Behavioral Health and Substance Use, Fall 2018 Cycle: CDP Report

TECHNICAL REPORT

August 5, 2019

This report is funded by the Department of Health and Human Services under contract HHSM-500-2017-00060I Task Order HHSM-500-T0001.

NATIONAL QUALITY FORUM

Contents

Executive Summary **3**

Introduction **5**

NQF Portfolio of Performance Measures for Behavioral Health and Substance Use Conditions **6**

Table 1. NQF Behavioral Health and Substance Use Portfolio of Measures 6

Behavioral Health and Substance Use Measure Evaluation **7**

Table 2. Behavioral Health and Substance Use Measure Evaluation Summary 7

Comments Received Prior to Committee Evaluation 7

Comments Received After Committee Evaluation 7

Overarching Issues 8

Summary of Measure Evaluation 10

Measures Withdrawn from Consideration 13

Table 3. Measures Withdrawn from Consideration 13

References **14**

Appendix A: Details of Measure Evaluation **17**

Measures Endorsed 17

0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment 17

2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling 21

3453 Continuity of care after inpatient or residential treatment for substance use disorder (SUD) 24

Measure Not Endorsed 28

3451 Non-Acute Mental Health Services Utilization for Dual Eligible Beneficiaries 28

Appendix B: Behavioral Health and Substance Use Portfolio— Use in Federal Programs **31**

Appendix C: Behavioral Health and Substance Use Standing Committee and NQF Staff **34**

Appendix D: Measure Specifications **37**

0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment 37

2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling 44

3453 Continuity of care after inpatient or residential treatment for substance use disorder (SUD) 48

Appendix E1: Related and Competing Measures (tabular version) **54**

Appendix E2: Related and Competing Measures (narrative version) **92**

Appendix F: Pre-Evaluation Comment **160**

Behavioral Health and Substance Use, Fall 2018 Cycle

TECHNICAL REPORT

Executive Summary

This report summarizes the most recent measurement evaluation and deliberation activities of the National Quality Forum's (NQF) Behavioral Health and Substance Use (BHSU) Standing Committee.

BHSU disorders—composed of psychiatric illnesses (mental illnesses) and substance use disorders (SUDs) (e.g., tobacco, and heroin abuse and dependence)—are an important organizational construct of healthcare. These disorders share brain-based etiology and emotional and cognitive symptomology. Such illnesses directly impact 20 percent of the U.S. population and correlated with more measurable disability than any other major category of disease including circulatory diseases.[1, 2] Accordingly, BHSU disorders are a dominant U.S. illness category, but also one in which treatment rates are well below 50 percent of those in need. For SUDs alone, treatment rates fall below 15 percent.[1] Accordingly, quality of care in the BHSU prevention and illness domain remains one of the great challenges in healthcare.

NQF presently has 54 NQF-endorsed behavioral health measures. A description of NQF's most recent BHSU Standing Committee meeting as well as previous meetings is available on NQF's project webpage. This Committee oversees the BHSU portfolio by directly reviewing each measure for new or ongoing NQF endorsement. Such endorsed measures are subsequently used as national accountability and quality metrics relevant to the delivery of BHSU services. This report details the Committee's most recent decision making meeting and includes the evaluation and voting results for measures pertaining to the early detection and downstream treatment of SUDs, including alcohol and illegal drugs, as well as access to mental health services among persons dually eligible for Medicare and Medicaid.

During the fall 2018 cycle, the Standing Committee evaluated two newly submitted measures and two measures undergoing maintenance review according to NQF's standard evaluation criteria. The Committee recommended three measures for endorsement and did not recommend one measure. NQF's Consensus Standards Approval Committee (CSAC) upheld the Standing Committee's recommendations and thus formally endorsed the following measures:

- 0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment
- 2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling
- 3453 Continuity of Care After Inpatient or Residential Treatment for Substance Use Disorder (SUD)

The following measure was not endorsed:

- 3451 Non-Acute Mental Health Services Utilization for Dual Eligible Beneficiaries

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

In addition to evaluating the four performance measures describe above, the Standing Committee discussed gaps and harmonization issues surrounding those measures as well as the BHSU measurement endeavor more generally. Substantive points that emerged from those discussions included interest in capturing new therapies and therapy modalities (e.g., novel pharmaceuticals, telehealth) in the definition of BHSU treatments, and encouraging the pipeline of measures that consider BHSU outcomes across the life-span and disease continuum from prevention to recovery. The Committee also discussed how best to harmonize measures which share population or process/outcome definitions or both, and they expressed strong interest in having NQF staff and collaborators develop strategies to promote the development of new measures which adhere to such harmonization goals.

Introduction

Behavioral healthcare refers to a continuum of services for individuals at risk of—or suffering from—mental (i.e., emotional and/or cognitive issues) or addictive disorders, challenges broadly ranging from mood and anxiety disorders, to learning disabilities and substance abuse or dependence (including tobacco dependence). In the United States, over 56 million adolescents and adults suffer from a discernable behavioral health disorder (roughly 1 in 5),[1] which includes over 11 million persons with the most serious forms of mental illness (schizophrenia, bipolar, major depression) and a similar number of persons (substantially overlapping with that 11 million) who suffer simultaneously from a mental illness and an SUD.

The most comprehensive annual report of BHSU disorder prevalence data in the U.S. is the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Survey on Drug Use and Health (NSDUH). Results from the 2017 NSDUH indicated that in the U.S. 19.7 million persons (age ≥12 years) suffered from an apparent SUD (not including tobacco dependence), and 46.6 million persons (age ≥18 years) suffered from a mental illness.[1]

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 including cancers, heart disease, injuries, and kidney disease. Specifically, 2015 data which quantified age-standardized disability adjusted life years (DALYs) showed that BHSU disorders yield more years lost to suboptimal health per 100,000 persons in the U.S. (3,355 DALYs) than any other major disease category including cancers (3,131 DALYs), circulatory diseases (3,065 DALYs), injuries (2,419 DALYs), and kidney diseases (1,827 DALYs).[2]

BHSU disorders are substantial correlates to death in the United States. Opioid overdose deaths have recently become a particular concern, and data compiled by the U.S. Centers for Disease Control and Prevention placed such deaths at over 47,000 in 2017 alone.[3] U.S. suicides in 2016 approached that number,[4] and deaths attributable to alcohol use (overdose, accidents, cirrhosis, cancers) numbered approximately 88,000 annually, per 2006-2010 data, thus making alcohol use the third most common cause of preventable mortality behind tobacco use (first) and poor diet and physical inactivity (second).[5] Finally, mental illness correlates markedly with premature death by an average of 8 years for all mental illnesses and 25 years for the most serious forms.[6] The causes for this premature mortality are multifactorial including tobacco use, suicide, poor self-advocacy, and risk of victimization, but at least one fairly recent study found that 95 percent of these premature deaths are from "medical rather than unnatural causes."[7]

The NSDUH from 2017 further reveals an important concern about BHSU care in this country: Only 12.5 percent of persons with SUDs reported treatment during that year, and only 43.6 percent of those with any mental illness reported receiving care for that distinctive and debilitating constellation of conditions.[1] The gap between marked BHSU pathology and treatment alone should give one pause about the quality of the U.S. healthcare system regarding such issues, and it certainly represents unmet or untapped need. This unfulfilled need persists even as good treatments exist to ease suffering caused by these disorders.

Recent work in behavioral health has confirmed or newly described the existence of effective psychosocial or pharmaceutical therapies for depression, opioid addiction, anxiety, schizophrenia, and bipolar disorder.[8-15] However, this same work also demonstrates ongoing challenges in the prevention, diagnosis, and treatment of behavioral health disorders—illnesses that are typically chronic, cycling, and difficult to diagnose precisely because they do not correlate with salient biologic markers.

Despite the deep challenges posed by BHSU illnesses, there exist many evidence-based approaches to prevent such illnesses and to treat persons and families impacted by them.[16-18] Applications of these strategies, however, are neither easy nor universal, made challenging by the complexity and uncertainty of the underlying pathology and by stigma that shrouds a category of diseases which often impair social functioning.[19-22] Accordingly, quality measurement and quality improvement tools are essential to behavioral health—extraordinarily so compared to most other conditions that fall under the purview of the U.S. healthcare system.

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

The Behavioral Health and Substance Use Standing Committee (Appendix C) oversees NQF's portfolio of Behavioral Health and Substance Use measures (Appendix B) that includes measures pertaining to serious mental illnesses (e.g., schizophrenia, mania, major depression), dysthymia, anxiety, ADHD and other learning behavioral problems, alcohol and illegal drug use, tobacco dependence, care coordination (between and within the spheres of psychiatric, substance use, and related physical illness), medication use, and patient care experience. This portfolio contains 54 measures: 45 process measures, eight outcome measures, and one composite measure (see table below).

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

	Process	Outcome	Composite
Alcohol and Drug Use	8	0	1
Care Coordination	2	0	0
Depression	5	4	0
Medication Use	10	0	0
Experience of Care	3	0	0
Tobacco	8	0	0
Physical Health	9	4	0
Total	45	8	1

Additional behavioral health measures have been assigned to other portfolios. Examples include patient experience measures (Patient Experience and Function project); measures focused on antipsychotics, screening for drugs of abuse in psychosis, and tobacco use (Pediatrics/Patient Safety projects); measures related to pharmacotherapy for opioid use disorder (Patient Safety project), unplanned readmissions following psychiatric hospitalization (All-Cause Admissions and Readmissions project), and smoking prevalence (Prevention and Population Health project).

Behavioral Health and Substance Use Measure Evaluation

On January 30 and 31, 2019 the Behavioral Health and Substance Use Standing Committee evaluated two new measures and two measures undergoing maintenance review against NQF's standard evaluation criteria.

Table 2. Behavioral Health and Substance Use Measure Evaluation Summary

	Maintenance	New	Total
Measures under consideration	2	2	4
Measures recommended for endorsement	2	1	3
Measures not recommended for endorsement	0	1	1
Measures withdrawn from consideration	6	0	6
Reasons for not recommending	Importance – 0 Scientific Acceptability – 0 Use – 0 Overall Suitability – 0 Competing Measure – 0	Importance – 1 Scientific Acceptability – 0 Overall Suitability – 0 Competing Measure – 0	

Comments Received Prior to Committee Evaluation

NQF solicits 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 November 29, 2019 and closed on April 9, 2019. As of January 18, one comment was submitted and shared with the Committee prior to the measure evaluation meetings (see Appendix F). This comment pertained to measure 0004 (initiation of and engagement in substance abuse services) and encouraged the full inclusion of residential treatment levels of care in the measure's definition.

Comments Received After Committee Evaluation

The continuous 16-week public (i.e., NQF member and the public at large) commenting closed on April 9, 2019. Following the Committee's evaluation of the measures under consideration, NQF received 16 comments from four member organizations pertaining to the draft report and to the measures under consideration. All comments for each measure under consideration have been summarized in Appendix A.

Throughout the 16-week continuous public commenting period, NQF members had the opportunity to express their "support" or "nonsupport" for each measure submitted for endorsement consideration to inform the Committee's recommendations. One NQF member expressed support for the Committee's recommendations to endorse measures 0004 and 2152 and not to endorse measure 3451.

Overarching Issues

During the Standing Committee's discussion of the measures, several overarching issues emerged that were factored into the Committee's ratings and recommendations. Those overarching issues are summarized in this section and are thus not necessarily repeated in detail with each individual measure description. This section further summarizes themes that emerged from the Standing Committee's more general harmonization and gaps discussions.

Standardization around Measuring Continuity of Care

Triggered by discussion of measure 3453 *Continuity of Care After Inpatient or Residential Treatment for Substance Use Disorder (SUD),* the Committee had the following ideas or questions regarding "coordination of care" measures more generally:

- What are proper durations for follow-up to achieve the desired level of coordination after discharge: same day, within 7 days, 14 days, and/or 34 days? Moreover, the Committee encouraged future measures to use scientific evidence to determine an intervention window.
- Who (including which facilities) should be credited for (and thus encouraged towards) care coordination activities: physicians, physician assistants, social workers, discharge staff, outpatient program admitting staff, or others who facilitate the transition?
- How can coordination of care measures be designed to efficiently address the full spectrum of behavioral health: across the life-span and including interventions oriented toward prevention, screening, diagnosis, treatment, and recovery?
- A Committee member shared a recent publication which reviewed over 700 quality measures (many NQF-endorsed) and then isolated, organized, and prioritized those relevant to the integration of behavioral health and general medical care efforts.[23]

Inclusion of Telehealth Services

With the evolution of the internet and telecommunication more generally, telehealth is now being widely adopted or considered as a billable and fully functional way for patients and providers to interact. Three measures being reviewed for endorsement (i.e., 0004, 3451, 3453) include at least some telehealth services as applicable events that meet the numerator definition, while one (i.e., 2152) did not include such services. The Committee generally approved of the use of telehealth for inclusion in the measure specifications. As such, there was little concern expressed that these remote encounters would compromise care.

Harmonizing Measures Sharing Overlapping Disease, Process, or Diagnostic Constructs

The Committee discussed the need to promote efficient measure use and simplify measurement in areas where there are multiple related measures. For example, rather than having several measures for a singular and cross-cutting treatment phase or construct (e.g., inpatient, care coordination, prevention) and different patient populations (e.g., any behavioral health disorder, SMI) the Committee advocated for the development of one measure that then could be applied separately to various subpopulations of interest. Related to this point specifically, one Committee member cited a recently published essay which advocates that SMI should be designated as a disparities category (like race and gender), thereby suggesting that this specific behavioral health disease status is important both as a broad diagnostic

cluster and as a stratification dimension to uncover potentially unjust or otherwise inappropriate healthcare practices across the prevention and treatment spectrum.[24]

Alignment efforts need to harmonize related measures or justify their divergence. For example, measures 2152 *Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling* and 2599 *Alcohol Screening and Follow-up for People with Serious Mental Illness* are related, but the periodicity that the latter measure uses for appropriate screening is intensified (i.e., more frequent) given the increased risk that the SMI population faces. This is an example of a diverging definition that is justified using logic (e.g., epidemiology) tied to the measure targets.

Per the discussion on related and competing measures, the Committee also encouraged the development of measures which either "nest" similar process or outcome measures together (e.g., care coordination, inpatient care) or completely unify them such that they could be applied across the life-span and the total care continuum. Some members of the Committee advocated for NQF to pursue more aggressively such harmonization goals (i.e., unifying measures sharing either disease-state or process/outcome constructs) via leading edge framework activities that, in turn, could inspire all standing committees and developers toward greater measurement efficiencies.

Gaps and Future Directions

The Committee discussed gaps apparent in the portfolio and future directions they hoped the pipeline of new measures might connect to. This gaps/pipeline discussion was inspired by a listing of such aspirations from the 2016-2017 review cycle. Below is a summary of gaps and future directions emerging from the Committee's discourse during this review cycle.

- More measures focused on social determinants of health were encouraged including those pertaining to housing, employment, and criminal justice issues.
- Adding to discussion already summarized above, care coordination across the life-span and full course of the wellness/illness continuum (from prevention to prodromal to illness and recovery) was reiterated as an important target of measurement science. Related to these specific ideas, measures of recovery, overall well-being, and total cost of care (including composite measures) were encouraged.
- Presumably to make measurement more patient-centered, at least one member of the Committee advocated for more measures that precisely paired patient goals with functional outcomes.
- One member of the Committee suggested that quality measurement could address provider "burnout" by targeting efficiency issues including those tied to payer-managed care (e.g., prior authorization, treatment limits).
- One member suggested that top priorities at present include: (1) the opioid crisis, (2) care integration especially between mental health and substance use disorders, but also between those two behavioral health issues and physical health (e.g., primary care), and (3) measures of overall well-being.

NQF received the following public comments about the report:

- Serious mental illness (SMI) should be designated as a disparities category. The Committee had suggested this in their previous discussions and in the draft report which likely prompted this comment. In the post-comment meeting, the Committee again expressed support for this idea noting, for example, that individuals with SMI have unique risks/vulnerabilities which include heightened exposure to victimization and violence, and very high rates (~80 percent) of tobacco use. During this discussion, Committee members also cautioned against the use of disparity subgroups as risk-adjustment variables because such adjustments may encourage accountable entities to deliver substandard care to persons with SMI.
- More quality of life measures are needed, and two specific instruments were cited as examples to fill that gap.
- More life-span and full-spectrum of illness measures are needed.
- Use of long-acting injectable (LAIs) antipsychotics. In response to that comment, one Committee member encouraged this suggestion, arguing that LAIs are underutilized therapy and many persons in need do not like to take daily pills. Another member of the Committee, however, cautioned that some patients may not like LAIs—a suggestion leading to general agreement by the Committee that tailored/custom/patient-oriented approaches are essential to quality treatment and measurement concepts.
- More patient-focused (customized) treatment measures are needed.
- More measures are needed to address specific issues faced by individuals dually eligible for Medicare and Medicaid, persons who are older and have higher rates of categorical disability than the general population.

Summary of Measure Evaluation

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

0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (National Committee for Quality Assurance): Endorsed

Description: This measure assesses the degree to which a health plan 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; and 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. **Measure Type:** Process; **Level of Analysis:** Health Plan; **Setting of Care:** Emergency Department, Inpatient/Hospital, Outpatient Services; **Data Source:** Claims

Since this measure's last maintenance review in 2012, it has been updated to include evidence-based pharmacotherapy, telehealth services, and new diagnostic codes. Additionally, the post-initiation

engagement study period has been extended from 30 to 34 days. The Standing Committee indicated overall support of the endorsement of the measure and agreed that the updated specifications improved the measure overall. During the Committee discussions, the following salient points of interest or concerns emerged regarding this measure: refused initiations were treated as non-initiations; Medicaid and Medicare yielded distinctive rates suggesting risk adjustment should be considered; combined drug and counseling therapy was not differentiated; data systems to deploy this measure may presently be lacking and costly to achieve; and the measure is short-term only (34 days). The discourse underscored the Committee's interest regarding the following points: (1) the measure holds promise to consider differences in treatment pathways for different substances of abuse (e.g., opioids versus alcohol), and (2) concerns about a "woodwork penalty," i.e., that those detecting more cases would fail to achieve the measure more often. This idea of a "woodwork penalty" was refuted by the citation of data suggesting the opposite correlation.

Public comment regarding this measure included queries or concerns about the following issues: the full inclusion of residential treatment codes, the duration of follow-up being extended from 30 to 34 days, sensitivity to multimodal treatment (medication and counseling) as an explicit numerator event, adaptation of the phrase substance "use disorder" in lieu of "abuse and dependence," accounting for those who refuse treatment, and the long lag between an encounter and claims availability to the referring entity.

2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling (PCPI Foundation): Endorsed

Description: Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user; **Measure Type**: Process; **Level of Analysis**: Clinician: Group/Practice, Clinician: Individual; **Setting of Care**: Outpatient Services, Home Care; **Data Source**: Registry Data

This process measure, originally endorsed in 2014, intends to increase screening rates for unhealthy alcohol use using a systematic screening method and further to ensure those that screened positive receive brief counseling. The Standing Committee confirmed that the evidence base for the measure has not changed since the 2014 review and agreed to accept the previous vote on evidence. The Committee had no concerns with the updated score-level reliability and validity testing. Committee members noted concern about the absence of telehealth codes and the possibility of data not reflecting brief intervention encounters with nonbehavioral health providers who do not document screening activity in medical records. The measure is currently used in the Centers for Medicare and Medicaid's Physician Quality Reporting System (PQRS) and Merit-based Incentive Payment System (MIPS) programs. Overall, the Committee agreed that this is an important measure and voted to recommend it for continued endorsement.

Public comment regarding this measure addressed concerns about some relevant transactions (i.e., numerator events) being "hidden" in claims because they were not reimbursed by the payer, or because they were bundled with other services. One commenter also noticed that past testing revealed only a "fair" Kappa agreement statistic of 0.31 for the denominator data element.

3453 Continuity of Care After Inpatient or Residential Treatment for Substance Use Disorder (SUD) (Centers for Medicare & Medicaid Services): Endorsed

Description: Percentage of discharges from an inpatient or residential treatment facility for substance use disorder (SUD) for Medicaid beneficiaries, ages 18 to 64, which were followed by a treatment service for SUD; **Measure Type**: Process; **Level of Analysis**: Population: Regional and State; **Setting of Care**: Home Care, Inpatient/Hospital, Outpatient Services; **Data Source**: Claims

This new measure assesses whether patients discharged for SUD received an outpatient visit, intensive outpatient encounter, or partial hospitalization, telehealth encounter; filled a prescription; or were administered or ordered a medication for SUD (e.g., methadone, buprenorphine). The measure is sensitive to primary and secondary diagnoses. Follow-up services in the primary care setting are included in the numerator. Two rates are reported: continuity within 7 and 14 days after discharge. The Standing Committee affirmed that credible evidence indicates that continuity of care postdischarge is related to reductions in substance use, readmissions, criminal justice involvement, unemployment, and mortality.

The developer provided evidence that Medicaid-based performance on this measure is generally low and variable. The Standing Committee agreed that the score-level reliability and validity testing were appropriate and further that these results indicate that the measure can distinguish between high- and low-performing states. At least one Committee member expressed concern that the validity testing—dependent upon comparing the current measure to other similar process measures—was not persuasive regarding a quality-of-care connection. In response to this concern, the developer cited two studies[25, 26] that support the connectivity between this measure and reduced mortality and readmissions. Committee members had slight sensitivity concerns around not crediting certain same-day-as-discharge services, but generally agreed with the need for other contacts within days 1–14. This claims-based measure is intended to monitor and improve the quality of care for Medicaid beneficiaries with SUD, and the Committee recommended it for endorsement.

Public comment regarding this measure included the following supports or concerns about the measure: (1) Support was expressed for inclusion of telehealth generally and medication therapies for opioid use disorders, (2) Concern about the exclusion of peer supports or case management services, per se, as qualifying events, (3) Concern that the denominator is not sensitive to secondary diagnostic entries, and (4) Concern that because Medicaid benefits differ between states, interstate comparisons may lack full validity.

3451 Non-Acute Mental Health Services Utilization for Dual Eligible Beneficiaries (Centers for Medicare & Medicaid Services): Not Endorsed

Description: The percentage of dual eligible (Medicare/Medicaid) beneficiaries with a mental health service need who received a non-acute mental health service in the measurement year. **Measure Type**: Process; **Level of Analysis**: Health Plan; **Setting of Care**: Home Care, Outpatient Services, Post-Acute Care; **Data Source**: Claims

This new measure did not pass NQF's Evidence criterion and thus deliberations halted. Concerns regarding the Evidence were principally that the numerator and denominator definitions lacked either

reasonable sensitivity or specificity. Specifically, the Committee made three points: (1) The denominator may be overly sensitive to single prescription fills for substances such as anxiolytics, thereby potentially including some cases that do not warrant any other mental health service. (2) The numerator lacks desired sensitivity to primary care mental health services where the primary diagnosis on the claim is not a mental health indication. (3) The numerator will capture rendered mental health services even if the services are inappropriate in terms of duration/dose or diagnostic-treatment pairings. The developer acknowledged these concerns, but noted that the measure was designed to assess access to any mental health service, not the appropriateness of that care. In response the Committee expressed concern that such a limited definition of access may not correlate to quality care. Finally, regarding the measure's denominator definition, at least one Committee member expressed concern about the inclusion of dementia cases. In response to this concern, the developer commented that their dementia inclusion was rare and approved as relevant by their technical expert panel (TEP).

Public comment regarding this measure supported the need for measures like this one (which focused on dual Medicare/Medicaid population), but also supported the Committee's concern that this measure's numerator is not specific enough, i.e., it risks capturing services that are not evidence-based.

