET Stand Alone Visits" value set (worksheet tab 4); or
2. Any procedure code from "HEDIS IET Visits Group 1" value set (worksheet tab 5) along with place of service from "HEDIS IET POS Group 1" value set (worksheet tab 6); or
3. Any procedure code from "HEDIS IET Visits Group 2" value set (worksheet tab 7) along with place of service from "HEDIS IET POS Group 2" value set (worksheet tab 8). To ensure that the claim is for a visit (and not telehealth), the claim must also have procedure code modifier that is missing or is not a telehealth modifier (worksheet tab 9).

- Step 2.A.2: Telehealth: Identify visits for telehealth meeting continuity of care criteria using outpatient claims files or tables that contain diagnosis, procedure, or revenue codes, procedure code modifiers, or place of service codes. For telehealth treatment to count as continuity, there must be an SUD diagnosis in any position – primary or secondary. Telehealth has to occur the day after discharge through 7 or 14 days after discharge. We identify telehealth as:

1. Any procedure code from the "HEDIS Telephone Visit" value set (worksheet tab 12); or
2. Any procedure code or UB revenue code from "HEDIS IET Stand Alone Visits" value set (worksheet tab 4); or
3. Any procedure code from "HEDIS IET Visits Group 1" value set (worksheet tab 5) along with place of service from "HEDIS IET POS Group 1" value set (worksheet tab 6); or
4. Any procedure code from "HEDIS IET Visits Group 2" value set (worksheet tab 7) along with place of service from "HEDIS IET POS Group 2" value set (worksheet tab 8).

Claims identified using logic in #2–4 must also have procedure code modifier from the "HEDIS Telehealth Modifier" value set (worksheet tab 9).

Step 2A.3: Identify pharmacotherapy events:

Pharmacotherapy includes naltrexone (short or long acting), acamprosate, or disulfiram for alcohol dependence treatment and buprenorphine for opioid dependence treatment, as well HCPCS codes to identify procedures related to injectable pharmacotherapy (e.g., long-acting, injectable naltrexone) and dispensing of methadone. Code lists for this measure are in the attached value sets. States may need to adapt the list of codes to include state-specific codes.

- Indications of pharmacotherapy can occur in outpatient or pharmacy files or tables that contain procedure codes or NDCs. Pharmacotherapy events could be provided on the same day as the discharge through day 7 or 14. Pharmacotherapy continuity claims are identified as follows:

1. In OT file,

a) any procedure code from "HEDIS Medication Assisted Treatment" value set (worksheet tab 10); or

b) any HCPCS procedure code from "MAT Additional Codes" value set (worksheet tab 11); or

c) any state-specific procedure code from "MAT Additional Codes" value set (worksheet tab 11) for the two states listed in the value set (these codes were identified through consultation with these states).

2. In RX file, any NDC from "AOD Pharmacotherapy" value set (worksheet tab 13).

Step 3: Calculate rate

- Step 3A: Calculate the overall 7- or 14-day continuity of care rate by dividing the number of discharges with evidence of a qualifying continuity of care visit or pharmacotherapy event (Step 2A) by the denominator (after exclusions) (Step 1D). Calculate the rates separately for 7 and 14 days after discharge. 120752| 141015| 110874| 113612

Submission Items

#3590 Continuity of Care After Receiving Hospital or Residential Substance Use Disorder (SUD) Treatment

5.1 Identified measures: 3453 : Continuity of Care after Inpatient or Residential Treatment for Substance Use Disorder (SUD)

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: The measure is harmonized with the parallel measure that was developed for use at the health plan or Medicaid program level (NQF 3453). In both measures, the population is Medicaid beneficiaries age 18 – 64. The same diagnosis codes are used to identify substance use disorders. The same services and procedures are included to define follow-up treatment. While NQF# 3453 examines post-discharge follow-up at 7 and 14 days, we are proposing that #3590 Continuity of Care After Receiving Hospital or Residential Substance Use Disorder (SUD) Treatment be reported at 7 and 30 days. This is because review of the evidence and discussion with addiction professionals supported measuring follow up for an extended period of time. Also, NQF# 3488 Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence, NQF#3489 Follow-up after Emergency Department Visit for MH, and NQF# 0577 Followup after a hospitalization for a mental illness indicated that these measures are reported at 7 and 30 days. Finally, HEDIS has implemented NQF #3453 as measuring following-up at 7 and 30 days, not at 7 and 14 days (https://www.ncqa.org/wp-content/uploads/2019/02/20190208_06_FUI.pdf). This difference between using a 14 or 30 day follow-up does not impact interpretability or data collection burden.

5b.1 If competing, why superior or rationale for additive value: Not applicable.

#0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

5.1 Identified measures:

5a.1 Are specs completely harmonized?

5a.2 If not completely harmonized, identify difference, rationale, impact:

5b.1 If competing, why superior or rationale for additive value: N/A

#0576 Follow-Up After Hospitalization for Mental Illness

5.1 Identified measures:

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: N/A

5b.1 If competing, why superior or rationale for additive value: N/A

#2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence

5.1 Identified measures: 0576 : Follow-Up After Hospitalization for Mental Illness (FUH)

1937 : Follow-Up After Hospitalization for Schizophrenia (7- and 30-day)

3312 : Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact: Portions of the specifications for this measure have been adapted from the existing health plan measures (Follow-up After Hospitalization for Mental Illness NQF #0576 and Follow-up After Hospitalization for Schizophrenia NQF#1937). The proposed measure is harmonized with the two existing NQF-endorsed measures. The following highlights the differences between the measures: -Population focus (denominator): The proposed measure targets patients discharged from the emergency department (not inpatient) and also focuses on patients with alcohol or other drug dependence disorders.-Numerator: The proposed measure captures follow-up with a primary mental health or alcohol or other drug dependence diagnosis (regardless of the type of provider).