Measures Withdrawn from Consideration

Six measures previously endorsed by NQF have not been re-submitted for maintenance of endorsement or have been withdrawn during the endorsement evaluation process. Endorsement for these measures will be removed.

Table 3. Measures Withdrawn from Consideration

Measure	Reason for withdrawal
1651 TOB-1 Tobacco Use Screening	The developer withdrew this chart-based measure to align with CMS's goal of promoting eCQM use. The measure is being retooled as an eCQM.
1654 TOB-2 Tobacco Use Treatment Provided or Offered & TOB-2a Tobacco Use Treatment	The developer withdrew this chart-based measure to align with CMS's goal of promoting eCQM use. The measure is being retooled as an eCQM.
1656 TOB-3 Tobacco Use Treatment Provided or Offered at Discharge and TOB-3a Tobacco Use Treatment at Discharge	The developer withdrew this chart-based measure to align with CMS's goal of promoting eCQM use. The measure is being retooled as an eCQM.
1661 SUB-1 Alcohol Use Screening	The developer withdrew this chart-based measure to align with CMS's goal of promoting eCQM use. The measure is being retooled as an eCQM.
1663 SUB-2 Alcohol Use Brief Intervention Provided or Offered & SUB-2a Alcohol Use Brief Intervention	The developer withdrew this chart-based measure to align with CMS's goal of promoting eCQM use. The measure is being retooled as an eCQM.
1664 SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge & SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge	The developer withdrew this chart-based measure to align with CMS's goal of promoting eCQM use. The measure is being retooled as an eCQM.

References

1 Bose J, Hedden SI, Lipari RN, et al. Key Substance Use and Mental Health Indicators in the United States: Results from the 2017 National Survey on Drug Use and Health. Rockville, MD: SAMHSA; 2018:124. https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHFFR2017/NSDUHFFR2017.pdf.

2 Kamal R. What are the current costs and outcomes related to mental health and substance abuse disorders? Peterson-Kaiser Health System Tracker. https://www.healthsystemtracker.org/chart-collection/current-costs-outcomes-related-mental-health-substance-abuse-disorders/. Published July 31, 2017. Last accessed February 2019.

3 Scholl L, Seth P, Kariisa M, et al. Drug and opioid-involved overdose deaths — United States, 2013-2017. 2019;67:9.

4 CDC. More than a mental health problem. Centers for Disease Control and Prevention. https://www.cdc.gov/vitalsigns/suicide/index.html. Published November 27, 2018. Last accessed March 2019.

5 National Institute on Alcohol Abuse and Alcoholism. Alcohol Facts and Statistics. https://www.niaaa.nih.gov/alcohol-health/overview-alcohol-consumption/alcohol-facts-and-statistics. Published August 2018. Last accessed March 2019.

6 Roberts LW, Louie AK, Guerrero APS, et al. Premature mortality among people with mental illness: advocacy in academic psychiatry. Acad Psychiatry. 2017;41(4):441-446.

7 Druss BG, Zhao L, Von Esenwein S, et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Med Care. 2011;49(6):599-604.

8 Hunot V, Churchill R, Teixeira V, et al. Psychological therapies for generalised anxiety disorder. Cochrane Database Syst Rev. 2007;(1). https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD001848.pub4/abstract. Last accessed February 2019.

9 Mattick RP, Breen C, Kimber J, et al. Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence. Cochrane Drugs and Alcohol Group, ed. Cochrane Database Syst Rev. February 2014. http://doi.wiley.com/10.1002/14651858.CD002207.pub4. Last accessed March 2019.

10 Burgess SS, Geddes J, Hawton KK, et al. Lithium for maintenance treatment of mood disorders. Cochrane Database Syst Rev. 2001;(3). https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD003013/abstract. Last accessed March 2019.

11 Subramanian S, Völlm BA, Huband N. Clozapine dose for schizophrenia. Cochrane Schizophrenia Group, ed. Cochrane Database Syst Rev. June 2017. http://doi.wiley.com/10.1002/14651858.CD009555.pub2. Last accessed March 2019.

12 Hartung B, Wada M, Laux G, et al. Perphenazine for schizophrenia. Cochrane Database Syst Rev. 2005;(1). https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD003443.pub2/abstract. Last accessed March 2019.

13 Arroll B, Elley CR, Fishman T, et al. Antidepressants versus placebo for depression in primary care. Cochrane Database Syst Rev. 2009;(3):CD007954.

14 Dennis C-L. Psychosocial and psychological interventions for prevention of postnatal depression: systematic review. BMJ. 2005;331(7507):15.

15 Archer J, Bower P, Gilbody S, et al. Collaborative care for depression and anxiety problems. Cochrane Database Syst Rev. 2012;(10). https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD006525.pub2/abstract. Last accessed March 2019.

16 MentalHealth.gov. Mental Health Myths and Facts. https://www.mentalhealth.gov/basics/mental-health-myths-facts. Published August 9, 2017. Last accessed March 2019.

17 Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders. Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press; 2006. http://www.ncbi.nlm.nih.gov/books/NBK19830/. Last accessed March 2019.

18 Schaefer JA, Ingudomnukul E, Harris AHS, et al. Continuity of care practices and substance use disorder patients' engagement in continuing care. Med Care. 2005;43(12):1234-1241.

19 Duckworth K, Hosking R, Brister T, et al. Advancing discovery for new, better treatments. February 2019. https://www.nami.org/About-NAMI/NAMI-News/2019/Advancing-Discovery-for-New-Better-Treatments. Last accessed March 2019.

20 Tanenbaum SJ. Evidence-based practice as mental health policy: three controversies and a caveat. Health Aff Millwood. 2005;24(1):163-173.

21 Weil AR. Behavioral health. Health Aff Millwood. 2016;35(6):955-955.

22 Whitaker R. Anatomy of an Epidemic. New York: Crown Publishing Group; 2010. https://www.penguinrandomhouse.com/books/189611/anatomy-of-an-epidemic-by-robert-whitaker/9780307452429. Last accessed March 2019.

23 Pincus HA, Li M, Scharf DM, et al. Prioritizing quality measure concepts at the interface of behavioral and physical healthcare. Int J Qual Health Care. 2017;29(4):557-563.

24 Goldman ML, Spaeth-Rublee B, Pincus HA. The case for severe mental illness as a disparities category. Psychiatr Serv. 2018;69(6):726-728.

25 Harris AHS, Gupta S, Bowe T, et al. Predictive validity of two process-of-care quality measures for residential substance use disorder treatment. Addict Sci Clin Pract. 2015;10:22.

26 Reif S, Acevedo A, Garnick DW, et al. Reducing behavioral health inpatient readmissions for people with substance use disorders: do follow-up services matter? Psychiatr Serv. 2017;68(8):810-818.

Appendix A: Details of Measure Evaluation

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

Measures Endorsed

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

Submission | Specifications

Description: 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.

Numerator Statement: 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.

Denominator Statement: 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).

Exclusions: 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.

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: Health Plan

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

Type of Measure: Process

Data Source: Claims

Measure Steward: National Committee for Quality Assurance

STANDING COMMITTEE MEETING 1/31/2019

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

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

1a. Evidence: **H-7**; **M-11**; **L-0**; **I-0**; 1b. Performance Gap: **H-10**; **M-8**; **L-0**; **I-0**

Rationale:

- The measure developer submitted updated evidence that includes pharmacotherapy as an appropriate treatment modality for those with opioid and alcohol use disorders.
- The measure developer updated the measure to include Medication-assisted treatment (MAT) and evidence-based telehealth services to deliver psychosocial treatment and added diagnosis codification (e.g., separately specified alcohol, opioid, or other drug abuse or dependence and appropriate pharmacotherapy).
- Overall, the Committee agreed that the evidence submitted enhanced the submission from the last measure maintenance review in 2012.
- Standing Committee members expressed concern that disparities were evident by insurance type (an optional stratification criteria per the developer), but such determinants were otherwise not sufficiently considered in regards to other social determinants such as race and ethnicity.

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

Rationale:

- The measure developer conducted performance measure score reliability testing using a beta-binomial model (Adams 2009).
- The measure developer extended the engagement of the AOD treatment time frame from 30 to 34 days, thereby increasing sensitivity of the numerator for "engagement" to just outside of 1 month after the pathology is detected.
- The Standing Committee noted concern about not being able to determine if individuals were receiving both medication and counselling when such multimodal treatment is likely indicated.
- At least one Committee member suggested "woodwork penalties" may emerge for entities that screen aggressively, whereas a second member noted that empirical studies actually demonstrate that higher initiation and engagement rates positively correlate with higher screening rates. This was a risk-benefit concern, but it did not prevent support for the measure's testing.

3. Feasibility: H-10; M-7; 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:

- Overall, the Committee agreed that this measure is feasible.
- All data elements are electronically available.

- At least one Committee member commented that incentives for providers may be necessary to ensure encounters pertinent to this measure are documented. However, this concern did not impede the progress of this measure passing the feasibility criterion.

---

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: **Pass-18; No Pass-0** *4b. Usability:* **H-4; M-13; L-1; I-0**

Rationale:

- This measure is currently in use in quality improvement and public reporting programs.
- One public commenter said the measure may be limited because it omits codes for multiple ASAM residential treatment levels of care. The developer was asked about the inclusion of residential treatment codes specifically and confirmed that they were included. Certainty about the completeness of that residential treatment list; however, was not confirmed during the meeting.

---

5. Related and Competing Measures

There are no competing measures. The following measures are related:

- #2599: Alcohol Screening and Follow-up for People with Serious Mental Illness (NCQA)
- #3312: Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs (CMS)
- #3605: Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence (NCQA)
- #2152: Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling (PCPI)

---

6. Standing Committee Recommendation for Endorsement: **Y-18**; **N-0**

---

7. Public and Member Comment

- One comment was received during the pre-commenting period. The commenter shared support for the measure, but noted a limitation in that it excludes multiple ASAM residential treatment levels of care. The commenter suggested this observation be considered during the next update to the measure.

The following comments were received after the Committee's evaluation:

- One commenter echoed Committee concern that the follow-up period of this measure was extended from 30 to 34 days and more generally that follow-up periods for this sort of measure can be 7, 14, 30 or 34. In response the developer stated that the additional days served to make the numerator of the measure sensitive to two practicalities: a)Pharmacy refills for a presumed 30 day supply which might be delayed slightly, and b) Lags in claims processing/reporting.

- A comment pursuant this measure encouraged the adoption the terminology "substance use disorder" instead of "substance abuse and dependence." The rational for this nomenclature change is to keep in line with the change that occurred several years ago in the Diagnostic Statistic Manual (DSM) when it evolved from DSM-IV to DSM-5. That change included combining abuse and dependence into one criteria, with slightly altered thresholds and with changes in the specific criteria that de-emphasized criminal justice involvement and added "craving", per se, as a symptom of interest (Hasin DS et al., *AJP*, 2013, pub number: 12060782). The Committee agreed with this lexicon suggestion.
- One commenter expressed concern that persons refusing treatment would simply be lost from the denominator of this measure. In response the developer noted only that they were limited by the claims data. The Committee generally accepted this argument, but was also sympathetic to the commenter and in the future hoped for measure that would account for such lost-to-follow-up issues.
- A commenter supported the new addition of telehealth codes as qualifying numerator events. Both the Committee and the commenter agree that telehealth should represent reimbursable and bona fide follow-up services for persons with alcohol and other drug treatment needs.
- One commenter expressed concern that claims typically are created too slowly to be used as a referral tool to follow-up services.
- NQF received a comment expressing concern that this measure may not be sufficiently sensitive to medication assisted therapy (MAT) (e.g., methadone, buprenorphine) for opioid use because such codes alone (absent other psychotherapy codes) were not classified as sufficient for numerator inclusion. In response the developer indicated that the psychotherapy code requirement was in line with existing guidelines, though they would keep track of those guidelines if they changed towards MAT alone. During the Committee discussion; however, it was determined that the current specifications of the measure actually do not require the psychotherapy codes, so MAT alone is permissible as a numerator event.

---

8. Consensus Standards Approval Committee: (June 10, 2019)

- CSAC Review: **Y-14; N-0**
- CSAC Decision: **Approved for continued endorsement**

---

9. Appeals:

- No appeals were received.

2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

Submission | Specifications

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

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

Denominator Statement: All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period

Exclusions: Documentation of medical reason(s) for not screening for unhealthy alcohol use (e.g., limited life expectancy, other medical reasons)

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: Clinician : Group/Practice, Clinician : Individual

Setting of Care: Home Care, Outpatient Services

Type of Measure: Process

Data Source: Registry Data

Measure Steward: PCPI Foundation

STANDING COMMITTEE MEETING [01/30/2019]

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

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

1a. Evidence: **Previous Evidence Evaluation Accepted**; 1b. Performance Gap: H-9; M-9; L-0; I-0;

Rationale:

- The Standing Committee agreed that the evidence base for the measure has not changed and consented to the previous vote on evidence.
- The measure developer provided performance data from the CMS Physician Quality Reporting System (PQRS) from 2012 through 2015 (data for those patients only receiving screening for unhealthy alcohol use). Additionally, the developer included the 2016 rate, 68.7% (this rate includes screening and brief intervention).
- The Committee agreed that the performance gap continues to be significant in all populations presented. One Committee member noted that this measure remains valuable because it continues to encourage primary care providers to screen for alcohol misuse and perform brief intervention as necessary.
- The measure developer was not able to provide updated disparities data as the reporting programs have not yet made these data available. The developer, however, was able to identify studies that demonstrate variation in risk for alcohol use disorder and prevalence of screening based on racial, ethnic, and educational differences.

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

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

2a. Reliability: H-3; M-12; L-3; I-0; 2b. Validity: H-3; M-11; L-3; I-0

<u>Rationale</u>:

- The developer provided updated measure score reliability testing using 2016 PQRS registry data. A beta-binominal model was used to assess the signal-to-noise ratio. The results of the reliability test, 0.99 using Adams' R calculation, indicated that variability between providers is in excess of variability within providers.
- The developer provided updated measure score validity testing by conducting a correlation analysis with two measures: Preventive Care and Screening: Screening for High Blood Pressure and Follow-up (PQRS #317) and Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan (PQRS #134). The results indicate a positive correlation with the two evidence-based process of care measures focused on preventive care services noted:
    - Preventive Care and Screening: Screening for High Blood Pressure and Follow-up has a moderate positive correlation (0.29)
    - Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan has a strong positive correlation (0.61).
- The Standing Committee had no concerns with the updated reliability and validity testing.
- Several Committee members commented on the measure's inability to capture all the ways in which counseling may occur, including telehealth and/or counseling provided by medical professionals located in the same facility, but employed by different organizations. The developer does not presently include telehealth encounters within the specifications.

3. Feasibility: H-3; M-12; 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)

<u>Rationale</u>:

- The Standing Committee agreed the measure is feasible for implementation. Some data elements are in defined fields in electronic sources. The developer notes that this measure's data can be pulled from EHRs and use claims data in PQRS.

4. Usability and Use: <u>The maintenance measure meets the Use subcriterion</u>

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

4a. Use**:** Pass-15; No Pass-2; 4b. Usability: H-3; M-15; L-1; I-0

<u>Rationale</u>:

- The measure is publicly reported and used in the Merit Based Incentive Payment System (MIPS) program. Prior to 2016, the measure was used in the PQRS. 2018 data will be available for public reporting on Physician Compare in late 2019.

5. Related and Competing Measures

- There are no competing measures. The following measures are related:
    - #2599: Alcohol Screening and Follow-Up for People with Serious Mental Illness (NCQA)
    - #1661: SUB-1 Alcohol Use Screening (TJC) (lost endorsement in 2018)
    - #1663: SUB-2 Alcohol Use Brief Intervention Provided or Offered and SUB 2a Alcohol Use Brief Intervention (TJC) (lost endorsement in 2018)
- These measures are currently harmonized to the extent possible.

6. Standing Committee Recommendation for Endorsement: Yes-16; **No-2**

7. Public and Member Comment

- A commenter noted concerns that administrative claims may not contain records of brief interventions and other services-of-interest to this measure, i.e., this was a concern about the measure's sensitivity to all numerator events, some of which might be unbilled or "hidden" in bundled transactions. At least one Committee member expressed rivaling concerns that such "hidden" encounters often do not reflect substantial therapeutic efforts (e.g., good quality care in terms of intensity and duration). Accordingly, the Committee agreed that in future versions of this sort of measure, the numerator definitions especially should be created to account both for sensitivity and specificity concerns.
- A comment expressed concern regarding a low data-element reliability coefficient demonstrating only "fair" reproducibility of the denominator: *Kappa*=.31. In response the developer noted that coefficient corresponding to test-retest percent agreement which was more than reasonable (87%), that it is well known that the Cohen's Kappa is stringent when chance agreement is high, and mostly importantly, that their recent testing with Adam-R statistics (score-level) any ways was exceptionally high (0.98) demonstrating reproducibility of the inter-entity differences was substantial and in accordance with NQF quality testing criteria. The Committee did not take exception to this response by the developer

8. Consensus Standards Approval Committee: (June 10, 2019)

- CSAC Review: **Y-14; N-0**
- CSAC Decision: **Approved for continued endorsement**

9. Appeals:

- No appeals were received.

3453 Continuity of care after inpatient or residential treatment for substance use disorder (SUD)

Submission | Specifications

Description: Percentage of discharges from an inpatient or residential treatment for substance use disorder (SUD) for Medicaid beneficiaries, ages 18 to 64, which was followed by a treatment service for SUD. SUD treatment includes having an outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth encounter, or filling a prescription or being 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 Statement: 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.

Denominator Statement: 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.

Exclusions: 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.

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: Population : Regional and State

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

Type of Measure: Process

Data Source: Claims

Measure Steward: Centers for Medicare & Medicaid Services, Centers for Medicaid & CHIP Services

STANDING COMMITTEE MEETING 1/31/2019

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

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

1a. Evidence: **M-16**; **L-2**; **I-0**; 1b. Performance Gap: **H-10**; **M-7**; **L-0**; **I-0**

Rationale:

- This measure is based on evidence from review articles as well as additional studies that indicate continuity of care for SUD–defined differently in the literature–is linked to improved 2-year mortality, reduced hospital readmissions and criminal justice activity, sustained treatment, and improved employment status.
- The Committee agreed that both literature and the analysis of Medicaid data (7-day rate average across 13 states: 18.4%; 14-day rate: 24.2%) indicate there is generally low performance with variation by state.
- There were also differences in rates by subgroups, including higher continuity rates for those in rural areas. The developer suggests this may be related to intensified discharge planning because of long distances between the inpatient facility and the patient's home. The Committee encouraged the developer to further explore differences between rural and urban populations and examine the distribution of types of follow-up services used in rural versus urban areas.

---

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

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

2a. Reliability: **H-3**; **M-14**; **L-0**; **I-0** 2b. Validity: **H-5**; **M-11**; **L-1**; **I-0**

<u>Rationale</u>:

- The developer used 2014 Medicaid Analytic Extract data to conduct measure score reliability testing. A beta-binominal model was used to assess the signal-to-noise ratio. Adams' R values were >=0.9 across states for both the 7- and 14-day rates.
- To test convergent validity, performance on this measure was compared to measures #3312 *Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs* and
- *#0576 Follow-Up After Hospitalization for Mental Illness (FUH).* Spearman rank correlation results indicated moderate, positive, but not significant correlations between the measure and the two external measures. A technical expert panel (TEP) strongly supported the measure's validity, but two members only strongly supported the 7-day rate since they believed follow-up should occur within 7 days.
- The Committee discussed the time period in which follow-up services should be performed. The developer shared that same-day services only count for the pharmacotherapy, which aligns with similar measures.
- The developer acknowledged the following are included in the measure: case management visits if the client was directly included, only discharges with SUD as a primary or principle diagnosis (for inclusion in the denominator), and follow-up services in the primary care setting.
- The developer stated that self-help services (e.g., Alcoholics Anonymous) are not included in the measure since even with that type of care, in-parallel medical care would also be indicated.
- One Committee member commented that excluding those who relapse to inpatient care suggests the burden falls on the patient when, perhaps, the health system could have bettered prepared the patient before leaving inpatient or residential treatment. Sensitivity testing of the inpatient relapse exclusion from the denominator of this measure was deemed by the developer to be a rare event that did not appreciably change the results. The developer also responded that these patients are excluded since relapses to inpatient care could be related to the initial care received in hospital, care provided after discharge, or individual factors/social determinants of health.

- There was concern that judging validity based on correlation with another measure, though an accepted and widely-used method, is not the best way to determine validity.
- Overall, the Committee agreed the measure is valid, citing evidence in the literature linking continuity of care to improved mortality and improved outcomes.

---

3. Feasibility: H-10; M-8; 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:

- This claims-based measure is feasible to implement as users have successfully implemented similarly structured measures.

---

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: **Pass-18; No Pass-0** *4b. Usability:* **H-6; M-12; L-0; I-0**

Rationale:

- This new measure is intended for use by states to improve care for Medicaid recipients with SUD.
- Testing indicated low performance rates, and the Committee agreed the measure's benefits outweigh potential unintended consequences related to organizations finding care quickly or refusing clients that are higher risk or harder to place.

---

5. Related and Competing Measures

- There are no directly competing measures. The following measures are related:
    - #0004: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment
    - #0576: Follow-Up After Hospitalization for Mental Illness (FUH)
    - #2605: Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence
    - #3312: Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs
- Parts of the specifications for the proposed measure harmonize with some measures but not others.
    - The developer examined similarities and differences in timing of continuity of care, population, diagnosis (i.e., primary versus secondary diagnosis), services, and practitioner allowed to provide follow-up in the numerator and diagnosis and age in the denominator.
- The Committee approved the specifications used in the measure, but was interested in additional alignment and standardization of elements in all continuity of care measures.

6. Standing Committee Recommendation for Endorsement: **Y-18**; **N-0**

7. Public and Member Comment

- Similar to measure 0004, one commenter expressed support for the new inclusion of telehealth codes as qualifying services for this measure's numerator. Support was further expressed for inclusion of medication assisted treatment (e.g., methadone, buprenorphine) for opioid use disorder.
- One comment expressed concern that this measure did not include peer supports or case management services as qualifying events in the numerator. The developer responded by stating that presently their reading of the evidence-base literature did not support these sort of services (especially peer supports), per se, as standard of care for persons discharged from inpatient/residential care for SUD. The developer did note that in future iterations of the measure they would consider if their numerator definition should be expanded to include peer supports or case management services alone. The Committee generally agreed with the developer's assessment in that regard.
- One comment expressed concerned that the denominator inclusion criteria for this measure was sensitive only to primary rather than higher order (second, third, etc.) diagnoses recorded in the medical record. In response the developer acknowledged this 'sensitivity to cases' limitation, but further noted that for the numerator secondary or higher order (confirmed by the develop on the conference call) diagnoses were considered. As such it can be said that this measure has somewhat limited case/disease sensitivity, but more liberal treatment sensitivity. In follow-up discussion the Committee did not express major concern about these sensitivity/specificity issues.
- One commenter noted that this measure is limited because Medicaid claims especially reflect potentially difference benefits packages (i.e., different paid-for services) in each state. The Committee cautioned interstate comparisons absent consideration of different state Medicaid regulations. However, the Committee did not change their recommendation of the measure.

8. Consensus Standards Approval Committee: (June 10, 2019)

- CSAC Review: **Y-14; N-0**
- CSAC Decision: **Approved for endorsement**

9. Appeals:

- No appeals were received.

Measure Not Endorsed

3451 Non-Acute Mental Health Services Utilization for Dual Eligible Beneficiaries

Submission

Description: The percentage of dual eligible beneficiaries with a mental health service need who received a non-acute mental health service in the measurement year.

Numerator Statement: The number of dual eligible beneficiaries receiving at least one non-acute mental health service in the 12-month measurement year. The following services are included as non-acute mental health services:

- Outpatient service with a mental health provider for a mental health diagnosis
- Mental health outpatient encounter
- Mental health condition management in primary care

Denominator Statement: The number of dual eligible beneficiaries age 21 and older with a mental health service need in the 18-month identification window (the 12-month measurement year plus six months prior to the measurement year).

Exclusions: None

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: Health Plan

Setting of Care: Home Care, Outpatient Services, Post-Acute Care

Type of Measure: Process

Data Source: Claims

Measure Steward: Centers for Medicare & Medicaid Services

STANDING COMMITTEE MEETING 01/30/2019

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

1a. Evidence: **M-7**; **L-8**; **I-4** 1b. Performance Gap: **N/A**

Rationale:

- The developer stated that the measure is not intended to assess the adequacy or intensity of the services or treatment, but rather aims to tabulate a 'low-bar' indicator for mental health service access. This explanation left the Committee concerned about the indicator's validity as a quality of care measure.
- The Committee was concerned about the sensitivity and specificity of both the numerator and denominator. Several of those concerns are listed here:
    - Numerator events were counted irrespective of their treatment appropriateness or duration.
    - The numerator excluded primary care visits if the claim entry had the mental health diagnosis in a secondary position. At least one Committee member noted that individuals visiting primary care settings often have multiple diagnoses entered in their claims record, and the order of those entries may not reflect issue urgency.
    - The denominator may be overly sensitive (e.g., a single anti-anxiety medication prescription may flag someone with a treatable mental illness who only has a very acute

adjustment problem). The Committee thus encouraged the developer to consider narrowing the denominator specifications.
    - The Committee expressed concern about including some dementia cases in the measure denominator. The developer commented that their empirical data showing such diagnoses are rare relative to their total population of interest and a technical expert panel (TEP) supported the measure's face validity. Still, the Committee remained concern about this diagnostic inclusion.
- The Committee agreed that lack of access to mental health services is a major issue for the dual-eligible population, but they ultimately decided to reject the measure because of the concerns summarized above.
- After the failed vote on evidence, the Committee offered the developer brief advice towards the measure's re-submission. That advice included the suggestion that a future submission should better describe why California and Rhode Island data is not suitable to test their measure.

---

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

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

2a. Reliability: **N/A** 2b. Validity: **N/A**

---

3. Feasibility: N/A

(3a. Data generated during care; 3b. Electronic sources; and 3c. Data collection can be implemented (eMeasure feasibility assessment of data elements and logic)

---

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: **N/A** *4b. Usability:* **N/A**

---

5. Related and Competing Measures

- This measure is related to NQF #0576: Follow-Up After Hospitalization for Mental Illness (FUH).

---

6. **Standing Committee Recommendation for Endorsement: N/A**

---

7. Public and Member Comment

- All comments expressed support for the need for more Medicare/Medicaid dual relevant measures (this idea is expressed in the "gaps" section of this report). All comments also echoed the Committee's stated concern that the current measure is not specific enough regarding numerator and denominator definitions to well capture appropriate clients for intervention and appropriate treatment/indication pairings for inclusion in the denominator. In response, the developer acknowledged these concerns, but also noted the intent of the measure was purely to measure access to services, not deployment of evidence-based treatment responses more

directly. The specific responses from the developer appear below. These responses did not trigger the Committee to re-consider their vote 'not to recommend' this measure in its current form.

The measure developer provided the following responses to the comments:

- Thank you for your comment. We agree that the measure lacks specificity, but note that this is by design to support the measure's intent to provide a metric of access to non-acute mental health services for individuals with a mental health need. During the development of the measure, we received feedback through a public comment period, expert work group meeting, and a technical expert panel meeting that a broad definition of mental health need was most appropriate for a measure intended to capture access to non-acute mental health services. We also received feedback from a technical expert panel that limiting the measure to capture only those mental health encounters where a mental health condition was listed as the primary diagnosis was an appropriate restriction on the sensitivity of the measure. This is because the measure is intended to capture only those encounters in which a mental health condition is actually treated. Reports from the field indicate that many providers use secondary or tertiary diagnosis fields to capture conditions that are present during an encounter but were not necessarily treated during that encounter.
- Thank you for your comment. In reviewing the evidence for the measure concept, we found numerous studies that demonstrate a significant proximal link between access to and use of non-acute mental health services for individuals with a mental health service need with increase quality of life, as well as a reduction in negative outcomes such as homelessness, hospitalization, incarceration, and episodes of violence. Please note that the measure is not intended to assess the appropriateness, adequacy, or intensity of care, but rather whether beneficiaries with mental health needs have access to non-acute mental health services. Our testing results and the review of the evidence indicate that there is a substantial gap in such access, which leave many individuals in the measure population at increased risk for negative consequences related to non-treatment of mental health conditions.

---

8. Consensus Standards Approval Committee: (June 10, 2019)

- CSAC Review: **Y-14; N-0**
- CSAC Decision: **Not Approved 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 May 01, 2019
0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Merit-based Incentive Payment System (MIPS) (Finalized 2016) Qualified Health Plan (QHP) Quality Rating System (QRS) (Implemented 2015)
0004e	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (eMeasure)	Merit-based Incentive Payment System (MIPS) (Finalized 2018)
0027	Medical Assistance With Smoking and Tobacco Use Cessation	Medicaid (Implemented 2018) Qualified Health Plan (QHP) Quality Rating System (QRS) (Implemented 2016)
0028	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	Merit-based Incentive Payment System (MIPS) (Finalized 2016) Medicare Shared Savings Program (MSSP) (Implemented 2012)
0028e	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (eMeasure)	Merit-based Incentive Payment System (MIPS) (Implemented 2018) Million Hearts (Implemented 2018)
0104	Adult Major Depressive Disorder: Suicide Risk Assessment	Merit-based Incentive Payment System (MIPS) (Implemented 2016)
0104e	Adult Major Depressive Disorder: Suicide Risk Assessment (eMeasure)	Merit-based Incentive Payment System (MIPS) (Implemented 2018)
0105	Antidepressant Medication Management (AMM)	Merit-based Incentive Payment System (MIPS) (Finalized 2016) Qualified Health Plan (QHP) Quality Rating System (QRS) (Implemented 2016) Medicaid (Implemented 2013)
0105e	Antidepressant Medication Management (AMM) (eMeasure)	Merit-based Incentive Payment System (MIPS) (Implemented 2018)
0108	Follow-Up Care for Children Prescribed ADHD Medication (ADD)	Merit-based Incentive Payment System (MIPS) (Implemented 2018)
0108	Follow-Up Care for Children Prescribed ADHD Medication (ADD) (eMeasure)	Merit-based Incentive Payment System (MIPS) (Implemented 2018)
0418	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Medicaid (Implemented 2018)

[a] Per CMS Measures Inventory Tool as of 02/27/2019

NQF #	Title	Federal Programs: Finalized or Implemented as of May 01, 2019
0418e	Preventive Care and Screening: Screening for Depression and Follow-Up Plan (eMeasure)	Merit-based Incentive Payment System (MIPS) (Implemented 2018)
0560	HBIPS-5 Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification	Hospital Compare (Implemented 2013) Inpatient Psychiatric Quality Reporting (Implemented 2013)
0576	Follow-Up After Hospitalization for Mental Illness (FUH)	Merit-based Incentive Payment System (MIPS) (Finalized 2016) Hospital Compare (Implemented 2015) Inpatient Psychiatric Facility Quality Reporting (Implemented 2015) Qualified Health Plan (QHP) Quality Rating System (QRS) (Implemented 2015) 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 Twelve Months (eMeasure)	Merit-based Incentive Payment System (MIPS) (Implemented 2018)
0711	Depression Remission at Six Months	Merit-Based Incentive Payment System (MIPS) Program (Finalized 2016)
0712e	Depression Utilization of the PHQ-9 Tool (eMeasure)	Merit-based Incentive Payment System (MIPS) (Implemented 2018)
1365	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment	Merit-based Incentive Payment System (MIPS) (Finalized 2016)
1365e	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment (eMeasure)	Merit-based Incentive Payment System (MIPS) (Implemented 2018)
1651	TOB-1 Tobacco Use Screening	Hospital Compare (Implemented 2016) Inpatient Psychiatric Facility Quality Reporting (Implemented 2016; to be removed 2019)
1654	TOB - 2 Tobacco Use Treatment Provided or Offered and the subset measure TOB-2a Tobacco Use Treatment	Hospital Compare (Implemented 2016) Inpatient Psychiatric Hospital Facility Reporting (Implemented 2016)

NQF #	Title	Federal Programs: Finalized or Implemented as of May 01, 2019
1656	TOB-3 Tobacco Use Treatment Provided or Offered at Discharge and the subset measure TOB-3a Tobacco Use Treatment at Discharge	Hospital Compare (Implemented 2017) Inpatient Psychiatric Hospital Facility Reporting (Implemented 2017)
1661	SUB-1 Alcohol Use Screening	Hospital Compare (Implemented 2015) Inpatient Psychiatric Facility Quality Reporting (Implemented 2015; to be removed 2019)
1663	SUB-2 Alcohol Use Brief Intervention Provided or Offered and SUB-2a Alcohol Use Brief Intervention	Hospital Compare (Implemented 2017) Inpatient Psychiatric Facility Quality Reporting (Implemented 2017)
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	Inpatient Psychiatric Facility Quality Reporting (Implemented 2017)
1879	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Merit-based Incentive Payment System (MIPS) (Finalized 2013) Medicaid (Implemented 2018)
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	Merit-based Incentive Payment System (MIPS) (Finalized 2016)
2605	Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence	Medicaid (Implemented 2018)
2607	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	Medicaid (Implemented 2017)

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

STANDING COMMITTEE

Peter Briss, MD, MPH (Co-chair)
Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion
Chamblee, Georgia

Harold Pincus, MD (Co-chair)
New York-Presbyterian Hospital, The University Hospital of Columbia and Cornell
New York, New York

Mady Chalk, PhD, MSW
The Chalk Group
Washington, District of Columbia

David Einzig, MD
Children's Hospital And Clinics Of Minnesota
Saint Paul, Minnesota

Julie Goldstein Grumet, PhD
Education Development Center/Suicide Prevention Resource Center/National Action Alliance for Suicide Prevention
Washington, District of Columbia

Constance Horgan, ScD
The Heller School for Social Policy and Management, Brandeis University
Waltham, Massachusetts

Lisa Jensen, DNP, APRN
Office of Nursing Services, Veteran's Health Administration
North Salt Lake, Utah

Dolores (Dodi) Kelleher, MS, DMH
D Kelleher Consulting
Alameda, California

Kraig Knudsen, PhD
Ohio Department of Mental Health and Addiction Services
Columbus, Ohio

Michael R. Lardieri, LCSW
Northwell Health, Behavioral Health Services Line
Glen Oaks, New York

Tami Mark, PhD, MBA
RTI International
Bethesda, Maryland

Raquel Mazon Jeffers, MPH, MIA
The Nicholson Foundation
Hopewell, New Jersey

Bernadette Melnyk, PhD, RN, CPNP/FAANP, FNAP, FAAN
The Ohio State University
Columbus, Ohio

Laurence Miller, MD
University of Arkansas for Medical Sciences
Little Rock, Arkansas

Brooke Parish, MD
Blue Cross Blue Shield of New Mexico
Albuquerque, New Mexico

David Pating, MD
Kaiser Permanente
San Francisco, California

Vanita Pindolia, PharmD, MBA
Henry Ford Health System
Detroit, Michigan

Lisa Shea, MD, DFAPA
Lifespan
Providence, Rhode Island

Andrew Sperling, JD
National Alliance on Mental Illness
Arlington, Virginia

Jeffery Susman, MD
Northeast Ohio Medical University
Rootstown, Ohio

Michael Trangle, MD
HealthPartners Medical Group
Minnetonka, Minnesota

Bonnie Zima, MD, MPH
University of California, Los Angeles (UCLA) Semel Institute for Neuroscience and Human Behavior
Los Angeles, California

Leslie S. Zun, MD, MBA
Sinai Health System
Chicago, Illinois

NQF STAFF

Elisa Munthali, MPH
Senior Vice President, Quality Measurement

Michael Abrams, MPH, PhD
Senior Director

Nicolette Mehas, PharmD
Director

Shaconna Gorham, MS, PMP
Senior Project Manager

Desmirra Quinnonez
Project Analyst

Appendix D: Measure Specifications

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

STEWARD

National Committee for Quality Assurance

DESCRIPTION

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.

TYPE

Process

DATA SOURCE

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).

LEVEL

Health Plan

SETTING

Emergency Department and Services, Inpatient/Hospital, Outpatient Services

NUMERATOR STATEMENT

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.

NUMERATOR DETAILS

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.

DENOMINATOR STATEMENT

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).

DENOMINATOR DETAILS

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.

EXCLUSIONS

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.

EXCLUSION DETAILS

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.

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

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.

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

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.

2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

STEWARD

PCPI Foundation

DESCRIPTION

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

TYPE

Process

DATA SOURCE

Registry Data Not applicable.

LEVEL

Clinician : Group/Practice, Clinician : Individual

SETTING

Home Care, Outpatient Services

NUMERATOR STATEMENT

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

NUMERATOR DETAILS

Time Period for Data Collection: At least once during the 24 month period.

Definitions:

Systematic screening method - For purposes of this measure, one of the following systematic methods to assess unhealthy alcohol use must be utilized. Systematic screening methods and thresholds for defining unhealthy alcohol use include:

- AUDIT Screening Instrument (score >= 8)
- AUDIT-C Screening Instrument (score >= 4 for men; score >= 3 for women)
- Single Question Screening - How many times in the past year have you had 5 (for men) or 4 (for women and all adults older than 65 years) or more drinks in a day? (response >= 2)

Brief counseling - Brief counseling for unhealthy alcohol use refers to one or more counseling sessions, a minimum of 5-15 minutes, which may include: feedback on alcohol use and harms; identification of high risk situations for drinking and coping strategies; increased motivation and the development of a personal plan to reduce drinking.

NUMERATOR NOTE: In the event that a patient is screened for unhealthy alcohol use and identified as a user but did not receive brief alcohol cessation counseling submit G9624.

For Registry:

Report Quality Data Code:

G9621 - Patient identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method and received brief counseling

OR

G9622 - Patient not identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method

DENOMINATOR STATEMENT

All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period

DENOMINATOR DETAILS

Time Period for Data Collection: 12 consecutive months

For Registry:

Patients aged >= 18 years

AND

At least two patient encounters during the performance period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 90845, 96150, 96151, 96152, 97165, 97166, 97167, 97168, 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0270, G0271

WITHOUT

Telehealth Modifier: GQ, GT, 95, POS 2

OR

At Least One Preventive Visit during the performance period (CPT or HCPCS): 99385, 99386, 99387, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99429, G0438, G0439

WITHOUT

Telehealth Modifier: GQ, GT, 95, POS 02

EXCLUSIONS

Documentation of medical reason(s) for not screening for unhealthy alcohol use (eg, limited life expectancy, other medical reasons)

EXCLUSION DETAILS

Time Period for Data Collection: Denominator Exception(s) are determined on the date of the most recent denominator eligible encounter.

Exceptions are used to remove a patient from the denominator of a performance measure when the patient does not receive a therapy or service AND that therapy or service would not be appropriate due to patient-specific reasons. The patient would otherwise meet the denominator criteria. Exceptions are not absolute, and are based on clinical judgment, individual patient characteristics, or patient preferences. The PCPI exception methodology uses three categories of reasons for which a patient may be removed from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For measure Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling, exceptions may include medical reason(s) (eg, limited life expectancy, other medical reasons). Although this

methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement.

For Registry:

Report Quality Data Code:

G9623 - Documentation of medical reason(s) for not screening for unhealthy alcohol use (e.g., limited life expectancy, other medical reasons)

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

Consistent with CMS' Measures Management System Blueprint and recent national recommendations put forth by the IOM and NQF, the PCPI encourages the collection of race and ethnicity data as well as the results of this measure to be stratified by race, ethnicity, administrative sex, and payer.

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

To calculate performance rates:

1. Find the patients who meet the initial population (ie, the general group of patients that a set of performance measures is designed to address).

2. From the patients within the initial population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial population and denominator are identical.

3. From the patients within the denominator, find the patients who meet the numerator criteria (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator

4. From the patients who did not meet the numerator criteria, determine if the provider has documented that the patient meets any criteria for exception when denominator exceptions have been specified [for this measure: medical reason(s) (eg, limited life expectancy, other medical reasons)]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the exception rate (ie, percentage with valid exceptions) should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.

If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure.

Physician Performance Measures (Measures) and related data specifications, developed by the Physician Consortium for Performance Improvement® (the Consortium), are intended to facilitate quality improvement activities by physicians.

These Measures are intended to assist physicians in enhancing quality of care. Measures are designed for use by any physician who manages the care of a patient for a specific condition or for prevention. These performance Measures are not clinical guidelines and do not establish a standard of medical care. The Consortium has not tested its Measures for all potential applications. The Consortium encourages the testing and evaluation of its Measures.

Measures are subject to review and may be revised or rescinded at any time by the Consortium. The Measures may not be altered without the prior written approval of the Consortium. Measures developed by the Consortium, while copyrighted, can be reproduced and distributed, without modification, for noncommercial purposes, e.g., use by health care providers in connection with their practices. Commercial use is defined as the sale, license, or distribution of the Measures for commercial gain, or incorporation of the Measures into a product or service that is sold, licensed or distributed for commercial gain. Commercial uses of the Measures require a license agreement between the user and American Medical Association, on behalf of the Consortium. Neither the Consortium nor its members shall be responsible for any use of these Measures.

THE MEASURES ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND

Limited proprietary coding is contained in the Measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. The AMA, the Consortium and its members disclaim all liability for use or accuracy of any Current Procedural Terminology (CPT®) or other coding contained in the specifications.

THE SPECIFICATIONS ARE PROVIDED “AS IS” WITHOUT WARRANTY OF ANY KIND.

3453 Continuity of care after inpatient or residential treatment for substance use disorder (SUD)

STEWARD

Centers for Medicare & Medicaid Services, Centers for Medicaid & CHIP Services

DESCRIPTION

Percentage of discharges from an inpatient or residential treatment for substance use disorder (SUD) for Medicaid beneficiaries, ages 18 to 64, which was followed by a treatment service for SUD. SUD treatment includes having an outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth encounter, or filling a prescription or being 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.

TYPE

Process

DATA SOURCE

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.

LEVEL

Population : Regional and State

SETTING

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

NUMERATOR STATEMENT

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

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

Public comments supported a measure for 7- and 14-day continuity and voiced that beyond that would be too long, risking losing the patient from the treatment system. The Technical Expert Panel unanimously agreed on the appropriateness of 7-day continuity of care. However, three TEP members felt that 14-days continuity of care is too long. Our approach balances clinical best practice thinking that the sooner the patient is connected to treatment the better while also allowing treatment programs more time for placement of patients in continuing treatment. Because it may be difficult at times for treatment programs to place clients in continuing care in a timely fashion after discharge due to limits in systems capacity, it is particularly important to allow more time for continuity of care to occur.

Inpatient or residential treatment was considered to be SUD related if it had a primary SUD diagnosis or a procedure indicating SUD. SUD diagnoses are identified through ICD-9 codes. Procedures are defined using a combination of Healthcare Common Procedure Coding System (HCPCS) codes, Uniform Billing (UB) Revenue Codes and ICD-9/ICD-10 procedure codes.

Value sets for the measure are attached in the Excel workbook provided for question S.2b. We include 2016 HEDIS value sets because we used these value sets in measure testing. HEDIS value sets are used because they represent an existing set that states are already familiar with, they are an element of harmonizing with other endorsed measures, and they are updated by the National Committee on Quality Assurance (NCQA). Also, some states may need to include relevant state-specific codes.

DENOMINATOR STATEMENT

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

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 Tabs 1-3 of the attached Excel file. SUD diagnoses are identified using the value sets in Tabs 1-2.

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 15 of the measurement year. December 15th is selected to allow sufficient time for continuity activities.

EXCLUSIONS

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

Codes reflecting exclusions are attached in S.2b. Residential treatment is identified using the value sets in Tabs 1-3 of the attached Excel file. SUD diagnoses are identified using the value sets in Tabs 1-2.

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

Not applicable.

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

In the steps below we reference the Excel workbook we attached for S.2b. The workbook includes:

- 2016 HEDIS value sets used in measure testing
- 2018 HEDIS value sets used in measure testing for pharmacotherapy and telehealth codes
- Value sets developed during the specification and testing of this measure, and the value sets from NQF #3312 Continuity of Care for Medicaid Beneficiaries After Detoxification (Detox) from Alcohol and/or Drugs and NQF #3400 Use of Pharmacotherapy for Opioid Use Disorder (OUD) that were used in the specification of this measure.

Note - some states may need to also include relevant state-specific codes.

Step 1: Identify denominator

Step 1A. Eligible population: : Identify non-dually enrolled Medicaid beneficiaries age 18 through 64 years with any discharges from inpatient or residential treatment with a principal diagnosis of SUD during January 1 - December 15 of the measurement year. Patients 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, the principal diagnosis of SUD is identified using a principal diagnosis from the 2016 “HEDIS AOD Dependence” value set (Tab 1 in the attached Excel file) or any procedure code from the 2016 “HEDIS AOD Procedures” value set (Tab 2). Secondary diagnosis of SUD is identified using the same value sets.

Step 1B. Flag claims as inpatient or as residential treatment: 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-9/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 (Tab 3). If 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 counts 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. To facilitate this consolidation, sort the inpatient, outpatient and ambulatory discharges by Beneficiary ID and service dates to ensure the discharges from these multiple data sources are in chronological order. Use all inpatient and residential treatment claims, regardless of diagnosis, to create episodes.

Step 1C: Assign treatment location to episodes: Use HCPCS, ICD-9/ICD-10 procedure or diagnosis codes, place of service, or UB revenue codes in the SUD Residential Treatment value set (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 principal diagnosis (with 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 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, identify discharges from inpatient or residential treatment for SUD with a principal diagnosis of SUD with qualifying continuity of care for SUD (principal or secondary diagnosis) within 7 or 14 days of 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. SUD diagnoses can be in any position – primary or secondary – for continuity services. 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 (Tab 4); or

2. Any procedure code from "HEDIS IET Visits Group 1" value set (Tab 5) along with place of service from "HEDIS IET POS Group 1" value set (Tab 6); or

3. Any procedure code from "HEDIS IET Visits Group 2" value set (Tab 7) along with place of service from "HEDIS IET POS Group 2" value set (Tab 8).

The claim must also have procedure code modifier that is missing or a value other than those in the "HEDIS Telehealth Modifier" value set (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. SUD diagnoses can be in any position – primary or secondary – for continuity services. Telehealth has to occur the day after discharge through day 7 or 14. We identify telehealth as:

1. Any procedure code from the "HEDIS Telephone Visit" value set (Tab 12); or

2. Any procedure code or UB revenue code from "HEDIS IET Stand Alone Visits" value set (Tab 4); or

3. Any procedure code from "HEDIS IET Visits Group 1" value set (Tab 5) along with place of service from "HEDIS IET POS Group 1" value set (Tab 6); or

4. Any procedure code from "HEDIS IET Visits Group 2" value set (Tab 7) along with place of service from "HEDIS IET POS Group 2" value set (Tab 8).

Claims identified using logic in #2-4 must also have procedure code modifier from the "HEDIS Telehealth Modifier" value set (Tab 9).