5b.1 If competing, why superior or rationale for additive value: Not applicable.

#3312 Continuity of Care After Medically Managed Withdrawal From Alcohol and/or Drugs

5.1 Identified measures: 0004 : Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

2605 : Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: Follow-up time period: NQF 2605 examines follow-up care 7 days and 30 days after discharge. Our proposed measure (#3312) examines follow-up care 7 days and 14 days after discharge. The 14 day follow-up time period aligns with NQF 0004 and the non-NQF endorsed Continuity of Care After Detoxification measure developed by the Washington Circle, and reflects the input of some public commenters that adults should receive some type of care within two weeks of discharge from detoxification. Diagnoses: NQF 2605 requires a primary diagnosis of alcohol and other drug dependence (AOD) for the follow-up service. Our proposed measure (#3312) requires a primary or secondary diagnosis of AOD. We allow a primary or secondary AOD diagnosis to address potential inaccuracies in how

AOD diagnoses are coded. For example, some providers may be concerned about the stigma associated with an AOD diagnosis and therefore code it as a secondary diagnosis. Also, for adults with co-occurring mental health and AOD disorders, the assignment of primary and secondary diagnoses can be challenging and sometimes arbitrary. The differences in follow-up time period, location and diagnoses between NQF 2605 and our proposed measure (3312) do not impact the measure's interpretability in which a higher rate is indicative of better quality. Both measures rely on administrative data. The differences in measure specifications between 2605 and 3312 are minor and expected to have minimal impact on data collection burden.

5b.1 If competing, why superior or rationale for additive value: Not applicable. There are no other NQF-endorsed measures that conceptually address the same measure focus and same target population.

#3453 Continuity of Care After Inpatient or Residential Treatment for Substance Use Disorder (SUD)

5.1 Identified measures: 0576 : Follow-Up After Hospitalization for Mental Illness

0004 : Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

1937 : Follow-Up After Hospitalization for Schizophrenia (7- and 30-day)

2605 : Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence

3312 : Continuity of Care After Medically Managed Withdrawal from Alcohol and/or Drugs

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: Parts of the specifications for the proposed measure harmonize with some measures but not others. Below we describe similarities and differences between the proposed measure and other measures. The differences do not impose additional data collection burden to states, because the data elements are available in administrative data and are consistent with some measures states are already likely collecting. Numerator: Timing of continuity of care. The proposed measure specifies continuity of care within 7- and 14-days of discharge and is harmonized with NQF 3312, Continuity of care for Medicaid beneficiaries after detoxification (detox) from alcohol and/or drugs, which also focuses on a SUD population. NQF 0576, 1937, and 2605 all specify follow-up within 7 and 30 days. The populations for NQF 0576 and 1937 include patients with mental health related diagnoses rather than focusing on substance use disorders. NQF 2605 has a target mixed population of mental health and SUD patients. In measure testing, stakeholders expressed concern that 30 days is too long for SUD patients to wait for a continuity of care service after discharge from inpatient or residential care. Timelier follow-up with these patients is needed so as not to lose them. NQF 0004 is partially harmonized with the proposed measure in that the initiation visit is specified as within 14 days of the index episode start date (diagnosis). Diagnoses in the continuity of care visit. The proposed measure is harmonized with NQF 3312 and NQF 0004 by allowing SUD to either be the primary or a secondary diagnosis for treatment services that count toward continuity in the numerator. This is to address potential inaccuracies in how SUD diagnoses are coded. For example, some providers may be concerned about the stigma associated with an SUD diagnosis and therefore code it as a secondary diagnosis. Also, for adults with co-occurring mental health and SUD disorders, the assignment of primary and secondary diagnoses can be challenging and sometimes arbitrary. NQF 2605 does not allow a secondary SUD diagnosis. NQF 0576, NQF 1937, are not clear on whether only a primary diagnosis is allowed in the numerator. Services to include as continuity of care. The proposed measure includes pharmacotherapy and telehealth as services that count as continuity of care. NQF 2605, 0576, and 1937 do not include these services. Adding an SUD medication or telehealth claim as evidence of continuity of care is consistent with recent changes made to the

2018 HEDIS specification of NQF 0004 (National Committee on Quality Assurance, 2018). Practitioners valid for providing follow-up services. The proposed measure and NQF 2605 allow any practitioner to provide follow-up services, because of the expectation that the follow-up services captured in the measure may be provided by primary care clinicians. NQF 0576 and 1937 only allow non-mental health practitioners in specified settings and with specific diagnosis codes. Denominator: Diagnoses in denominator. The denominators for the proposed measure and all the related measures are harmonized in requiring a primary diagnosis for the condition that is the measure's focus. Age. The proposed measure is intended for an adult Medicaid population. Similar to NQF 3312 and NQF 1937, it includes ages 18-64.The proposed measure excludes adults over 64 years, because complete data on services received by dually-eligible (Medicaid and Medicare) adults are not available in Medicaid data. NQF 2605 includes adults age 18 and older. NQF 0576 includes individuals age 6 and older and NQF 0004 includes age 13 and older. In terms of impact on interpretability, the proposed measure would have lower continuity rates than the measures that have a 30-day follow-up time period and higher continuity rates than the measures that only count non-mental health practitioners in certain settings and with certain diagnosis codes.

5b.1 If competing, why superior or rationale for additive value: Not applicable; there are no competing measures.

Appendix F: Pre-Evaluation Comments

No comments were received as of January 15, 2020.

National Quality Forum
1099 14th Street NW, Suite 500
Washington, DC 20005
https://www.qualityforum.org