Step 2A.3: Identify pharmacotherapy events: 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 (Tab 10); or b) any HCPCS procedure code from "MAT Additional Codes" value set (Tab 11) (developed as part of testing for NQF 3312); or c) any state-specific procedure code from "MAT Additional Codes" value set (Tab 11) for the two states listed in the value set (these codes were identified through consultation for these states).

2. In RX file, any NDC from "AOD Pharmacotherapy" value set (Tab 13). This value set contains NDCs identified as part of testing for NQF 3312 and 3400.

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 each continuity of care time period.

COPYRIGHT / DISCLAIMER

specifications may be used by health plans and other health care delivery organizations for the purpose of calculating and reporting Measure results or using Measure results for their internal quality improvement purposes. All other uses of the NUBC codes require a license from the AHA. Anyone desiring to use the NUBC codes in a commercial product to generate measure results, or for any other commercial use, must obtain a commercial use license directly from the AHA. To inquire about licensing, contact ub04@healthforum.com.

NDC codes change periodically and should be updated whenever the measure is applied.

This measure contains HEDIS® Value Sets that were developed, are owned by and are included with the permission of the National Committee for Quality Assurance ("NCQA"). Proprietary coding is contained in the HEDIS Value Sets. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. NCQA disclaims all liability for use or accuracy of any coding contained in the HEDIS Value Sets. The HEDIS Value Sets are provided "as is" without warranty of any kind. Users shall not have the right to alter, enhance or otherwise modify the HEDIS Value Sets, and shall not disassemble, recompile or reverse engineer the HEDIS Value Sets. All uses of the HEDIS Value Sets outside the measure must be approved by NCQA and are subject to a license at the discretion of NCQA. ©2016 and 2018 NCQA, all rights reserved."

Appendix E1: Related and Competing Measures (tabular version)

Comparison of NQF 3451 and NQF 0576

	3451 Non-Acute Mental Health Services Utilization for Dual Eligible Beneficiaries	0576 Follow-Up After Hospitalization for Mental Illness (FUH)
Steward	Centers for Medicare & Medicaid Services	National Committee for Quality Assurance
Description	The percentage of dual eligible beneficiaries with a mental health service need who received a non-acute mental health service in the measurement year.	The percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported: - The percentage of discharges for which the patient received follow-up within 30 days of discharge - The percentage of discharges for which the patient received follow-up within 7 days of discharge.
Type	Process	Process
Data Source	Claims Both the numerator and denominator for this measure are based on administrative claims data. No data collection instrument provided Attachment FINAL_-_7.18.18_-_Duals12_ValueSets.xlsx	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_Value_Sets.xlsx
Level	Health Plan	Health Plan, Integrated Delivery System
Setting	Home Care, Outpatient Services, Post-Acute Care	Inpatient/Hospital, Outpatient Services
Numerator Statement	The number of dual eligible beneficiaries receiving at least one non-acute mental health service in the 12-month measurement year. The following services are included as non-acute mental health services: - Outpatient service with a mental health provider for a mental health diagnosis - Mental health outpatient encounter - Mental health condition management in primary care	30-Day Follow-Up: A follow-up visit with a mental health practitioner within 30 days after discharge. 7-Day Follow-Up: A follow-up visit with a mental health practitioner within 7 days after discharge.
Numerator Details	Include in the numerator all dual eligible beneficiaries receiving at least one non-acute mental health service (defined below) in the 12-month measurement year: Non-Acute Mental Health Service Definition A non-acute mental health service use is identified by the occurrence of any of the following three criteria: 1. Any claim with from a mental health provider with a primary diagnosis code for mental health diagnosis (Mental Health Diagnosis Value Set) AND servicing provider taxonomy code is in the set: 101Y00000X, 101YM0800X, 101YP2500X, 103G00000X, 103T00000X, 103TB0200X, 103TC0700X, 103TC1900X, 103TC2200X, 103TF0000X, 103TH0100X, 103TP0016X, 103TP0814X, 103TP2700X, 103TP2701X, 103TR0400X, 104100000X, 1041C0700X, 106H00000X, 163WP0809X, 2080P0006X, 2084A0401X, 2084F0202X, 2084N0400X, 2084N0402X, 2084N0600X, 2084P0015X, 2084P0800X, 2084P0802X, 2084P0804X, 2084P0805X, 2084S0012X, 2084V0102X, 251S00000X, 261QM0801X, 273R00000X, 283Q00000X, 323P00000X, 363LP0808X, 364SP0808X 2. Any claim with a mental health service procedure code in the following value sets (MPT IOP/PH Group 1, MPT Stand Alone Outpatient Group 1, Electroconvulsive Therapy, Transcranial Magnetic Stimulation) OR any procedure code in the following set: 90791, 90792, 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815, 90816, 90817, 90818, 90819, 90821, 90822, 90823, 90824, 90825, 90826, 90827, 90828, 90829, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90846, 90847, 90849, 90853, 90857, 90862, 90889, 96101, 96102, 96103, 96110, 96111, 96116, 96118, 96119, 96120, 90867, 90868, 90869, 90870, 90875, 90876, 96127, G0155, G0176, G0177, H0004, H0023, H0025, H0027, H0030, H0031, H0032, H0035, H0036, H0037, H0038, H0039, H0040, H0046, H1011, H2011, H2012, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, H2021, H2022, H2023, H2035, H2027, H2030, H2031, H2033, M0064, Q5008, S9480, S9482, S9484, S9485, T1025, T1026, T2038, T2048 3. Any claim from a primary care provider with a primary diagnosis code for mental health diagnosis (Mental Health Diagnosis Value Set) AND procedure code is in the set: 99201-99215 (Office), 99241-99255 (Consultation), or?99441-99444 (telephonic or online)	For both indicators, a follow-up visit includes outpatient visits, intensive outpatient visits or partial hospitalizations that occur on the date of discharge. Any of the following meet criteria for a follow-up visit: - A visit (FUH Stand Alone Visits Value Set; FUH Visits Group 1 Value Set and FUH POS Group 1 Value Set; FUH Visits Group 2 Value Set and FUH POS Group 2 Value Set) with a mental health practitioner (see definition below). - 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 mental health practitioner. - A visit to a non-behavioral healthcare facility (FUH RevCodes Group 2 Value Set) with a diagnosis of mental illness (Mental Illness Value Set). - Transitional care management services (TCM 7 Day Value Set). The following meets criteria for only the 30-Day Follow-Up indicator: - Transitional care management services (TCM 14 Day Value Set) (See corresponding Excel document for the value sets referenced above) Mental Health Practitioner Definition: A practitioner who provides mental health services and meets any of the following criteria: • An MD or doctor of osteopathy (DO) who is certified as a psychiatrist or child psychiatrist by the American Medical Specialties Board of Psychiatry and Neurology or by the American Osteopathic Board of Neurology and Psychiatry; or, if not certified, who successfully completed an accredited program of graduate medical or osteopathic education in psychiatry or child psychiatry and is licensed to practice patient care psychiatry or child psychiatry, if required by the state of practice. • An individual who is licensed as a psychologist in his/her state of practice, if required by the state of practice. • An individual who is certified in clinical social work by the American Board of Examiners; who is listed on the National Association of Social Worker's Clinical Register; or who has a master's degree in social work and is licensed or certified to practice as a social worker, if required by the state of practice. • A registered nurse (RN) who is certified by the American Nurses Credentialing Center (a subsidiary of the American Nurses Association) as a psychiatric nurse or mental health clinical nurse specialist, or who has a master's degree in nursing with a specialization in psychiatric/mental health and two years of supervised clinical experience and is licensed to practice as a psychiatric or mental health nurse, if required by the state of practice. • An individual (normally with a master's or a doctoral degree in marital and family therapy and at least two years of

	3451 Non-Acute Mental Health Services Utilization for Dual Eligible Beneficiaries	0576 Follow-Up After Hospitalization for Mental Illness (FUH)
		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).
Denominator Statement	The number of dual eligible beneficiaries age 21 and older with a mental health service need in the 18-month identification window (the 12-month measurement year plus six months prior to the measurement year).	Discharges from an acute inpatient setting (including acute care psychiatric facilities) with a principal diagnosis of mental illness during the first 11 months of the measurement year (i.e., January 1 to December 1) for patients 6 years and older.
Denominator Details	Include in the denominator all dual eligible beneficiaries age 21 and older continuously enrolled in the 12-month measurement year and at least 5 months of the 6 months prior to the measurement year with a mental health service need (defined below) in the 18-month identification window. Mental Health Service Need Definition Mental health service need is identified by the occurrence of any of the following conditions: 1. Receipt of any mental health service meeting the numerator service criteria in the 18-month identification window 2. Any diagnosis of mental illness (not restricted to primary) in the 18-month identification window. These include diagnoses from the following value sets: a) Psychotic Diagnosis Value Set 101 b) Mania/Bipolar Diagnosis Value Set 102 c) Depression Diagnosis Value Set 103 d) Anxiety Diagnosis Value Set 104 e) ADHD Diagnosis Value Set 105 f) Disruptive/Impulse/Conduct Diagnosis Value Set 106 g) Adjustment Diagnosis Value Set 107 h) Other Mental Health Diagnosis Value Set 3. Receipt of any psychotropic medication listed in the Rx Table (see attached excel spreadsheet) in the 18-month identification window. These medications comprise the following drug therapy classes: a) Antianxiety Rx b) Antidepressants Rx c) Antimania Rx d) Antipsychotic Rx e) ADHD Rx 4. Any claim with a mental health service procedure code in the following set: 90791, 90792, 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815, 90816, 90817, 90818, 90819, 90821, 90822, 90823, 90824, 90825, 90826, 90827, 90828, 90829, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90846, 90847, 90849, 90853, 90857, 90862, 90889, 96101, 96102, 96103, 96110, 96111, 96116, 96118, 96119, 96120, 90867, 90868, 90869, 90870, 90875, 90876, 96127, G0155, G0176, G0177, H0004, H0023, H0025, H0027, H0030, H0031, H0032, H0035, H0036, H0037, H0038, H0039, H0040, H0046, H1011, H2011, H2012, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, H2021, H2022, H2023, H2035, H2027, H2030, H2031, H2033, M0064, Q5008, S9480, S9482, S9484, S9485, T1025, T1026, T2038, T2048 5. Any psychiatric inpatient stay in the following facility types: Community Psychiatric Hospital, Evaluation & Treatment Center	An acute inpatient discharge with a principal diagnosis of mental illness (Mental Illness Value Set) on or between January 1 and December 1 of the measurement year. To identify acute inpatient discharges: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). 3. Identify the discharge date for the stay. The denominator for this measure is based on discharges, not on patients. If patients have more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year. Acute facility readmission or direct transfer: If the discharge is followed by readmission or direct transfer to an acute inpatient care setting for a principal diagnosis of mental health (Mental Health Diagnosis Value Set) within the 30-day follow-up period, count only the last discharge. To identify readmissions to an acute inpatient care setting: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). 3. Identify the admission date for the stay. *Due to the extensive volume of codes associated with identifying the denominator for this measure, we are attaching a separate file with value sets. See value sets located in question S.2b.
Exclusions	None	Exclude from the denominator for both rates, patients who receive hospice services during the measurement year. 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 for non-mental health. These discharges are excluded from the measure because rehospitalization or transfer may prevent an outpatient follow-up visit from taking place.
Exclusion Details	None	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

	3451 Non-Acute Mental Health Services Utilization for Dual Eligible Beneficiaries	0576 Follow-Up After Hospitalization for Mental Illness (FUH)
		methods, which may include but are not limited to enrollment data, medical record or claims/encounter data (Hospice Value Set). Exclude both the initial discharge and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year. Exclude discharges followed by readmission or direct transfer to a nonacute care setting within the 30-day follow-up period, regardless of principal diagnosis for the readmission. To identify readmissions to a nonacute inpatient care setting: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim. 3. Identify the admission date for the stay. Exclude discharges followed by readmission or direct transfer to an acute inpatient care setting within the 30-day follow-up period if the principal diagnosis was for non-mental health (any principal diagnosis code other than those included in the Mental Health Diagnosis Value Set). To identify readmissions to an acute inpatient care setting: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). 3. Identify the admission date for the stay. These discharges are excluded from the measure because rehospitalization or 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	Stratification by risk category/subgroup	No risk adjustment or risk stratification
Stratification	Measure is stratified by patient age as of the last day of the measurement period: 1. Age 21 to 64 2. Age 65 and older	N/A
Type Score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score
Algorithm	1. Identify the denominator – individuals with a mental health service need in the measurement year or 6 months prior to the measurement year (see S.7). 2. Stratify individuals in the denominator into age groups (i.e., 18-64, 65+) based on age on the last day of the measurement period (see S.10). 3. Among the remainder denominator population, identify the numerator – individuals who received a mental health service in the measurement year (S.5). 4. For each age group, divide the numerator population (step 3) by the denominator (step 2).	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.
Submission items	5.1 Identified measures: 5a.1 Are specs completely harmonized? 5a.2 If not completely harmonized, identify difference, rationale, impact: Not applicable. There are no related NQF-endorsed measures. 5b.1 If competing, why superior or rationale for additive value: Not applicable. This measure does not address both the same measure focus and same target population as another NQF-endorsed measure.	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

Comparison of NQF 2152 and NQF 2599

	2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	2599 Alcohol Screening and Follow-up for People with Serious Mental Illness
Steward	PCPI Foundation	National Committee for Quality Assurance
Description	Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user	The percentage of patients 18 years and older with a serious mental illness, who were screened for unhealthy alcohol use and received brief counseling or other follow-up care if identified as an unhealthy alcohol user. Note: The proposed health plan measure is adapted from an existing provider-level measure for the general population (NQF #2152: Preventive Care & Screening: Unhealthy Alcohol Use: Screening & Brief Counseling). It was originally endorsed in 2014 and is currently stewarded by the American Medical Association (AMA-PCPI).
Type	Process	Process
Data Source	Registry Data Not applicable. No data collection instrument provided No data dictionary	Claims, Electronic Health Records, Paper Medical Records The denominator for this measure is based on administrative claims. The numerator for this measure is based on administrative claims and/or medical record documentation collected in the course of providing care to health plan patients. No data collection instrument provided Attachment 2599_Alcohol_Screening_for_People_With_Mental_Illness_Value_Set-636583545268612951-636769175260262857.xlsx
Level	Clinician : Group/Practice, Clinician : Individual	Health Plan
Setting	Home Care, Outpatient Services	Outpatient Services
Numerator Statement	Patients who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user	Patients 18 years and older who are screened for unhealthy alcohol use during the last 3 months of the year prior to the measurement year through the first 9 months of the measurement year and received two events of counseling if identified as an unhealthy alcohol user.
Numerator Details	Time Period for Data Collection: At least once during the 24 month period. Definitions: Systematic screening method - For purposes of this measure, one of the following systematic methods to assess unhealthy alcohol use must be utilized. Systematic screening methods and thresholds for defining unhealthy alcohol use include: • AUDIT Screening Instrument (score >= 8) • AUDIT-C Screening Instrument (score >= 4 for men; score >= 3 for women) • Single Question Screening - How many times in the past year have you had 5 (for men) or 4 (for women and all adults older than 65 years) or more drinks in a day? (response >= 2) Brief counseling - Brief counseling for unhealthy alcohol use refers to one or more counseling sessions, a minimum of 5-15 minutes, which may include: feedback on alcohol use and harms; identification of high risk situations for drinking and coping strategies; increased motivation and the development of a personal plan to reduce drinking. NUMERATOR NOTE: In the event that a patient is screened for unhealthy alcohol use and identified as a user but did not receive brief alcohol cessation counseling submit G9624. For Registry: Report Quality Data Code: G9621 - Patient identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method and received brief counseling OR G9622 - Patient not identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method	Alcohol Use Screening ADMINISTRATIVE: Patients who had systematic screening for unhealthy alcohol use (see Alcohol Screening Value Set) as identified by claim/encounter data during the last 3 months of the year prior to the measurement year through the first 9 months of the measurement year. MEDICAL RECORD: Patients who had systematic screening for unhealthy alcohol use during the last 3 months of the year prior to the measurement year through the first 9 months of the measurement year. Systematic Screening A systematic screening method is defined as: Asking the patient about their weekly use (alcoholic drinks per week), or Asking the patient about their per occasion use (alcoholic drinks per drinking day) or Using a standardized tool such as the AUDIT, AUDIT-C, or CAGE or Using another standardized tool Unhealthy Alcohol Use Unhealthy alcohol use covers a spectrum that is associated with varying degrees of risk to health. Categories representing unhealthy alcohol use include risky use, problem drinking, harmful use, and alcohol abuse, and the less common but more severe alcoholism and alcohol dependence. Risky use is defined as >7 standard drinks per week or >3 drinks per occasion for women and persons >65 years of age; >14 standard drinks per week or >4 drinks per occasion for men =65 years of age. Follow-Up ADMINISTRATIVE: Patients who received two events of counseling (see Alcohol Screening and Brief Counseling Value Set) as identified by claim/encounter data within three months of screening if identified as unhealthy alcohol users. MEDICAL RECORD: Patients who received two events of counseling within three months of screening if identified as unhealthy alcohol users. The two event of counseling could be with the provider who performed screening or another provider including health plan clinical case managers. Participation in peer led support activities (such as Alcoholics Anonymous or Narcotics Anonymous) can count if documented in the health record (referrals alone do not count). Counseling Counseling may include at least one of the following: Feedback on alcohol use and harms Identification of high risk situations for drinking and coping strategies Increase the motivation to reduce drinking Development of a personal plan to reduce drinking
Denominator Statement	All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period	All patients 18 years of age or older as of December 31 of the measurement year with at least one inpatient visit or two outpatient visits for schizophrenia or bipolar I disorder, or at least one inpatient visit for major depression during the measurement year.
Denominator Details	Time Period for Data Collection: 12 consecutive months For Registry: Patients aged >= 18 years AND At least two patient encounters during the performance period (CPT or HCPCS): 90791, 90792,	Age: 18 years and older Benefit: Medical Continuous Enrollment: No more than one gap in enrollment of up to 45 days during each year of the measurement year and the year prior. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the person may not have more than a one month gap in

	2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	2599 Alcohol Screening and Follow-up for People with Serious Mental Illness
	90832, 90834, 90837, 90845, 96150, 96151, 96152, 97165, 97166, 97167, 97168, 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0270, G0271 WITHOUT Telehealth Modifier: GQ, GT, 95, POS 2 OR At Least One Preventive Visit during the performance period (CPT or HCPCS): 99385, 99386, 99387, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99429, G0438, G0439 WITHOUT Telehealth Modifier: GQ, GT, 95, POS 02	coverage (i.e., a person whose coverage lapses for two months [60 days] is not considered continuously enrolled). Diagnosis Criteria: Identify patients with a serious mental illness. They must meet at least one of the following criteria during the measurement year or the year prior: At least one acute inpatient claim/encounter with any diagnosis of schizophrenia, bipolar I disorder, or major depression using any of the following code combinations: BH Stand Alone Acute Inpatient Value Set with one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set - Major Depression Value Set BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set and one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set - Major Depression Value Set At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or non-acute inpatient setting, on different dates of service, with any diagnosis of schizophrenia or bipolar I disorder. Any two of the following code combinations meet criteria: BH Stand Alone Outpatient/PH/IOP Value Set with one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set and one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set ED Value Set with one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set BH ED Value Set with BH ED POS Value Set and one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set BH Stand Alone Nonacute Inpatient Value Set with one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set BH Nonacute Inpatient Value Set with BH Nonacute Inpatient POS Value Set and one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set
Exclusions	Documentation of medical reason(s) for not screening for unhealthy alcohol use (eg, limited life expectancy, other medical reasons)	Active diagnosis of alcohol abuse or dependence during the first nine months of the year prior to the measurement year (see Alcohol Disorders Value Set).
Exclusion Details	Time Period for Data Collection: Denominator Exception(s) are determined on the date of the most recent denominator eligible encounter. Exceptions are used to remove a patient from the denominator of a performance measure when the patient does not receive a therapy or service AND that therapy or service would not be appropriate due to patient-specific reasons. The patient would otherwise meet the denominator criteria. Exceptions are not absolute, and are based on clinical judgment, individual patient characteristics, or patient preferences. The PCPI exception methodology uses three categories of reasons for which a patient may be removed from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For measure Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling, exceptions may include medical reason(s) (eg, limited life expectancy, other medical reasons). Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions	Denominator exclusions are found through medical record or claims data (see Alcohol Disorders Value Set).

	2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	2599 Alcohol Screening and Follow-up for People with Serious Mental Illness
	data to identify practice patterns and opportunities for quality improvement. For Registry: Report Quality Data Code: G9623 - Documentation of medical reason(s) for not screening for unhealthy alcohol use (e.g., limited life expectancy, other medical reasons)	
Risk Adjustment	No risk adjustment or risk stratification	No risk adjustment or risk stratification
Stratification	Consistent with CMS' Measures Management System Blueprint and recent national recommendations put forth by the IOM and NQF, the PCPI encourages the collection of race and ethnicity data as well as the results of this measure to be stratified by race, ethnicity, administrative sex, and payer.	Not applicable.
Type Score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score
Algorithm	To calculate performance rates: 1. Find the patients who meet the initial population (ie, the general group of patients that a set of performance measures is designed to address). 2. From the patients within the initial population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial population and denominator are identical. 3. From the patients within the denominator, find the patients who meet the numerator criteria (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator 4. From the patients who did not meet the numerator criteria, determine if the provider has documented that the patient meets any criteria for exception when denominator exceptions have been specified [for this measure: medical reason(s) (eg, limited life expectancy, other medical reasons)]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. -- Although the exception cases are removed from the denominator population for the performance calculation, the exception rate (ie, percentage with valid exceptions) should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI. If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure.	Step 1: Determine the eligible population. Step 1A: Identify all patients 18 years of age or older with a serious mental illness Step 1B: Exclude patients from step 1A who have a diagnosis of unhealthy alcohol use during the first 9 months of the year prior to the measurement year. Step 2: Identify Numerator. Step 2A: Identify the date of screening for unhealthy alcohol use during the measurement year or the year prior within the medical chart Step 2B: Identify the unhealthy alcohol screening result within the medical chart. If negative for unhealthy alcohol use, stop. Step 2C: If positive for unhealthy alcohol use, identify the date of any follow-up care occurring within three months of screening. Step 3: Calculate the rate by adding the number of patients with a negative screening for unhealthy alcohol use (from step 2B) plus the number of patients with positive screening for unhealthy alcohol use and those who received follow-up care (from step 2C) and divide this by the number of patients calculated to be in the eligible population (those remaining after Step 1B is complete.) 123834| 140881| 135810
Submission items	5.1 Identified measures: 5a.1 Are specs completely harmonized? Yes 5a.2 If not completely harmonized, identify difference, rationale, impact: The related measures listed in 5.1b were developed after our measure. The NCQA measure focuses on a specific sub-population (people with serious mental illness) and is intended for use at the health plan level. In the TJC measures, screening and intervention are separate measures. Additionally, the TJC measures are intended for use at the hospital level. PCPI was contacted by these measure stewards respectively while the measures were developed, and they are currently harmonized to the extent feasible. 5b.1 If competing, why superior or rationale for additive value: No competing NQF-endorsed measure.	5.1 Identified measures: 2152 : Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling 5a.1 Are specs completely harmonized? 5a.2 If not completely harmonized, identify difference, rationale, impact: This measure was adapted from the existing provider-level measure (NQF #2152: Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling) for use at the health plan level for the high risk subpopulation of people with serious mental illness. The measure is harmonized and has been reviewed with the original measure stewards and developers. The differences between the existing measure and the proposed serious mental illness subpopulation measure were developed with expert input and are described here. -The population focus: This measure focuses on people with serious mental illness, who are at a higher risk of unhealthy alcohol use than the general population and have demonstrated disparities in care -What counts as follow-up and the number of events for follow-up: This measure requires two events of counseling, raising expectations for the intensity of service for the serious mental illness population compared to the original measure for the general population, and is reasonably achievable, particularly in the health plan context. USPSTF recommendation supports multi-contact counseling which seems to have the best evidence of effectiveness. -In addition, the existing measure (NQF #2152) is reported at the provider level and is focused on follow-up conducted at time of screening making a single event sufficient. However, at the health plan level, there is opportunity/responsibility for follow-up care beyond the visit. We believe our measure focused on screening patients with SMI for unhealthy alcohol use and capturing more intensive evidence-based follow-up care for a vulnerable population contributes to the national quality agenda. 5b.1 If competing, why superior or rationale for additive value: Not applicable.

Comparison of NQF 3453, 0004, 0576, 2605, and 3312

	3453 Continuity of care after inpatient or residential treatment for substance use disorder (SUD)	0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	0576 Follow-Up After Hospitalization for Mental Illness (FUH)	2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence	3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs
Steward	Centers for Medicare & Medicaid Services, Centers for Medicaid & CHIP Services	National Committee for Quality Assurance	National Committee for Quality Assurance	National Committee for Quality Assurance	Centers for Medicare & Medicaid Services, Centers for Medicaid & CHIP Services
Description	Percentage of discharges from an inpatient or residential treatment for substance use disorder (SUD) for Medicaid beneficiaries, ages 18 to 64, which was followed by a treatment service for SUD. SUD treatment includes having an outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth encounter, or filling a prescription or being 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.	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.	The percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported: - The percentage of discharges for which the patient received follow-up within 30 days of discharge - The percentage of discharges for which the patient received follow-up within 7 days of discharge.	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.	Percentage of discharges from a detoxification episode for adult Medicaid Beneficiaries, age 18-64, that was 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. This measure is reported across all detoxification settings.
Type	Process	Process	Process	Process	Process
Data Source	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 SUD-18_measure_value_sets_FINAL_08.09.18_tested_sets_-_locked.xlsx	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	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_Value_Sets.xlsx	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	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 Cont_Care_After_Detox_Value_Sets.xlsx
Level	Population : Regional and State	Health Plan	Health Plan, Integrated Delivery System	Health Plan, Population : Regional and State	Population : Regional and State

	3453 Continuity of care after inpatient or residential treatment for substance use disorder (SUD)	0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	0576 Follow-Up After Hospitalization for Mental Illness (FUH)	2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence	3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs
Setting	Emergency Department and Services, Home Care, Inpatient/Hospital, Outpatient Services	Emergency Department and Services, Inpatient/Hospital, Outpatient Services	Inpatient/Hospital, Outpatient Services	Inpatient/Hospital, Outpatient Services	Inpatient/Hospital, Outpatient Services
Numerator Statement	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.	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.	30-Day Follow-Up: A follow-up visit with a mental health practitioner within 30 days after discharge. 7-Day Follow-Up: A follow-up visit with a mental health practitioner within 7 days after discharge.	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	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 a detoxification episode.
Numerator Details	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 Public comments supported a measure for 7- and 14-day continuity and voiced that	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	For both indicators, a follow-up visit includes outpatient visits, intensive outpatient visits or partial hospitalizations that occur on the date of discharge. Any of the following meet criteria for a follow-up visit: - A visit (FUH Stand Alone Visits Value Set; FUH Visits Group 1 Value Set and FUH POS Group 1 Value Set; FUH Visits Group 2 Value Set and FUH POS Group 2 Value Set) with a mental health practitioner (see definition below). - 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 mental health practitioner. - A visit to a non-behavioral healthcare facility (FUH RevCodes Group 2 Value Set) with a diagnosis of mental illness (Mental Illness Value Set).	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	Measure data will be reported annually (12 months). To account for the 14-day time period after discharge from detoxification, the denominator period will start January 1 and end December 15 of the measurement year. The numerator includes individuals with any of the following within 14 days after discharge from detoxification: -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.

	3453 Continuity of care after inpatient or residential treatment for substance use disorder (SUD)	0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	0576 Follow-Up After Hospitalization for Mental Illness (FUH)	2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence	3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs
	beyond that would be too long, risking losing the patient from the treatment system. The Technical Expert Panel unanimously agreed on the appropriateness of 7-day continuity of care. However, three TEP members felt that 14-days continuity of care is too long. Our approach balances clinical best practice thinking that the sooner the patient is connected to treatment the better while also allowing treatment programs more time for placement of patients in continuing treatment. Because it may be difficult at times for treatment programs to place clients in continuing care in a timely fashion after discharge due to limits in systems capacity, it is particularly important to allow more time for continuity of care to occur. Inpatient or residential treatment was considered to be SUD related if it had a primary SUD diagnosis or a procedure indicating SUD. SUD diagnoses are identified through ICD-9 codes. Procedures are defined using a combination of Healthcare Common Procedure Coding System (HCPCS) codes, Uniform Billing (UB) Revenue Codes and ICD-9/ICD-10 procedure codes. Value sets for the measure are attached in the Excel workbook provided for question S.2b. We include 2016 HEDIS value sets because we used these value sets in measure testing. HEDIS value sets are used because they represent an existing set that states are already familiar with, they are an element of harmonizing with other endorsed measures, and they are updated by the National Committee on Quality Assurance (NCQA). Also, some states may need to include relevant state-specific codes.	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,	- Transitional care management services (TCM 7 Day Value Set). The following meets criteria for only the 30-Day Follow-Up indicator: - Transitional care management services (TCM 14 Day Value Set) (See corresponding Excel document for the value sets referenced above) Mental Health Practitioner Definition: A practitioner who provides mental health services and meets any of the following criteria: • An MD or doctor of osteopathy (DO) who is certified as a psychiatrist or child psychiatrist by the American Medical Specialties Board of Psychiatry and Neurology or by the American Osteopathic Board of Neurology and Psychiatry; or, if not certified, who successfully completed an accredited program of graduate medical or osteopathic education in psychiatry or child psychiatry and is licensed to practice patient care psychiatry or child psychiatry, if required by the state of practice. • An individual who is licensed as a psychologist in his/her state of practice, if required by the state of practice. • An individual who is certified in clinical social work by the American Board of Examiners; who is listed on the National Association of Social Worker's Clinical Register; or who has a master's degree in social work and is licensed or certified to practice as a social worker, if required by the state of practice. • A registered nurse (RN) who is certified by the American Nurses Credentialing Center (a subsidiary of the American Nurses Association) as a psychiatric nurse or mental health clinical nurse specialist, or who has a master's degree in nursing with a specialization in psychiatric/mental health and two years of supervised clinical experience and is licensed to practice as a psychiatric or mental health nurse, if required by the state of practice. • An individual (normally with a master's or a doctoral degree in marital and family therapy	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)	-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. Continuity is reset to zero if an overdose diagnosis code appears on the same outpatient or inpatient claim. SUD diagnoses are used to identify procedures connected to SUD diagnoses. SUD diagnoses are identified through ICD-9 codes. Procedures are defined using a combination of Healthcare Common Procedure Coding System (HCPCS) codes, Uniform Billing (UB) Revenue Codes and ICD-9/ICD-10 procedure codes. 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). A list of value sets for the measure is attached in the Excel workbook provided for question S.2b. 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)	0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	0576 Follow-Up After Hospitalization for Mental Illness (FUH)	2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence	3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs
		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	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).	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	

	3453 Continuity of care after inpatient or residential treatment for substance use disorder (SUD)	0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	0576 Follow-Up After Hospitalization for Mental Illness (FUH)	2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence	3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs
		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		(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).	

	3453 Continuity of care after inpatient or residential treatment for substance use disorder (SUD)	0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	0576 Follow-Up After Hospitalization for Mental Illness (FUH)	2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence	3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs
		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			

	3453 Continuity of care after inpatient or residential treatment for substance use disorder (SUD)	0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	0576 Follow-Up After Hospitalization for Mental Illness (FUH)	2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence	3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs
		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			

	3453 Continuity of care after inpatient or residential treatment for substance use disorder (SUD)	0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	0576 Follow-Up After Hospitalization for Mental Illness (FUH)	2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence	3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs
		numerator. The Total Column is not the sum of the diagnosis columns.			
Denominator Statement	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.	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).	Discharges from an acute inpatient setting (including acute care psychiatric facilities) with a principal diagnosis of mental illness during the first 11 months of the measurement year (i.e., January 1 to December 1) for patients 6 years and older.	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.	Adult Medicaid beneficiary discharges from detoxification from January 1 to December 15 of the measurement year.
Denominator Details	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 Tabs 1-3 of the attached Excel file. SUD diagnoses are identified using the value sets in Tabs 1-2. 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 15 of the measurement year. December 15th is selected to allow sufficient time for continuity activities.	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	An acute inpatient discharge with a principal diagnosis of mental illness (Mental Illness Value Set) on or between January 1 and December 1 of the measurement year. To identify acute inpatient discharges: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). 3. Identify the discharge date for the stay. The denominator for this measure is based on discharges, not on patients. If patients have more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year. Acute facility readmission or direct transfer: If the discharge is followed by readmission or direct transfer to an acute inpatient care setting for a principal diagnosis of mental health (Mental Health Diagnosis Value Set) within the 30-day follow-up period, count only the last discharge. To identify readmissions to an acute inpatient care setting: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). 3. Identify the admission date for the stay. *Due to the extensive volume of codes associated with identifying the denominator for this measure, we are attaching a separate file with value sets. See value sets located in question S.2b.	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.	Measure data will be reported annually (12 months). To account for the 14-day time period after discharge from detoxification, the denominator period will start January 1 and end December 15 of the measurement year. Target population meets the following conditions: • Medicaid beneficiaries aged 18 years and older and less than 65 years with at least one detox discharge during the year January 1-December 15. • Enrolled in Medicaid during the month of detoxification discharge and the following month. The denominator is based on discharges, not individuals. A beneficiary may have more than one qualifying detox episode. Detoxification is identified using a combination of HCPCS codes, UB Revenue Codes and ICD-9/ICD-10 procedure codes. A list of value sets for the measure is attached in the Excel workbook provided for question S.2b. As with the numerator specifications, this document lists standardized specification for this measure. 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)	0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	0576 Follow-Up After Hospitalization for Mental Illness (FUH)	2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence	3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs
		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.			
Exclusions	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.	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	Exclude from the denominator for both rates, patients who receive hospice services during the measurement year. 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.	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	Not applicable. The measure does not have denominator exclusions.

	3453 Continuity of care after inpatient or residential treatment for substance use disorder (SUD)	0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	0576 Follow-Up After Hospitalization for Mental Illness (FUH)	2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence	3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs
	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.	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.	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 for non-mental health. These discharges are excluded from the measure because rehospitalization or transfer may prevent an outpatient follow-up visit from taking place.	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.	
Exclusion Details	Codes reflecting exclusions are attached in S.2b. Residential treatment is identified using the value sets in Tabs 1-3 of the attached Excel file. SUD diagnoses are identified using the value sets in Tabs 1-2.	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.	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). Exclude both the initial discharge and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year. Exclude discharges followed by readmission or direct transfer to a nonacute care setting within the 30-day follow-up period, regardless of principal diagnosis for the readmission. To identify readmissions to a nonacute inpatient care setting: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim. 3. Identify the admission date for the stay. Exclude discharges followed by readmission or direct transfer to an acute inpatient care setting within the 30-day follow-up period if the principal diagnosis was for non-mental health (any principal diagnosis code other than those included in the Mental Health Diagnosis Value Set). To identify readmissions to an acute inpatient care setting:	See Section S.10 for exclusion details	Not applicable.

	3453 Continuity of care after inpatient or residential treatment for substance use disorder (SUD)	0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	0576 Follow-Up After Hospitalization for Mental Illness (FUH)	2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence	3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs
			1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). 3. Identify the admission date for the stay. These discharges are excluded from the measure because rehospitalization or 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	No risk adjustment or risk stratification	No risk adjustment or risk stratification	No risk adjustment or risk stratification	No risk adjustment or risk stratification
Stratification	Not applicable.	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.	N/A	Not applicable.	Location of detox is used as a stratification variable in analyses. If an inpatient hospital claim had an ICD-9/ICD-10 detoxification procedure code or a UB revenue code indicating detoxification, hospital inpatient treatment is assigned as the location of detox. In addition, hospital inpatient treatment is also assigned if a non-inpatient claim contains a HCPCS code indicating hospital inpatient detox. The remaining detox location assignments are very straightforward. Whenever possible, use of the HCPCS codes to determine location is most desired as it reflects the more precise detoxification location. The other stayover treatment location is designed to capture detox location from non-inpatient claims that do not contain a HCPCS code. A list of value sets for the measure is attached in the Excel workbook provided for question S.2b.
Type Score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score
Algorithm	In the steps below we reference the Excel workbook we attached for S.2b. The workbook includes: • 2016 HEDIS value sets used in measure testing • 2018 HEDIS value sets used in measure testing for pharmacotherapy and telehealth codes • Value sets developed during the specification and testing of this measure, and the value sets from NQF #3312 Continuity of Care for Medicaid Beneficiaries After Detoxification (Detox) from Alcohol and/or Drugs and NQF #3400 Use of Pharmacotherapy for Opioid Use Disorder (OUD)	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.	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.	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	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 enrolled Medicaid beneficiaries ages 18-64 years who have any detoxification (withdrawal management) in inpatient hospital, residential addiction treatment program, or ambulatory detoxification (withdrawal management) discharge from January 1 to December 15 of the measurement year and are enrolled the month of

	3453 Continuity of care after inpatient or residential treatment for substance use disorder (SUD)	0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	0576 Follow-Up After Hospitalization for Mental Illness (FUH)	2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence	3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs
	that were used in the specification of this measure. Note - some states may need to also include relevant state-specific codes. Step 1: Identify denominator Step 1A. Eligible population: : Identify non-dually enrolled Medicaid beneficiaries age 18 through 64 years with any discharges from inpatient or residential treatment with a principal diagnosis of SUD during January 1 - December 15 of the measurement year. Patients 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, the principal diagnosis of SUD is identified using a principal diagnosis from the 2016 "HEDIS AOD Dependence" value set (Tab 1 in the attached Excel file) or any procedure code from the 2016 "HEDIS AOD Procedures" value set (Tab 2). Secondary diagnosis of SUD is identified using the same value sets. Step 1B. Flag claims as inpatient or as residential treatment: 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-9/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 (Tab 3). If 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 counts 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. To facilitate this consolidation, sort the inpatient, outpatient and ambulatory discharges by Beneficiary ID and service dates to ensure the discharges from these multiple data sources are in chronological order. Use all inpatient and residential treatment claims,			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).	detoxification and the following month. Age is calculated as of January 1 of the measurement year. Step 1B: Overall: Among the Medicaid beneficiaries in Step 1A, identify all detoxification discharges using all inpatient, outpatient and ambulatory claims files or tables that contain HCPCS or ICD-9/ICD-10 procedure codes and UB revenue codes. If more than one detoxification in a year, treat each detoxification as a separate observation, e.g., an inpatient hospital detoxification in January and an ambulatory detoxification in July, counts as two observations. Step 1B.1: Multiple detox claims that are within 1-2 days are combined into a single detox episode. Accordingly, sort the inpatient, outpatient and ambulatory detox discharges by Beneficiary ID and service dates to ensure the discharges from these multiple data sources are in chronological order. Then combine close-proximity episodes while retaining all clinical fields from each episode. Step 1C: Detox location assignment: hospital inpatient, inpatient residential addiction, outpatient residential outpatient addiction, other stayover treatment and ambulatory detoxification. Use HCPCs detox procedure codes to assign detox location whenever possible; revenue center detox will map to the hospital inpatient location when the revenue codes appear on an inpatient claim or table. They will map to other stayover treatment when the revenue codes appear on a non-inpatient claim. If there is more than 1 detox location when episodes are combined, assign the location using the first claim's location. If there is a TIE between a detox 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: Overall: From the denominator in Step 1B, identify those discharges from detoxification in any setting with a qualifying continuity service within 7 or 14 days after discharge.

	3453 Continuity of care after inpatient or residential treatment for substance use disorder (SUD)	0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	0576 Follow-Up After Hospitalization for Mental Illness (FUH)	2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence	3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs
	regardless of diagnosis, to create episodes. Step 1C: Assign treatment location to episodes: Use HCPCS, ICD-9/ICD-10 procedure or diagnosis codes, place of service, or UB revenue codes in the SUD Residential Treatment value set (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 principal diagnosis (with 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 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, identify discharges from inpatient or residential treatment for SUD with a principal diagnosis of SUD with qualifying continuity of care for SUD (principal or secondary diagnosis) within 7 or 14 days of 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. SUD				Step 2A.1: Identify SUD continuity services: Continuity services are assigned using clinical claims billing information (e.g., diagnosis, procedure, revenue codes). 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, the specification 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 detox 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. 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 detox through day 7 or 14. Step 2A.3: Co-occurring events: Continuity service flags and pharmacotherapy flags are reset to zero if an overdose diagnosis code appears on the SAME claim as the continuity service. Further, outpatient continuity is also reset to zero if an emergency department visit occurs on the same day. If an inpatient continuity claim has an emergency department visit, it is allowed to remain a continuity service.

	3453 Continuity of care after inpatient or residential treatment for substance use disorder (SUD)	0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	0576 Follow-Up After Hospitalization for Mental Illness (FUH)	2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence	3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs
	diagnoses can be in any position – primary or secondary – for continuity services. 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 (Tab 4); or 2. Any procedure code from "HEDIS IET Visits Group 1" value set (Tab 5) along with place of service from "HEDIS IET POS Group 1" value set (Tab 6); or 3. Any procedure code from "HEDIS IET Visits Group 2" value set (Tab 7) along with place of service from "HEDIS IET POS Group 2" value set (Tab 8). The claim must also have procedure code modifier that is missing or a value other than those in the "HEDIS Telehealth Modifier" value set (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. SUD diagnoses can be in any position – primary or secondary – for continuity services. Telehealth has to occur the day after discharge through day 7 or 14. We identify telehealth as: 1. Any procedure code from the "HEDIS Telephone Visit" value set (Tab 12); or 2. Any procedure code or UB revenue code from "HEDIS IET Stand Alone Visits" value set (Tab 4); or 3. Any procedure code from "HEDIS IET Visits Group 1" value set (Tab 5) along with place of service from "HEDIS IET POS Group 1" value set (Tab 6); or 4. Any procedure code from "HEDIS IET Visits Group 2" value set (Tab 7) along with place of service from "HEDIS IET POS Group 2" value set (Tab 8). Claims identified using logic in #2-4 must also have procedure code modifier from the "HEDIS Telehealth Modifier" value set (Tab 9). Step 2A.3: Identify pharmacotherapy events: 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.				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 detox location by dividing the respective number of discharges by each location with a qualifying continuity service (Step 2A) by the denominator (Step 1C). 120752

	3453 Continuity of care after inpatient or residential treatment for substance use disorder (SUD)	0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	0576 Follow-Up After Hospitalization for Mental Illness (FUH)	2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence	3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs
	Pharmacotherapy continuity claims are identified as follows: 1. In OT file, a) any procedure code from "HEDIS Medication Assisted Treatment" value set (Tab 10); or b) any HCPCS procedure code from "MAT Additional Codes" value set (Tab 11) (developed as part of testing for NQF 3312); or c) any state-specific procedure code from "MAT Additional Codes" value set (Tab 11) for the two states listed in the value set (these codes were identified through consultation for these states). 2. In RX file, any NDC from "AOD Pharmacotherapy" value set (Tab 13). This value set contains NDCs identified as part of testing for NQF 3312 and 3400. 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 each continuity of care time period.				
Submission items	5.1 Identified measures: 2605 : Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence 0576 : Follow-Up After Hospitalization for Mental Illness (FUH) 1937 : Follow-Up After Hospitalization for Schizophrenia (7- and 30-day) 0004 : Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment 3312 : Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) 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	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	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	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	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

	3453 Continuity of care after inpatient or residential treatment for substance use disorder (SUD)	0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	0576 Follow-Up After Hospitalization for Mental Illness (FUH)	2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence	3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs
	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			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.	(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)	0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	0576 Follow-Up After Hospitalization for Mental Illness (FUH)	2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence	3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs
	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.				

Comparison of NQF 0004, 2599, 3312, 2605, and 2152

	0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	2599 Alcohol Screening and Follow-up for People with Serious Mental Illness	3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs	2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence	2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling
Steward	National Committee for Quality Assurance	National Committee for Quality Assurance	Centers for Medicare & Medicaid Services, Centers for Medicaid & CHIP Services	National Committee for Quality Assurance	PCPI Foundation
Description	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.	The percentage of patients 18 years and older with a serious mental illness, who were screened for unhealthy alcohol use and received brief counseling or other follow-up care if identified as an unhealthy alcohol user. Note: The proposed health plan measure is adapted from an existing provider-level measure for the general population (NQF #2152: Preventive Care & Screening: Unhealthy Alcohol Use: Screening & Brief Counseling). It was originally endorsed in 2014 and is currently stewarded by the American Medical Association (AMA-PCPI).	Percentage of discharges from a detoxification episode for adult Medicaid Beneficiaries, age 18-64, that was 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. This measure is reported across all detoxification settings.	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.	Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user
Type	Process	Process	Process	Process	Process
Data Source	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	Claims, Electronic Health Records, Paper Medical Records The denominator for this measure is based on administrative claims. The numerator for this measure is based on administrative claims and/or medical record documentation collected in the course of providing care to health plan patients. No data collection instrument provided Attachment 2599_Alcohol_Screening_for_People_With_Mental_Illness_Value_Set-636583545268612951-636769175260262857.xlsx	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 Cont_Care_After_Detox_Value_Sets.xlsx	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	Registry Data Not applicable. No data collection instrument provided No data dictionary
Level	Health Plan	Health Plan	Population : Regional and State	Health Plan, Population : Regional and State	Clinician : Group/Practice, Clinician : Individual

	0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	2599 Alcohol Screening and Follow-up for People with Serious Mental Illness	3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs	2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence	2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling
Setting	Emergency Department and Services, Inpatient/Hospital, Outpatient Services	Outpatient Services	Inpatient/Hospital, Outpatient Services	Inpatient/Hospital, Outpatient Services	Home Care, Outpatient Services
Numerator Statement	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.	Patients 18 years and older who are screened for unhealthy alcohol use during the last 3 months of the year prior to the measurement year through the first 9 months of the measurement year and received two events of counseling if identified as an unhealthy alcohol user.	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 a detoxification episode.	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	Patients who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user
Numerator Details	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	Alcohol Use Screening ADMINISTRATIVE: Patients who had systematic screening for unhealthy alcohol use (see Alcohol Screening Value Set) as identified by claim/encounter data during the last 3 months of the year prior to the measurement year through the first 9 months of the measurement year. MEDICAL RECORD: Patients who had systematic screening for unhealthy alcohol use during the last 3 months of the year prior to the measurement year through the first 9 months of the measurement year. Systematic Screening A systematic screening method is defined as: Asking the patient about their weekly use (alcoholic drinks per week), or Asking the patient about their per occasion use (alcoholic drinks per drinking day) or	Measure data will be reported annually (12 months). To account for the 14-day time period after discharge from detoxification, the denominator period will start January 1 and end December 15 of the measurement year. The numerator includes individuals with any of the following within 14 days after discharge from detoxification: -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.	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	Time Period for Data Collection: At least once during the 24 month period. Definitions: Systematic screening method - For purposes of this measure, one of the following systematic methods to assess unhealthy alcohol use must be utilized. Systematic screening methods and thresholds for defining unhealthy alcohol use include: • AUDIT Screening Instrument (score >= 8) • AUDIT-C Screening Instrument (score >= 4 for men; score >= 3 for women) • Single Question Screening - How many times in the past year have you had 5 (for men) or 4 (for women and all adults older than 65 years) or more drinks in a day? (response >= 2) Brief counseling - Brief counseling for unhealthy alcohol use refers to one or more counseling sessions, a minimum of 5-15 minutes, which may include: feedback on alcohol use and

	0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	2599 Alcohol Screening and Follow-up for People with Serious Mental Illness	3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs	2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence	2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling
	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	Using a standardized tool such as the AUDIT, AUDIT-C, or CAGE or Using another standardized tool Unhealthy Alcohol Use Unhealthy alcohol use covers a spectrum that is associated with varying degrees of risk to health. Categories representing unhealthy alcohol use include risky use, problem drinking, harmful use, and alcohol abuse, and the less common but more severe alcoholism and alcohol dependence. Risky use is defined as >7 standard drinks per week or >3 drinks per occasion for women and persons >65 years of age; >14 standard drinks per week or >4 drinks per occasion for men =65 years of age. Follow-Up ADMINISTRATIVE: Patients who received two events of counseling (see Alcohol Screening and Brief Counseling Value Set) as identified by claim/encounter data within three months of screening if identified as unhealthy alcohol users. MEDICAL RECORD: Patients who received two events of counseling within three months of screening if identified as unhealthy alcohol users. The two event of counseling could be with the provider who performed screening or another provider including health plan clinical case managers. Participation in peer led support activities (such as Alcoholics Anonymous or Narcotics Anonymous) can count if documented in the health record (referrals alone do not count). Counseling Counseling may include at least one of the following: Feedback on alcohol use and harms Identification of high risk situations for drinking and coping strategies Increase the motivation to reduce drinking Development of a personal plan to reduce drinking	-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. Continuity is reset to zero if an overdose diagnosis code appears on the same outpatient or inpatient claim. SUD diagnoses are used to identify procedures connected to SUD diagnoses. SUD diagnoses are identified through ICD-9 codes. Procedures are defined using a combination of Healthcare Common Procedure Coding System (HCPCS) codes, Uniform Billing (UB) Revenue Codes and ICD-9/ICD-10 procedure codes. 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). A list of value sets for the measure is attached in the Excel workbook provided for question S.2b. States may need to adapt the list of codes to include state-specific codes.	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	harms; identification of high risk situations for drinking and coping strategies; increased motivation and the development of a personal plan to reduce drinking. NUMERATOR NOTE: In the event that a patient is screened for unhealthy alcohol use and identified as a user but did not receive brief alcohol cessation counseling submit G9624. For Registry: Report Quality Data Code: G9621 - Patient identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method and received brief counseling OR G9622 - Patient not identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method

	0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	2599 Alcohol Screening and Follow-up for People with Serious Mental Illness	3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs	2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence	2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling
	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).			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).	

	0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	2599 Alcohol Screening and Follow-up for People with Serious Mental Illness	3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs	2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence	2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling
	• 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				

	0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	2599 Alcohol Screening and Follow-up for People with Serious Mental Illness	3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs	2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence	2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling
	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				

	0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	2599 Alcohol Screening and Follow-up for People with Serious Mental Illness	3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs	2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence	2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling
	(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:				

	0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	2599 Alcohol Screening and Follow-up for People with Serious Mental Illness	3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs	2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence	2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling
	• 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.				
Denominator Statement	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).	All patients 18 years of age or older as of December 31 of the measurement year with at least one inpatient visit or two outpatient visits for schizophrenia or bipolar I disorder, or at least one inpatient visit for major depression during the measurement year.	Adult Medicaid beneficiary discharges from detoxification from January 1 to December 15 of the measurement year.	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.	All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period
Denominator Details	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,	Age: 18 years and older Benefit: Medical Continuous Enrollment: No more than one gap in enrollment of up to 45 days during each year of the measurement year and the year prior. To determine continuous enrollment for a Medicaid	Measure data will be reported annually (12 months). To account for the 14-day time period after discharge from detoxification, the denominator period will start January 1 and end December 15 of the measurement year.	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	Time Period for Data Collection: 12 consecutive months For Registry: Patients aged >= 18 years AND At least two patient encounters during the performance period (CPT or

	0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	2599 Alcohol Screening and Follow-up for People with Serious Mental Illness	3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs	2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence	2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling
	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.	beneficiary for whom enrollment is verified monthly, the person may not have more than a one month gap in coverage (i.e., a person whose coverage lapses for two months [60 days] is not considered continuously enrolled). Diagnosis Criteria: Identify patients with a serious mental illness. They must meet at least one of the following criteria during the measurement year or the year prior: At least one acute inpatient claim/encounter with any diagnosis of schizophrenia, bipolar I disorder, or major depression using any of the following code combinations: BH Stand Alone Acute Inpatient Value Set with one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set - Major Depression Value Set BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set and one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set - Major Depression Value Set At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or non-acute inpatient setting, on different dates of service, with any diagnosis of schizophrenia or bipolar I disorder. Any two of the following code combinations meet criteria: BH Stand Alone Outpatient/PH/IOP Value Set with one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set and one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set ED Value Set with one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set BH ED Value Set with BH ED POS Value Set and one of the following diagnoses:	Target population meets the following conditions: • Medicaid beneficiaries aged 18 years and older and less than 65 years with at least one detox discharge during the year January 1-December 15. • Enrolled in Medicaid during the month of detoxification discharge and the following month. The denominator is based on discharges, not individuals. A beneficiary may have more than one qualifying detox episode. Detoxification is identified using a combination of HCPCS codes, UB Revenue Codes and ICD-9/ICD-10 procedure codes. A list of value sets for the measure is attached in the Excel workbook provided for question S.2b. As with the numerator specifications, this document lists standardized specification for this measure. States will likely need to modify the specifications to include their state-specific codes.	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.	HCPCS): 90791, 90792, 90832, 90834, 90837, 90845, 96150, 96151, 96152, 97165, 97166, 97167, 97168, 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0270, G0271 WITHOUT Telehealth Modifier: GQ, GT, 95, POS 2 OR At Least One Preventive Visit during the performance period (CPT or HCPCS): 99385, 99386, 99387, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99429, G0438, G0439 WITHOUT Telehealth Modifier: GQ, GT, 95, POS 02

	0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	2599 Alcohol Screening and Follow-up for People with Serious Mental Illness	3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs	2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence	2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling
	• 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.	- Schizophrenia Value Set - Bipolar Disorder Value Set BH Stand Alone Nonacute Inpatient Value Set with one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set BH Nonacute Inpatient Value Set with BH Nonacute Inpatient POS Value Set and one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set			
Exclusions	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)	Active diagnosis of alcohol abuse or dependence during the first nine months of the year prior to the measurement year (see Alcohol Disorders Value Set).	Not applicable. The measure does not have denominator exclusions.	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,	Documentation of medical reason(s) for not screening for unhealthy alcohol use (eg, limited life expectancy, other medical reasons)

	0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	2599 Alcohol Screening and Follow-up for People with Serious Mental Illness	3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs	2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence	2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling
	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.			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.	
Exclusion Details	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.	Denominator exclusions are found through medical record or claims data (see Alcohol Disorders Value Set).	Not applicable.	See Section S.10 for exclusion details	Time Period for Data Collection: Denominator Exception(s) are determined on the date of the most recent denominator eligible encounter. Exceptions are used to remove a patient from the denominator of a performance measure when the patient does not receive a therapy or service AND that therapy or service would not be appropriate due to patient-specific reasons. The patient would otherwise meet the denominator criteria. Exceptions are not absolute, and are based on clinical judgment, individual patient characteristics, or patient preferences. The PCPI exception methodology uses three categories of reasons for which a patient may be removed from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For measure Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling, exceptions may include medical reason(s) (eg, limited life expectancy, other medical reasons). Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement. For Registry: Report Quality Data Code: G9623 - Documentation of medical reason(s) for not screening for unhealthy

	0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	2599 Alcohol Screening and Follow-up for People with Serious Mental Illness	3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs	2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence	2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling
					alcohol use (e.g., limited life expectancy, other medical reasons)
Risk Adjustment	No risk adjustment or risk stratification	No risk adjustment or risk stratification	No risk adjustment or risk stratification	No risk adjustment or risk stratification	No risk adjustment or risk stratification
Stratification	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.	Not applicable.	Location of detox is used as a stratification variable in analyses. If an inpatient hospital claim had an ICD-9/ICD-10 detoxification procedure code or a UB revenue code indicating detoxification, hospital inpatient treatment is assigned as the location of detox. In addition, hospital inpatient treatment is also assigned if a non-inpatient claim contains a HCPCS code indicating hospital inpatient detox. The remaining detox location assignments are very straightforward. Whenever possible, use of the HCPCS codes to determine location is most desired as it reflects the more precise detoxification location. The other stayover treatment location is designed to capture detox location from non-inpatient claims that do not contain a HCPCS code. A list of value sets for the measure is attached in the Excel workbook provided for question S.2b.	Not applicable.	Consistent with CMS' Measures Management System Blueprint and recent national recommendations put forth by the IOM and NQF, the PCPI encourages the collection of race and ethnicity data as well as the results of this measure to be stratified by race, ethnicity, administrative sex, and payer.
Type Score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score
Algorithm	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.	Step 1: Determine the eligible population. Step 1A: Identify all patients 18 years of age or older with a serious mental illness Step 1B: Exclude patients from step 1A who have a diagnosis of unhealthy alcohol use during the first 9 months of the year prior to the measurement year. Step 2: Identify Numerator. Step 2A: Identify the date of screening for unhealthy alcohol use during the measurement year or the year prior within the medical chart Step 2B: Identify the unhealthy alcohol screening result within the medical chart. If negative for unhealthy alcohol use, stop. Step 2C: If positive for unhealthy alcohol use, identify the date of any follow-up care occurring within three months of screening. Step 3: Calculate the rate by adding the number of patients with a negative screening for unhealthy alcohol use (from step 2B) plus the number of patients with positive screening for unhealthy	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 enrolled Medicaid beneficiaries ages 18-64 years who have any detoxification (withdrawal management) in inpatient hospital, residential addiction treatment program, or ambulatory detoxification (withdrawal management) discharge from January 1 to December 15 of the measurement year and are enrolled the month of detoxification and the following month. Age is calculated as of January 1 of the measurement year. Step 1B: Overall: Among the Medicaid beneficiaries in Step 1A, identify all detoxification discharges using all inpatient, outpatient and ambulatory claims files or tables that contain HCPCS or ICD-9/ICD-10 procedure codes and UB revenue codes. If more than one detoxification in a year, treat each detoxification as a separate observation,	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	To calculate performance rates: 1. Find the patients who meet the initial population (ie, the general group of patients that a set of performance measures is designed to address). 2. From the patients within the initial population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial population and denominator are identical. 3. From the patients within the denominator, find the patients who meet the numerator criteria (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator 4. From the patients who did not meet the numerator criteria, determine if the provider has documented that the patient meets any criteria for exception when denominator exceptions have been specified [for this measure: medical reason(s)

	0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	2599 Alcohol Screening and Follow-up for People with Serious Mental Illness	3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs	2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence	2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling
		alcohol use and those who received follow-up care (from step 2C) and divide this by the number of patients calculated to be in the eligible population (those remaining after Step 1B is complete.)	e.g., an inpatient hospital detoxification in January and an ambulatory detoxification in July, counts as two observations. Step 1B.1: Multiple detox claims that are within 1-2 days are combined into a single detox episode. Accordingly, sort the inpatient, outpatient and ambulatory detox discharges by Beneficiary ID and service dates to ensure the discharges from these multiple data sources are in chronological order. Then combine close-proximity episodes while retaining all clinical fields from each episode. Step 1C: Detox location assignment: hospital inpatient, inpatient residential addiction, outpatient residential outpatient addiction, other stayover treatment and ambulatory detoxification. Use HCPCs detox procedure codes to assign detox location whenever possible; revenue center detox will map to the hospital inpatient location when the revenue codes appear on an inpatient claim or table. They will map to other stayover treatment when the revenue codes appear on a non-inpatient claim. If there is more than 1 detox location when episodes are combined, assign the location using the first claim's location. If there is a TIE between a detox 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: Overall: From the denominator in Step 1B, identify those discharges from detoxification 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). 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, the	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).	(eg, limited life expectancy, other medical reasons)]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. -- Although the exception cases are removed from the denominator population for the performance calculation, the exception rate (ie, percentage with valid exceptions) should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI. If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure.

	0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	2599 Alcohol Screening and Follow-up for People with Serious Mental Illness	3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs	2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence	2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling
			specification 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 detox 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. 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 detox through day 7 or 14. Step 2A.3: Co-occurring events: Continuity service flags and pharmacotherapy flags are reset to zero if an overdose diagnosis code appears on the SAME claim as the continuity service. Further, outpatient continuity is also reset to zero if an emergency department visit occurs on the same day. If an inpatient continuity claim has an emergency department visit, 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 detox location by dividing the respective number of discharges by each location with a qualifying continuity service (Step 2A) by the denominator (Step 1C).		
Submission items	5.1 Identified measures: 5a.1 Are specs completely harmonized? 5a.2 If not completely harmonized, identify difference, rationale, impact:	5.1 Identified measures: 2152 : Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling 5a.1 Are specs completely harmonized? 5a.2 If not completely harmonized, identify	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	5.1 Identified measures: 0576 : Follow-Up After Hospitalization for Mental Illness (FUH) 1937 : Follow-Up After Hospitalization for Schizophrenia (7- and 30-day)	5.1 Identified measures: 5a.1 Are specs completely harmonized? Yes 5a.2 If not completely harmonized, identify difference, rationale, impact: The related measures listed in 5.1b were developed after our

	0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	2599 Alcohol Screening and Follow-up for People with Serious Mental Illness	3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs	2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence	2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling
	5b.1 If competing, why superior or rationale for additive value: N/A	difference, rationale, impact: This measure was adapted from the existing provider-level measure (NQF #2152: Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling) for use at the health plan level for the high risk subpopulation of people with serious mental illness. The measure is harmonized and has been reviewed with the original measure stewards and developers. The differences between the existing measure and the proposed serious mental illness subpopulation measure were developed with expert input and are described here. -The population focus: This measure focuses on people with serious mental illness, who are at a higher risk of unhealthy alcohol use than the general population and have demonstrated disparities in care -What counts as follow-up and the number of events for follow-up: This measure requires two events of counseling, raising expectations for the intensity of service for the serious mental illness population compared to the original measure for the general population, and is reasonably achievable, particularly in the health plan context. USPSTF recommendation supports multi-contact counseling which seems to have the best evidence of effectiveness. -In addition, the existing measure (NQF #2152) is reported at the provider level and is focused on follow-up conducted at time of screening making a single event sufficient. However, at the health plan level, there is opportunity/responsibility for follow-up care beyond the visit. We believe our measure focused on screening patients with SMI for unhealthy alcohol use and capturing more intensive evidence-based follow-up care for a vulnerable population contributes to the national quality agenda. 5b.1 If competing, why superior or rationale for additive value: Not applicable.	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.	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.	measure. The NCQA measure focuses on a specific sub-population (people with serious mental illness) and is intended for use at the health plan level. In the TJC measures, screening and intervention are separate measures. Additionally, the TJC measures are intended for use at the hospital level. PCPI was contacted by these measure stewards respectively while the measures were developed, and they are currently harmonized to the extent feasible.

Appendix E2: Related and Competing Measures (narrative version)

Comparison of NQF 3451 and NQF 0576

3451 Non-Acute Mental Health Services Utilization for Dual Eligible Beneficiaries
0576 Follow-Up After Hospitalization for Mental Illness (FUH)

Steward

3451 Non-Acute Mental Health Services Utilization for Dual Eligible Beneficiaries

Centers for Medicare & Medicaid Services

0576 Follow-Up After Hospitalization for Mental Illness (FUH)

National Committee for Quality Assurance

Description

3451 Non-Acute Mental Health Services Utilization for Dual Eligible Beneficiaries

The percentage of dual eligible beneficiaries with a mental health service need who received a non-acute mental health service in the measurement year.

0576 Follow-Up After Hospitalization for Mental Illness (FUH)

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

- The percentage of discharges for which the patient received follow-up within 30 days of discharge

- The percentage of discharges for which the patient received follow-up within 7 days of discharge.

Type

3451 Non-Acute Mental Health Services Utilization for Dual Eligible Beneficiaries

Process

0576 Follow-Up After Hospitalization for Mental Illness (FUH)

Process

Data Source

3451 Non-Acute Mental Health Services Utilization for Dual Eligible Beneficiaries

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

No data collection instrument provided Attachment FINAL_-_7.18.18_-_Duals12_ValueSets.xlsx

0576 Follow-Up After Hospitalization for Mental Illness (FUH)

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_Value_Sets.xlsx

Level

3451 Non-Acute Mental Health Services Utilization for Dual Eligible Beneficiaries

Health Plan

0576 Follow-Up After Hospitalization for Mental Illness (FUH)

Health Plan, Integrated Delivery System

Setting

3451 Non-Acute Mental Health Services Utilization for Dual Eligible Beneficiaries

Home Care, Outpatient Services, Post-Acute Care

0576 Follow-Up After Hospitalization for Mental Illness (FUH)

Inpatient/Hospital, Outpatient Services

Numerator Statement

3451 Non-Acute Mental Health Services Utilization for Dual Eligible Beneficiaries

The number of dual eligible beneficiaries receiving at least one non-acute mental health service in the 12-month measurement year. The following services are included as non-acute mental health services:

- Outpatient service with a mental health provider for a mental health diagnosis
- Mental health outpatient encounter
- Mental health condition management in primary care

0576 Follow-Up After Hospitalization for Mental Illness (FUH)

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

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

Numerator Details

3451 Non-Acute Mental Health Services Utilization for Dual Eligible Beneficiaries

Include in the numerator all dual eligible beneficiaries receiving at least one non-acute mental health service (defined below) in the 12-month measurement year:

Non-Acute Mental Health Service Definition

A non-acute mental health service use is identified by the occurrence of any of the following three criteria:

1. Any claim with from a mental health provider with a primary diagnosis code for mental health diagnosis (Mental Health Diagnosis Value Set) AND servicing provider taxonomy code is in the set: 101Y00000X, 101YM0800X, 101YP2500X, 103G00000X, 103T00000X, 103TB0200X, 103TC0700X, 103TC1900X, 103TC2200X, 103TF0000X, 103TH0100X, 103TP0016X, 103TP0814X, 103TP2700X, 103TP2701X, 103TR0400X, 104100000X, 1041C0700X, 106H00000X, 163WP0809X, 2080P0006X, 2084A0401X, 2084F0202X, 2084N0400X, 2084N0402X, 2084N0600X, 2084P0015X, 2084P0800X, 2084P0802X,

2084P0804X, 2084P0805X, 2084S0012X, 2084V0102X, 251S00000X, 261QM0801X, 273R00000X, 283Q00000X, 323P00000X, 363LP0808X, 364SP0808X

2. Any claim with a mental health service procedure code in the following value sets (MPT IOP/PH Group 1, MPT Stand Alone Outpatient Group 1, Electroconvulsive Therapy, Transcranial Magnetic Stimulation) OR any procedure code in the following set: 90791, 90792, 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815, 90816, 90817, 90818, 90819, 90821, 90822, 90823, 90824, 90825, 90826, 90827, 90828, 90829, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90846, 90847, 90849, 90853, 90857, 90862, 90889, 96101, 96102, 96103, 96110, 96111, 96116, 96118, 96119, 96120, 90867, 90868, 90869, 90870, 90875, 90876, 96127, G0155, G0176, G0177, H0004, H0023, H0025, H0027, H0030, H0031, H0032, H0035, H0036, H0037, H0038, H0039, H0040, H0046, H1011, H2011, H2012, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, H2021, H2022, H2023, H2035, H2027, H2030, H2031, H2033, M0064, Q5008, S9480, S9482, S9484, S9485, T1025, T1026, T2038, T2048

3. Any claim from a primary care provider with a primary diagnosis code for mental health diagnosis (Mental Health Diagnosis Value Set) AND procedure code is in the set: 99201-99215 (Office), 99241-99255 (Consultation), or?99441-99444 (telephonic or online)

0576 Follow-Up After Hospitalization for Mental Illness (FUH)

For both indicators, a follow-up visit includes outpatient visits, intensive outpatient visits or partial hospitalizations that occur on the date of discharge. Any of the following meet criteria for a follow-up visit:

- A visit (FUH Stand Alone Visits Value Set; FUH Visits Group 1 Value Set and FUH POS Group 1 Value Set; FUH Visits Group 2 Value Set and FUH POS Group 2 Value Set) with a mental health practitioner (see definition below).

- 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 mental health practitioner.

- A visit to a non-behavioral healthcare facility (FUH RevCodes Group 2 Value Set) with a diagnosis of mental illness (Mental Illness Value Set).

- Transitional care management services (TCM 7 Day Value Set).

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

- Transitional care management services (TCM 14 Day Value Set)

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

Mental Health Practitioner Definition:

A practitioner who provides mental health services and meets any of the following criteria:

- An MD or doctor of osteopathy (DO) who is certified as a psychiatrist or child psychiatrist by the American Medical Specialties Board of Psychiatry and Neurology or by the American Osteopathic Board of Neurology and Psychiatry; or, if not certified, who successfully completed an accredited program of graduate medical or osteopathic education in psychiatry or child psychiatry and is licensed to practice patient care psychiatry or child psychiatry, if required by the state of practice.
- An individual who is licensed as a psychologist in his/her state of practice, if required by the state of practice.

- An individual who is certified in clinical social work by the American Board of Examiners; who is listed on the National Association of Social Worker's Clinical Register; or who has a master's degree in social work and is licensed or certified to practice as a social worker, if required by the state of practice.
- A registered nurse (RN) who is certified by the American Nurses Credentialing Center (a subsidiary of the American Nurses Association) as a psychiatric nurse or mental health clinical nurse specialist, or who has a master's degree in nursing with a specialization in psychiatric/mental health and two years of supervised clinical experience and is licensed to practice as a psychiatric or mental health nurse, if required by the state of practice.
- An individual (normally with a master's or a doctoral degree in marital and family therapy and at least two years of supervised clinical experience) who is practicing as a marital and family therapist and is licensed or a certified counselor by the state of practice, or if licensure or certification is not required by the state of practice, who is eligible for clinical membership in the American Association for Marriage and Family Therapy.
- An individual (normally with a master's or doctoral degree in counseling and at least two years of supervised clinical experience) who is practicing as a professional counselor and who is licensed or certified to do so by the state of practice, or if licensure or certification is not required by the state of practice, is a National Certified Counselor with a Specialty Certification in Clinical Mental Health Counseling from the National Board for Certified Counselors (NBCC).

Denominator Statement

3451 Non-Acute Mental Health Services Utilization for Dual Eligible Beneficiaries

The number of dual eligible beneficiaries age 21 and older with a mental health service need in the 18-month identification window (the 12-month measurement year plus six months prior to the measurement year).

0576 Follow-Up After Hospitalization for Mental Illness (FUH)

Discharges from an acute inpatient setting (including acute care psychiatric facilities) with a principal diagnosis of mental illness during the first 11 months of the measurement year (i.e., January 1 to December 1) for patients 6 years and older.

Denominator Details

3451 Non-Acute Mental Health Services Utilization for Dual Eligible Beneficiaries

Include in the denominator all dual eligible beneficiaries age 21 and older continuously enrolled in the 12-month measurement year and at least 5 months of the 6 months prior to the measurement year with a mental health service need (defined below) in the 18-month identification window.

Mental Health Service Need Definition

Mental health service need is identified by the occurrence of any of the following conditions:

1. Receipt of any mental health service meeting the numerator service criteria in the 18-month identification window

2. Any diagnosis of mental illness (not restricted to primary) in the 18-month identification window. These include diagnoses from the following value sets:

a) Psychotic Diagnosis Value Set 101

b) Mania/Bipolar Diagnosis Value Set 102

c) Depression Diagnosis Value Set 103

d) Anxiety Diagnosis Value Set 104

e) ADHD Diagnosis Value Set 105

f) Disruptive/Impulse/Conduct Diagnosis Value Set 106

g) Adjustment Diagnosis Value Set 107

h) Other Mental Health Diagnosis Value Set

3. Receipt of any psychotropic medication listed in the Rx Table (see attached excel spreadsheet) in the 18-month identification window. These medications comprise the following drug therapy classes:

a) Antianxiety Rx

b) Antidepressants Rx

c) Antimania Rx

d) Antipsychotic Rx

e) ADHD Rx

4. Any claim with a mental health service procedure code in the following set:

90791, 90792, 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815, 90816, 90817, 90818, 90819, 90821, 90822, 90823, 90824, 90825, 90826, 90827, 90828, 90829, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90846, 90847, 90849, 90853, 90857, 90862, 90889, 96101, 96102, 96103, 96110, 96111, 96116, 96118, 96119, 96120, 90867, 90868, 90869, 90870, 90875, 90876, 96127, G0155, G0176, G0177, H0004, H0023, H0025, H0027, H0030, H0031, H0032, H0035, H0036, H0037, H0038, H0039, H0040, H0046, H1011, H2011, H2012, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, H2021, H2022, H2023, H2035, H2027, H2030, H2031, H2033, M0064, Q5008, S9480, S9482, S9484, S9485, T1025, T1026, T2038, T2048

5. Any psychiatric inpatient stay in the following facility types: Community Psychiatric Hospital, Evaluation & Treatment Center

0576 Follow-Up After Hospitalization for Mental Illness (FUH)

An acute inpatient discharge with a principal diagnosis of mental illness (Mental Illness Value Set) on or between January 1 and December 1 of the measurement year.

To identify acute inpatient discharges:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).

2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).

3. Identify the discharge date for the stay.

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

Acute facility readmission or direct transfer:

If the discharge is followed by readmission or direct transfer to an acute inpatient care setting for a principal diagnosis of mental health (Mental Health Diagnosis Value Set) within the 30-day follow-up period, count only the last discharge.

To identify readmissions to an acute inpatient care setting:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).

2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).

3. Identify the admission date for the stay.

*Due to the extensive volume of codes associated with identifying the denominator for this measure, we are attaching a separate file with value sets. See value sets located in question S.2b.

Exclusions

3451 Non-Acute Mental Health Services Utilization for Dual Eligible Beneficiaries

None

0576 Follow-Up After Hospitalization for Mental Illness (FUH)

Exclude from the denominator for both rates, patients who receive hospice services during the measurement year.

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 for non-mental health.

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

Exclusion Details

3451 Non-Acute Mental Health Services Utilization for Dual Eligible Beneficiaries

None

0576 Follow-Up After Hospitalization for Mental Illness (FUH)

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).

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

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

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).

2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.

3. Identify the admission date for the stay.

Exclude discharges followed by readmission or direct transfer to an acute inpatient care setting within the 30-day follow-up period if the principal diagnosis was for non-mental

health (any principal diagnosis code other than those included in the Mental Health Diagnosis Value Set). To identify readmissions to an acute inpatient care setting:

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

These discharges are excluded from the measure because rehospitalization or 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

3451 Non-Acute Mental Health Services Utilization for Dual Eligible Beneficiaries

Stratification by risk category/subgroup

0576 Follow-Up After Hospitalization for Mental Illness (FUH)

No risk adjustment or risk stratification

Stratification

3451 Non-Acute Mental Health Services Utilization for Dual Eligible Beneficiaries

Measure is stratified by patient age as of the last day of the measurement period:

1. Age 21 to 64
2. Age 65 and older

0576 Follow-Up After Hospitalization for Mental Illness (FUH)

N/A

Type Score

3451 Non-Acute Mental Health Services Utilization for Dual Eligible Beneficiaries

Rate/proportion better quality = higher score

0576 Follow-Up After Hospitalization for Mental Illness (FUH)

Rate/proportion better quality = higher score

Algorithm

3451 Non-Acute Mental Health Services Utilization for Dual Eligible Beneficiaries

1. Identify the denominator – individuals with a mental health service need in the measurement year or 6 months prior to the measurement year (see S.7).
2. Stratify individuals in the denominator into age groups (i.e., 18-64, 65+) based on age on the last day of the measurement period (see S.10).
3. Among the remainder denominator population, identify the numerator – individuals who received a mental health service in the measurement year (S.5).
4. For each age group, divide the numerator population (step 3) by the denominator (step 2).

0576 Follow-Up After Hospitalization for Mental Illness (FUH)

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.

Submission items

3451 Non-Acute Mental Health Services Utilization for Dual Eligible Beneficiaries

5.1 Identified measures:

5a.1 Are specs completely harmonized?

5a.2 If not completely harmonized, identify difference, rationale, impact: Not applicable. There are no related NQF-endorsed measures.

5b.1 If competing, why superior or rationale for additive value: Not applicable. This measure does not address both the same measure focus and same target population as another NQF-endorsed measure.

0576 Follow-Up After Hospitalization for Mental Illness (FUH)

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

Comparison of NQF 2152 and NQF 2599

2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling
2599 Alcohol Screening and Follow-up for People with Serious Mental Illness

Steward

2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

PCPI Foundation

2599 Alcohol Screening and Follow-up for People with Serious Mental Illness

National Committee for Quality Assurance

Description

2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

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

2599 Alcohol Screening and Follow-up for People with Serious Mental Illness

The percentage of patients 18 years and older with a serious mental illness, who were screened for unhealthy alcohol use and received brief counseling or other follow-up care if identified as an unhealthy alcohol user.

Note: The proposed health plan measure is adapted from an existing provider-level measure for the general population (NQF #2152: Preventive Care & Screening: Unhealthy Alcohol Use: Screening & Brief Counseling). It was originally endorsed in 2014 and is currently stewarded by the American Medical Association (AMA-PCPI).

Type

2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

Process

2599 Alcohol Screening and Follow-up for People with Serious Mental Illness

Process

Data Source

2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

Registry Data Not applicable.

No data collection instrument provided No data dictionary

2599 Alcohol Screening and Follow-up for People with Serious Mental Illness

Claims, Electronic Health Records, Paper Medical Records The denominator for this measure is based on administrative claims. The numerator for this measure is based on administrative claims and/or medical record documentation collected in the course of providing care to health plan patients.

No data collection instrument provided Attachment 2599_Alcohol_Screening_for_People_With_Mental_Illness_Value_Set-636583545268612951-636769175260262857.xlsx

Level

2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

Clinician : Group/Practice, Clinician : Individual

2599 Alcohol Screening and Follow-up for People with Serious Mental Illness

Health Plan

Setting

2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

Home Care, Outpatient Services

2599 Alcohol Screening and Follow-up for People with Serious Mental Illness

Outpatient Services

Numerator Statement

2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

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

2599 Alcohol Screening and Follow-up for People with Serious Mental Illness

Patients 18 years and older who are screened for unhealthy alcohol use during the last 3 months of the year prior to the measurement year through the first 9 months of the measurement year and received two events of counseling if identified as an unhealthy alcohol user.

Numerator Details

2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

Time Period for Data Collection: At least once during the 24 month period.

Definitions:

Systematic screening method - For purposes of this measure, one of the following systematic methods to assess unhealthy alcohol use must be utilized. Systematic screening methods and thresholds for defining unhealthy alcohol use include:

- AUDIT Screening Instrument (score >= 8)
- AUDIT-C Screening Instrument (score >= 4 for men; score >= 3 for women)
- Single Question Screening - How many times in the past year have you had 5 (for men) or 4 (for women and all adults older than 65 years) or more drinks in a day? (response >= 2)

Brief counseling - Brief counseling for unhealthy alcohol use refers to one or more counseling sessions, a minimum of 5-15 minutes, which may include: feedback on alcohol use and harms; identification of high risk situations for drinking and coping strategies; increased motivation and the development of a personal plan to reduce drinking.

NUMERATOR NOTE: In the event that a patient is screened for unhealthy alcohol use and identified as a user but did not receive brief alcohol cessation counseling submit G9624.

For Registry:

Report Quality Data Code:

G9621 - Patient identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method and received brief counseling

OR

G9622 - Patient not identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method

2599 Alcohol Screening and Follow-up for People with Serious Mental Illness

Alcohol Use Screening

ADMINISTRATIVE:

Patients who had systematic screening for unhealthy alcohol use (see Alcohol Screening Value Set) as identified by claim/encounter data during the last 3 months of the year prior to the measurement year through the first 9 months of the measurement year.

MEDICAL RECORD:

Patients who had systematic screening for unhealthy alcohol use during the last 3 months of the year prior to the measurement year through the first 9 months of the measurement year.

Systematic Screening

A systematic screening method is defined as:

Asking the patient about their weekly use (alcoholic drinks per week), or

Asking the patient about their per occasion use (alcoholic drinks per drinking day) or

Using a standardized tool such as the AUDIT, AUDIT-C, or CAGE or

Using another standardized tool

Unhealthy Alcohol Use

Unhealthy alcohol use covers a spectrum that is associated with varying degrees of risk to health. Categories representing unhealthy alcohol use include risky use, problem drinking, harmful use, and alcohol abuse, and the less common but more severe alcoholism and alcohol dependence. Risky use is defined as >7 standard drinks per week or >3 drinks per occasion for women and persons >65 years of age; >14 standard drinks per week or >4 drinks per occasion for men =65 years of age.

Follow-Up

ADMINISTRATIVE:

Patients who received two events of counseling (see Alcohol Screening and Brief Counseling Value Set) as identified by claim/encounter data within three months of screening if identified as unhealthy alcohol users.

MEDICAL RECORD:

Patients who received two events of counseling within three months of screening if identified as unhealthy alcohol users. The two event of counseling could be with the provider who performed screening or another provider including health plan clinical case managers. Participation in peer led support activities (such as Alcoholics Anonymous or Narcotics Anonymous) can count if documented in the health record (referrals alone do not count).

Counseling

Counseling may include at least one of the following:

Feedback on alcohol use and harms

Identification of high risk situations for drinking and coping strategies

Increase the motivation to reduce drinking

Development of a personal plan to reduce drinking

Denominator Statement

2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period

2599 Alcohol Screening and Follow-up for People with Serious Mental Illness

All patients 18 years of age or older as of December 31 of the measurement year with at least one inpatient visit or two outpatient visits for schizophrenia or bipolar I disorder, or at least one inpatient visit for major depression during the measurement year.

Denominator Details

2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

Time Period for Data Collection: 12 consecutive months

For Registry:

Patients aged >= 18 years

AND

At least two patient encounters during the performance period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 90845, 96150, 96151, 96152, 97165, 97166, 97167, 97168, 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0270, G0271

WITHOUT

Telehealth Modifier: GQ, GT, 95, POS 2

OR

At Least One Preventive Visit during the performance period (CPT or HCPCS): 99385, 99386, 99387, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99429, G0438, G0439

WITHOUT

Telehealth Modifier: GQ, GT, 95, POS 02

2599 Alcohol Screening and Follow-up for People with Serious Mental Illness

Age: 18 years and older

Benefit: Medical

Continuous Enrollment: No more than one gap in enrollment of up to 45 days during each year of the measurement year and the year prior. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the person may not have more than a one month gap in coverage (i.e., a person whose coverage lapses for two months [60 days] is not considered continuously enrolled).

Diagnosis Criteria: Identify patients with a serious mental illness. They must meet at least one of the following criteria during the measurement year or the year prior:

At least one acute inpatient claim/encounter with any diagnosis of schizophrenia, bipolar I disorder, or major depression using any of the following code combinations:

BH Stand Alone Acute Inpatient Value Set with one of the following diagnoses:

- Schizophrenia Value Set
- Bipolar Disorder Value Set
- Major Depression Value Set

BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set and one of the following diagnoses:

- Schizophrenia Value Set
- Bipolar Disorder Value Set
- Major Depression Value Set

At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or non-acute inpatient setting, on different dates of service, with any diagnosis of schizophrenia or bipolar I disorder. Any two of the following code combinations meet criteria:

BH Stand Alone Outpatient/PH/IOP Value Set with one of the following diagnoses:

- Schizophrenia Value Set
- Bipolar Disorder Value Set

BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set and one of the following diagnoses:

- Schizophrenia Value Set
- Bipolar Disorder Value Set

ED Value Set with one of the following diagnoses:

- Schizophrenia Value Set
- Bipolar Disorder Value Set

BH ED Value Set with BH ED POS Value Set and one of the following diagnoses:

- Schizophrenia Value Set
- Bipolar Disorder Value Set

BH Stand Alone Nonacute Inpatient Value Set with one of the following diagnoses:

- Schizophrenia Value Set
- Bipolar Disorder Value Set

BH Nonacute Inpatient Value Set with BH Nonacute Inpatient POS Value Set and one of the following diagnoses:

- Schizophrenia Value Set
- Bipolar Disorder Value Set

Exclusions

2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

Documentation of medical reason(s) for not screening for unhealthy alcohol use (eg, limited life expectancy, other medical reasons)

2599 Alcohol Screening and Follow-up for People with Serious Mental Illness

Active diagnosis of alcohol abuse or dependence during the first nine months of the year prior to the measurement year (see Alcohol Disorders Value Set).

Exclusion Details

2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

Time Period for Data Collection: Denominator Exception(s) are determined on the date of the most recent denominator eligible encounter.

Exceptions are used to remove a patient from the denominator of a performance measure when the patient does not receive a therapy or service AND that therapy or service would not be appropriate due to patient-specific reasons. The patient would otherwise meet the denominator criteria. Exceptions are not absolute, and are based on clinical judgment, individual patient characteristics, or patient preferences. The PCPI exception methodology uses three categories of reasons for which a patient may be removed from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For measure Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling, exceptions may include medical reason(s) (eg, limited life expectancy, other medical reasons). Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement.

For Registry:

Report Quality Data Code:

G9623 - Documentation of medical reason(s) for not screening for unhealthy alcohol use (e.g., limited life expectancy, other medical reasons)

2599 Alcohol Screening and Follow-up for People with Serious Mental Illness

Denominator exclusions are found through medical record or claims data (see Alcohol Disorders Value Set).

Risk Adjustment

2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

No risk adjustment or risk stratification

2599 Alcohol Screening and Follow-up for People with Serious Mental Illness

No risk adjustment or risk stratification

Stratification

2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

Consistent with CMS' Measures Management System Blueprint and recent national recommendations put forth by the IOM and NQF, the PCPI encourages the collection of

race and ethnicity data as well as the results of this measure to be stratified by race, ethnicity, administrative sex, and payer.

2599 Alcohol Screening and Follow-up for People with Serious Mental Illness

Not applicable.

Type Score

2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

Rate/proportion better quality = higher score

2599 Alcohol Screening and Follow-up for People with Serious Mental Illness

Rate/proportion better quality = higher score

Algorithm

2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

To calculate performance rates:

1. Find the patients who meet the initial population (ie, the general group of patients that a set of performance measures is designed to address).

2. From the patients within the initial population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial population and denominator are identical.

3. From the patients within the denominator, find the patients who meet the numerator criteria (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator

4. From the patients who did not meet the numerator criteria, determine if the provider has documented that the patient meets any criteria for exception when denominator exceptions have been specified [for this measure: medical reason(s) (eg, limited life expectancy, other medical reasons)]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the exception rate (ie, percentage with valid exceptions) should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.

If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure.

2599 Alcohol Screening and Follow-up for People with Serious Mental Illness

Step 1: Determine the eligible population.

Step 1A: Identify all patients 18 years of age or older with a serious mental illness

Step 1B: Exclude patients from step 1A who have a diagnosis of unhealthy alcohol use during the first 9 months of the year prior to the measurement year.

Step 2: Identify Numerator.

Step 2A: Identify the date of screening for unhealthy alcohol use during the measurement year or the year prior within the medical chart

Step 2B: Identify the unhealthy alcohol screening result within the medical chart. If negative for unhealthy alcohol use, stop.

Step 2C: If positive for unhealthy alcohol use, identify the date of any follow-up care occurring within three months of screening.

Step 3: Calculate the rate by adding the number of patients with a negative screening for unhealthy alcohol use (from step 2B) plus the number of patients with positive screening for unhealthy alcohol use and those who received follow-up care (from step 2C) and divide this by the number of patients calculated to be in the eligible population (those remaining after Step 1B is complete.) 123834| 140881| 135810

Submission items

2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

5.1 Identified measures:

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact: The related measures listed in 5.1b were developed after our measure. The NCQA measure focuses on a specific sub-population (people with serious mental illness) and is intended for use at the health plan level. In the TJC measures, screening and intervention are separate measures. Additionally, the TJC measures are intended for use at the hospital level. PCPI was contacted by these measure stewards respectively while the measures were developed, and they are currently harmonized to the extent feasible.

5b.1 If competing, why superior or rationale for additive value: No competing NQF-endorsed measure.

2599 Alcohol Screening and Follow-up for People with Serious Mental Illness

5.1 Identified measures: 2152 : Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

5a.1 Are specs completely harmonized?

5a.2 If not completely harmonized, identify difference, rationale, impact: This measure was adapted from the existing provider-level measure (NQF #2152: Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling) for use at the health plan level for the high risk subpopulation of people with serious mental illness. The measure is harmonized and has been reviewed with the original measure stewards and developers. The differences between the existing measure and the proposed serious mental illness subpopulation measure were developed with expert input and are described here. -The population focus: This measure focuses on people with serious mental illness, who are at a higher risk of unhealthy alcohol use than the general population and have demonstrated disparities in care -What counts as follow-up and the number of events for follow-up: This measure requires two events of counseling, raising expectations for the intensity of service for the serious mental illness population compared to the original measure for the general population, and is reasonably achievable, particularly in the health plan context. USPSTF recommendation supports multi-contact counseling which seems to have the best evidence of effectiveness. -In addition, the existing measure (NQF #2152) is reported at the provider level and is focused on follow-up conducted at time of screening making a single event sufficient. However, at the health plan level, there is opportunity/responsibility for follow-up care beyond the visit. We believe our measure focused on screening patients

with SMI for unhealthy alcohol use and capturing more intensive evidence-based follow-up care for a vulnerable population contributes to the national quality agenda.

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

Comparison of NQF 3453, 0004, 0576, 2605, and 3312

3453 Continuity of care after inpatient or residential treatment for substance use disorder (SUD)
0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment
0576 Follow-Up After Hospitalization for Mental Illness (FUH)
2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence
3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs

Steward

3453 Continuity of care after inpatient or residential treatment for substance use disorder (SUD)

Centers for Medicare & Medicaid Services, Centers for Medicaid & CHIP Services

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 (FUH)

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 for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs

Centers for Medicare & Medicaid Services, Centers for Medicaid & CHIP Services

Description

3453 Continuity of care after inpatient or residential treatment for substance use disorder (SUD)

Percentage of discharges from an inpatient or residential treatment for substance use disorder (SUD) for Medicaid beneficiaries, ages 18 to 64, which was followed by a treatment service for SUD. SUD treatment includes having an outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth encounter, or filling a prescription or being 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.

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 (FUH)

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

- The percentage of discharges for which the patient received follow-up within 30 days of discharge

- The percentage of discharges for which the patient received follow-up within 7 days of 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 for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs

Percentage of discharges from a detoxification episode for adult Medicaid Beneficiaries, age 18-64, that was 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. This measure is reported across all detoxification settings.

Type

3453 Continuity of care after inpatient or residential treatment for substance use disorder (SUD)

Process

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

Process

0576 Follow-Up After Hospitalization for Mental Illness (FUH)

Process

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

Process

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

Process

Data Source

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 SUD-18_measure_value_sets_FINAL_08.09.18_tested_sets_-_locked.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 (FUH)

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_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 for Medicaid Beneficiaries after Detoxification (Detox) 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 Cont_Care_After_Detox_Value_Sets.xlsx

Level

3453 Continuity of care after inpatient or residential treatment for substance use disorder (SUD)

Population : Regional and State

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

Health Plan

0576 Follow-Up After Hospitalization for Mental Illness (FUH)

Health Plan, Integrated Delivery System

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 for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs

Population : Regional and State

Setting

3453 Continuity of care after inpatient or residential treatment for substance use disorder (SUD)

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

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 (FUH)

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 for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs

Inpatient/Hospital, Outpatient Services

Numerator Statement

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.

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 (FUH)

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

7-Day Follow-Up: A follow-up visit with a mental health practitioner 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 for Medicaid Beneficiaries after Detoxification (Detox) 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 a detoxification episode.

Numerator Details

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

Public comments supported a measure for 7- and 14-day continuity and voiced that beyond that would be too long, risking losing the patient from the treatment system. The Technical Expert Panel unanimously agreed on the appropriateness of 7-day continuity of care. However, three TEP members felt that 14-days continuity of care is too long. Our approach balances clinical best practice thinking that the sooner the patient is connected to treatment the better while also allowing treatment programs more time for placement of patients in continuing treatment. Because it may be difficult at times for treatment programs to place clients in continuing care in a timely fashion after discharge due to limits in systems capacity, it is particularly important to allow more time for continuity of care to occur.

Inpatient or residential treatment was considered to be SUD related if it had a primary SUD diagnosis or a procedure indicating SUD. SUD diagnoses are identified through ICD-9 codes. Procedures are defined using a combination of Healthcare Common Procedure Coding System (HCPCS) codes, Uniform Billing (UB) Revenue Codes and ICD-9/ICD-10 procedure codes.

Value sets for the measure are attached in the Excel workbook provided for question S.2b. We include 2016 HEDIS value sets because we used these value sets in measure testing. HEDIS value sets are used because they represent an existing set that states are already familiar with, they are an element of harmonizing with other endorsed measures, and they are updated by the National Committee on Quality Assurance (NCQA). Also, some states may need to include relevant state-specific codes.

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 (FUH)

For both indicators, a follow-up visit includes outpatient visits, intensive outpatient visits or partial hospitalizations that occur on the date of discharge. Any of the following meet criteria for a follow-up visit:

- A visit (FUH Stand Alone Visits Value Set; FUH Visits Group 1 Value Set and FUH POS Group 1 Value Set; FUH Visits Group 2 Value Set and FUH POS Group 2 Value Set) with a mental health practitioner (see definition below).

- 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 mental health practitioner.

- A visit to a non-behavioral healthcare facility (FUH RevCodes Group 2 Value Set) with a diagnosis of mental illness (Mental Illness Value Set).

- Transitional care management services (TCM 7 Day Value Set).

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

- Transitional care management services (TCM 14 Day Value Set)

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

Mental Health Practitioner Definition:

A practitioner who provides mental health services and meets any of the following criteria:

• An MD or doctor of osteopathy (DO) who is certified as a psychiatrist or child psychiatrist by the American Medical Specialties Board of Psychiatry and Neurology or by the American Osteopathic Board of Neurology and Psychiatry; or, if not certified, who successfully completed an accredited program of graduate medical or osteopathic education in psychiatry or child psychiatry and is licensed to practice patient care psychiatry or child psychiatry, if required by the state of practice.

• An individual who is licensed as a psychologist in his/her state of practice, if required by the state of practice.

• An individual who is certified in clinical social work by the American Board of Examiners; who is listed on the National Association of Social Worker's Clinical Register; or who has a master's degree in social work and is licensed or certified to practice as a social worker, if required by the state of practice.

• A registered nurse (RN) who is certified by the American Nurses Credentialing Center (a subsidiary of the American Nurses Association) as a psychiatric nurse or mental health clinical nurse specialist, or who has a master's degree in nursing with a specialization in psychiatric/mental health and two years of supervised clinical experience and is licensed to practice as a psychiatric or mental health nurse, if required by the state of practice.

• An individual (normally with a master's or a doctoral degree in marital and family therapy and at least two years of supervised clinical experience) who is practicing as a marital and family therapist and is licensed or a certified counselor by the state of practice, or if licensure or certification is not required by the state of practice, who is eligible for clinical membership in the American Association for Marriage and Family Therapy.

• An individual (normally with a master's or doctoral degree in counseling and at least two years of supervised clinical experience) who is practicing as a professional counselor and who is licensed or certified to do so by the state of practice, or if licensure or certification is not required by the state of practice, is a National Certified Counselor with a Specialty Certification in Clinical Mental Health Counseling from the National Board for Certified Counselors (NBCC).

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 for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs

Measure data will be reported annually (12 months). To account for the 14-day time period after discharge from detoxification, the denominator period will start January 1 and end December 15 of the measurement year.

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

-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.

Continuity is reset to zero if an overdose diagnosis code appears on the same outpatient or inpatient claim.

SUD diagnoses are used to identify procedures connected to SUD diagnoses. SUD diagnoses are identified through ICD-9 codes. Procedures are defined using a combination of Healthcare Common Procedure Coding System (HCPCS) codes, Uniform Billing (UB) Revenue Codes and ICD-9/ICD-10 procedure codes.

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).

A list of value sets for the measure is attached in the Excel workbook provided for question S.2b. States may need to adapt the list of codes to include state-specific codes.

Denominator Statement

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.

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 (FUH)

Discharges from an acute inpatient setting (including acute care psychiatric facilities) with a principal diagnosis of mental illness during the first 11 months of the measurement year (i.e., January 1 to December 1) for patients 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 for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs

Adult Medicaid beneficiary discharges from detoxification from January 1 to December 15 of the measurement year.

Denominator Details

3453 Continuity of care after inpatient or residential treatment for substance use disorder (SUD)

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 Tabs 1-3 of the attached Excel file. SUD diagnoses are identified using the value sets in Tabs 1-2.

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 15 of the measurement year. December 15th is selected to allow sufficient time for continuity activities.

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 (FUH)

An acute inpatient discharge with a principal diagnosis of mental illness (Mental Illness Value Set) on or between January 1 and December 1 of the measurement year.

To identify acute inpatient discharges:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).

2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).

3. Identify the discharge date for the stay.

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

Acute facility readmission or direct transfer:

If the discharge is followed by readmission or direct transfer to an acute inpatient care setting for a principal diagnosis of mental health (Mental Health Diagnosis Value Set) within the 30-day follow-up period, count only the last discharge.

To identify readmissions to an acute inpatient care setting:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).

2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).

3. Identify the admission date for the stay.

*Due to the extensive volume of codes associated with identifying the denominator for this measure, we are attaching a separate file with value sets. See value sets located in question 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 for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs

Measure data will be reported annually (12 months). To account for the 14-day time period after discharge from detoxification, the denominator period will start January 1 and end December 15 of the measurement year.

Target population meets the following conditions:

• Medicaid beneficiaries aged 18 years and older and less than 65 years with at least one detox discharge during the year January 1-December 15.

• Enrolled in Medicaid during the month of detoxification discharge and the following month.

The denominator is based on discharges, not individuals. A beneficiary may have more than one qualifying detox episode.

Detoxification is identified using a combination of HCPCS codes, UB Revenue Codes and ICD-9/ICD-10 procedure codes. A list of value sets for the measure is attached in the Excel workbook provided for question S.2b. As with the numerator specifications, this document lists standardized specification for this measure. States will likely need to modify the specifications to include their state-specific codes.

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.

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 (FUH)

Exclude from the denominator for both rates, patients who receive hospice services during the measurement year.

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 for non-mental health.

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 for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs

Not applicable. The measure does not have denominator exclusions.

Exclusion Details

3453 Continuity of care after inpatient or residential treatment for substance use disorder (SUD)

Codes reflecting exclusions are attached in S.2b. Residential treatment is identified using the value sets in Tabs 1-3 of the attached Excel file. SUD diagnoses are identified using the value sets in Tabs 1-2.

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 (FUH)

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).

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

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

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).

2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.

3. Identify the admission date for the stay.

Exclude discharges followed by readmission or direct transfer to an acute inpatient care setting within the 30-day follow-up period if the principal diagnosis was for non-mental health (any principal diagnosis code other than those included in the Mental Health Diagnosis Value Set). To identify readmissions to an acute inpatient care setting:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).

2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).

3. Identify the admission date for the stay.

These discharges are excluded from the measure because rehospitalization or 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 for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs

Not applicable.

Risk Adjustment

3453 Continuity of care after inpatient or residential treatment for substance use disorder (SUD)

No risk adjustment or risk stratification

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

No risk adjustment or risk stratification

0576 Follow-Up After Hospitalization for Mental Illness (FUH)

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

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

No risk adjustment or risk stratification

Stratification

3453 Continuity of care after inpatient or residential treatment for substance use disorder (SUD)

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 (FUH)

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 for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs

Location of detox is used as a stratification variable in analyses. If an inpatient hospital claim had an ICD-9/ICD-10 detoxification procedure code or a UB revenue code indicating detoxification, hospital inpatient treatment is assigned as the location of detox. In addition, hospital inpatient treatment is also assigned if a non-inpatient claim contains a HCPCS code indicating hospital inpatient detox. The remaining detox location assignments are very straightforward. Whenever possible, use of the HCPCS codes to determine location is most desired as it reflects the more precise detoxification location. The other stayover treatment location is designed to capture detox location from non-inpatient claims that do not contain a HCPCS code. A list of value sets for the measure is attached in the Excel workbook provided for question S.2b.

Type Score

3453 Continuity of care after inpatient or residential treatment for substance use disorder (SUD)

Rate/proportion better quality = higher 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 (FUH)

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 for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs

Rate/proportion better quality = higher score

Algorithm

3453 Continuity of care after inpatient or residential treatment for substance use disorder (SUD)

In the steps below we reference the Excel workbook we attached for S.2b. The workbook includes:

- 2016 HEDIS value sets used in measure testing
- 2018 HEDIS value sets used in measure testing for pharmacotherapy and telehealth codes
- Value sets developed during the specification and testing of this measure, and the value sets from NQF #3312 Continuity of Care for Medicaid Beneficiaries After Detoxification (Detox) from Alcohol and/or Drugs and NQF #3400 Use of Pharmacotherapy for Opioid Use Disorder (OUD) that were used in the specification of this measure.

Note - some states may need to also include relevant state-specific codes.

Step 1: Identify denominator

Step 1A. Eligible population: : Identify non-dually enrolled Medicaid beneficiaries age 18 through 64 years with any discharges from inpatient or residential treatment with a principal diagnosis of SUD during January 1 - December 15 of the measurement year. Patients 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, the principal diagnosis of SUD is identified using a principal diagnosis from the 2016 “HEDIS AOD Dependence” value set (Tab 1 in the attached Excel file) or any procedure code from the 2016 “HEDIS AOD Procedures” value set (Tab 2). Secondary diagnosis of SUD is identified using the same value sets.

Step 1B. Flag claims as inpatient or as residential treatment: 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-9/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 (Tab 3). If 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 counts 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. To facilitate this consolidation, sort the inpatient, outpatient and ambulatory discharges by Beneficiary ID and service dates to ensure the discharges from these multiple data sources are in chronological order. Use all inpatient and residential treatment claims, regardless of diagnosis, to create episodes.

Step 1C: Assign treatment location to episodes: Use HCPCS, ICD-9/ICD-10 procedure or diagnosis codes, place of service, or UB revenue codes in the SUD Residential Treatment value set (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 principal diagnosis (with 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 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, identify discharges from inpatient or residential treatment for SUD with a principal diagnosis of SUD with qualifying continuity of care for SUD (principal or secondary diagnosis) within 7 or 14 days of 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. SUD diagnoses can be in any position – primary or secondary – for continuity services. 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 (Tab 4); or

2. Any procedure code from "HEDIS IET Visits Group 1" value set (Tab 5) along with place of service from "HEDIS IET POS Group 1" value set (Tab 6); or

3. Any procedure code from "HEDIS IET Visits Group 2" value set (Tab 7) along with place of service from "HEDIS IET POS Group 2" value set (Tab 8).

The claim must also have procedure code modifier that is missing or a value other than those in the "HEDIS Telehealth Modifier" value set (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. SUD diagnoses can be in any position – primary or secondary – for continuity services. Telehealth has to occur the day after discharge through day 7 or 14. We identify telehealth as:

1. Any procedure code from the "HEDIS Telephone Visit" value set (Tab 12); or

2. Any procedure code or UB revenue code from "HEDIS IET Stand Alone Visits" value set (Tab 4); or

3. Any procedure code from "HEDIS IET Visits Group 1" value set (Tab 5) along with place of service from "HEDIS IET POS Group 1" value set (Tab 6); or

4. Any procedure code from "HEDIS IET Visits Group 2" value set (Tab 7) along with place of service from "HEDIS IET POS Group 2" value set (Tab 8).

Claims identified using logic in #2-4 must also have procedure code modifier from the "HEDIS Telehealth Modifier" value set (Tab 9).

Step 2A.3: Identify pharmacotherapy events: 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 (Tab 10); or b) any HCPCS procedure code from "MAT Additional Codes" value set (Tab 11) (developed as part of testing for NQF 3312); or c) any state-specific procedure code from "MAT Additional Codes" value set (Tab 11) for the two states listed in the value set (these codes were identified through consultation for these states).

2. In RX file, any NDC from "AOD Pharmacotherapy" value set (Tab 13). This value set contains NDCs identified as part of testing for NQF 3312 and 3400.

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 each continuity of care time period.

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.

0576 Follow-Up After Hospitalization for Mental Illness (FUH)

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.

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).

3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) 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 enrolled Medicaid beneficiaries ages 18-64 years who have any detoxification (withdrawal management) in inpatient hospital, residential addiction treatment program, or ambulatory detoxification (withdrawal management)

discharge from January 1 to December 15 of the measurement year and are enrolled the month of detoxification and the following month. Age is calculated as of January 1 of the measurement year.

Step 1B: Overall: Among the Medicaid beneficiaries in Step 1A, identify all detoxification discharges using all inpatient, outpatient and ambulatory claims files or tables that contain HCPCS or ICD-9/ICD-10 procedure codes and UB revenue codes. If more than one detoxification in a year, treat each detoxification as a separate observation, e.g., an inpatient hospital detoxification in January and an ambulatory detoxification in July, counts as two observations.

Step 1B.1: Multiple detox claims that are within 1-2 days are combined into a single detox episode. Accordingly, sort the inpatient, outpatient and ambulatory detox discharges by Beneficiary ID and service dates to ensure the discharges from these multiple data sources are in chronological order. Then combine close-proximity episodes while retaining all clinical fields from each episode.

Step 1C: Detox location assignment: hospital inpatient, inpatient residential addiction, outpatient residential outpatient addiction, other stayover treatment and ambulatory detoxification. Use HCPCs detox procedure codes to assign detox location whenever possible; revenue center detox will map to the hospital inpatient location when the revenue codes appear on an inpatient claim or table. They will map to other stayover treatment when the revenue codes appear on a non-inpatient claim. If there is more than 1 detox location when episodes are combined, assign the location using the first claim's location. If there is a TIE between a detox 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: Overall: From the denominator in Step 1B, identify those discharges from detoxification 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). 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, the specification 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 detox 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. 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 detox through day 7 or 14.

Step 2A.3: Co-occurring events: Continuity service flags and pharmacotherapy flags are reset to zero if an overdose diagnosis code appears on the SAME claim as the continuity service. Further, outpatient continuity is also reset to zero if an emergency department visit occurs on the same day. If an inpatient continuity claim has an emergency department visit, 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 detox location by dividing the respective number of discharges by each location with a qualifying continuity service (Step 2A) by the denominator (Step 1C). 120752

Submission items

3453 Continuity of care after inpatient or residential treatment for substance use disorder (SUD)

5.1 Identified measures: 2605 : Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence

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

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

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

3312 : Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) 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.

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 (FUH)

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 for Medicaid Beneficiaries after Detoxification (Detox) 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.

Comparison of NQF 0004, 2599, 3312, 2605, and 2152

0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment
2599 Alcohol Screening and Follow-up for People with Serious Mental Illness
3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs
2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence
2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

Steward

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

National Committee for Quality Assurance

2599 Alcohol Screening and Follow-up for People with Serious Mental Illness

National Committee for Quality Assurance

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

Centers for Medicare & Medicaid Services, Centers for Medicaid & CHIP Services

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

National Committee for Quality Assurance

2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

PCPI Foundation

Description

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.

2599 Alcohol Screening and Follow-up for People with Serious Mental Illness

The percentage of patients 18 years and older with a serious mental illness, who were screened for unhealthy alcohol use and received brief counseling or other follow-up care if identified as an unhealthy alcohol user.

Note: The proposed health plan measure is adapted from an existing provider-level measure for the general population (NQF #2152: Preventive Care & Screening: Unhealthy

Alcohol Use: Screening & Brief Counseling). It was originally endorsed in 2014 and is currently stewarded by the American Medical Association (AMA-PCPI).

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

Percentage of discharges from a detoxification episode for adult Medicaid Beneficiaries, age 18-64, that was 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. This measure is reported across all detoxification settings.

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.

2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

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

Type

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

Process

2599 Alcohol Screening and Follow-up for People with Serious Mental Illness

Process

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

Process

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

Process

2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

Process

Data Source

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

2599 Alcohol Screening and Follow-up for People with Serious Mental Illness

Claims, Electronic Health Records, Paper Medical Records The denominator for this measure is based on administrative claims. The numerator for this measure is based on administrative claims and/or medical record documentation collected in the course of providing care to health plan patients.

No data collection instrument provided Attachment 2599_Alcohol_Screening_for_People_With_Mental_Illness_Value_Set-636583545268612951-636769175260262857.xlsx

3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) 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 Cont_Care_After_Detox_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

2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

Registry Data Not applicable.

No data collection instrument provided No data dictionary

Level

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

Health Plan

2599 Alcohol Screening and Follow-up for People with Serious Mental Illness

Health Plan

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

Population : Regional and State

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

Health Plan, Population : Regional and State

2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

Clinician : Group/Practice, Clinician : Individual

Setting

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

Emergency Department and Services, Inpatient/Hospital, Outpatient Services

2599 Alcohol Screening and Follow-up for People with Serious Mental Illness

Outpatient Services

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

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

2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

Home Care, Outpatient Services

Numerator Statement

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.

2599 Alcohol Screening and Follow-up for People with Serious Mental Illness

Patients 18 years and older who are screened for unhealthy alcohol use during the last 3 months of the year prior to the measurement year through the first 9 months of the measurement year and received two events of counseling if identified as an unhealthy alcohol user.

3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) 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 a detoxification episode.

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

2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

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

Numerator Details

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.

2599 Alcohol Screening and Follow-up for People with Serious Mental Illness

Alcohol Use Screening

ADMINISTRATIVE:

Patients who had systematic screening for unhealthy alcohol use (see Alcohol Screening Value Set) as identified by claim/encounter data during the last 3 months of the year prior to the measurement year through the first 9 months of the measurement year.

MEDICAL RECORD:

Patients who had systematic screening for unhealthy alcohol use during the last 3 months of the year prior to the measurement year through the first 9 months of the measurement year.

Systematic Screening

A systematic screening method is defined as:

Asking the patient about their weekly use (alcoholic drinks per week), or

Asking the patient about their per occasion use (alcoholic drinks per drinking day) or

Using a standardized tool such as the AUDIT, AUDIT-C, or CAGE or

Using another standardized tool

Unhealthy Alcohol Use

Unhealthy alcohol use covers a spectrum that is associated with varying degrees of risk to health. Categories representing unhealthy alcohol use include risky use, problem drinking, harmful use, and alcohol abuse, and the less common but more severe alcoholism and alcohol dependence. Risky use is defined as >7 standard drinks per week or >3 drinks per occasion for women and persons >65 years of age; >14 standard drinks per week or >4 drinks per occasion for men =65 years of age.

Follow-Up

ADMINISTRATIVE:

Patients who received two events of counseling (see Alcohol Screening and Brief Counseling Value Set) as identified by claim/encounter data within three months of screening if identified as unhealthy alcohol users.

MEDICAL RECORD:

Patients who received two events of counseling within three months of screening if identified as unhealthy alcohol users. The two event of counseling could be with the provider who performed screening or another provider including health plan clinical case managers. Participation in peer led support activities (such as Alcoholics Anonymous or Narcotics Anonymous) can count if documented in the health record (referrals alone do not count).

Counseling

Counseling may include at least one of the following:

Feedback on alcohol use and harms

Identification of high risk situations for drinking and coping strategies

Increase the motivation to reduce drinking

Development of a personal plan to reduce drinking

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

Measure data will be reported annually (12 months). To account for the 14-day time period after discharge from detoxification, the denominator period will start January 1 and end December 15 of the measurement year.

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

-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.

Continuity is reset to zero if an overdose diagnosis code appears on the same outpatient or inpatient claim.

SUD diagnoses are used to identify procedures connected to SUD diagnoses. SUD diagnoses are identified through ICD-9 codes. Procedures are defined using a combination of Healthcare Common Procedure Coding System (HCPCS) codes, Uniform Billing (UB) Revenue Codes and ICD-9/ICD-10 procedure codes.

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).

A list of value sets for the measure is attached in the Excel workbook provided for question S.2b. States may need to adapt the list of codes to include state-specific codes.

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).

2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

Time Period for Data Collection: At least once during the 24 month period.

Definitions:

Systematic screening method - For purposes of this measure, one of the following systematic methods to assess unhealthy alcohol use must be utilized. Systematic screening methods and thresholds for defining unhealthy alcohol use include:

- AUDIT Screening Instrument (score >= 8)
- AUDIT-C Screening Instrument (score >= 4 for men; score >= 3 for women)

• Single Question Screening - How many times in the past year have you had 5 (for men) or 4 (for women and all adults older than 65 years) or more drinks in a day? (response >= 2)

Brief counseling - Brief counseling for unhealthy alcohol use refers to one or more counseling sessions, a minimum of 5-15 minutes, which may include: feedback on alcohol use and harms; identification of high risk situations for drinking and coping strategies; increased motivation and the development of a personal plan to reduce drinking.

NUMERATOR NOTE: In the event that a patient is screened for unhealthy alcohol use and identified as a user but did not receive brief alcohol cessation counseling submit G9624.

For Registry:

Report Quality Data Code:

G9621 - Patient identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method and received brief counseling

OR

G9622 - Patient not identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method

Denominator Statement

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).

2599 Alcohol Screening and Follow-up for People with Serious Mental Illness

All patients 18 years of age or older as of December 31 of the measurement year with at least one inpatient visit or two outpatient visits for schizophrenia or bipolar I disorder, or at least one inpatient visit for major depression during the measurement year.

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

Adult Medicaid beneficiary discharges from detoxification from January 1 to December 15 of the measurement year.

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.

2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period

Denominator Details

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.

2599 Alcohol Screening and Follow-up for People with Serious Mental Illness

Age: 18 years and older

Benefit: Medical

Continuous Enrollment: No more than one gap in enrollment of up to 45 days during each year of the measurement year and the year prior. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the person may not have more than a one month gap in coverage (i.e., a person whose coverage lapses for two months [60 days] is not considered continuously enrolled).

Diagnosis Criteria: Identify patients with a serious mental illness. They must meet at least one of the following criteria during the measurement year or the year prior:

At least one acute inpatient claim/encounter with any diagnosis of schizophrenia, bipolar I disorder, or major depression using any of the following code combinations:

BH Stand Alone Acute Inpatient Value Set with one of the following diagnoses:

- Schizophrenia Value Set
- Bipolar Disorder Value Set
- Major Depression Value Set

BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set and one of the following diagnoses:

- Schizophrenia Value Set
- Bipolar Disorder Value Set
- Major Depression Value Set

At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or non-acute inpatient setting, on different dates of service, with any diagnosis of schizophrenia or bipolar I disorder. Any two of the following code combinations meet criteria:

BH Stand Alone Outpatient/PH/IOP Value Set with one of the following diagnoses:

- Schizophrenia Value Set
- Bipolar Disorder Value Set

BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set and one of the following diagnoses:

- Schizophrenia Value Set
- Bipolar Disorder Value Set

ED Value Set with one of the following diagnoses:

- Schizophrenia Value Set
- Bipolar Disorder Value Set

BH ED Value Set with BH ED POS Value Set and one of the following diagnoses:

- Schizophrenia Value Set
- Bipolar Disorder Value Set

BH Stand Alone Nonacute Inpatient Value Set with one of the following diagnoses:

- Schizophrenia Value Set
- Bipolar Disorder Value Set

BH Nonacute Inpatient Value Set with BH Nonacute Inpatient POS Value Set and one of the following diagnoses:

- Schizophrenia Value Set
- Bipolar Disorder Value Set

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

Measure data will be reported annually (12 months). To account for the 14-day time period after discharge from detoxification, the denominator period will start January 1 and end December 15 of the measurement year.

Target population meets the following conditions:

• Medicaid beneficiaries aged 18 years and older and less than 65 years with at least one detox discharge during the year January 1-December 15.

• Enrolled in Medicaid during the month of detoxification discharge and the following month.

The denominator is based on discharges, not individuals. A beneficiary may have more than one qualifying detox episode.

Detoxification is identified using a combination of HCPCS codes, UB Revenue Codes and ICD-9/ICD-10 procedure codes. A list of value sets for the measure is attached in the Excel workbook provided for question S.2b. As with the numerator specifications, this document lists standardized specification for this measure. States will likely need to modify the specifications to include their state-specific codes.

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.

2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

Time Period for Data Collection: 12 consecutive months

For Registry:

Patients aged >= 18 years

AND

At least two patient encounters during the performance period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 90845, 96150, 96151, 96152, 97165, 97166, 97167, 97168, 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0270, G0271

WITHOUT

Telehealth Modifier: GQ, GT, 95, POS 2

OR

At Least One Preventive Visit during the performance period (CPT or HCPCS): 99385, 99386, 99387, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99429, G0438, G0439

WITHOUT

Telehealth Modifier: GQ, GT, 95, POS 02

Exclusions

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.

2599 Alcohol Screening and Follow-up for People with Serious Mental Illness

Active diagnosis of alcohol abuse or dependence during the first nine months of the year prior to the measurement year (see Alcohol Disorders Value Set).

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

Not applicable. The measure does not have denominator exclusions.

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.

2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

Documentation of medical reason(s) for not screening for unhealthy alcohol use (eg, limited life expectancy, other medical reasons)

Exclusion Details

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.

2599 Alcohol Screening and Follow-up for People with Serious Mental Illness

Denominator exclusions are found through medical record or claims data (see Alcohol Disorders Value Set).

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

Not applicable.

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

2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

Time Period for Data Collection: Denominator Exception(s) are determined on the date of the most recent denominator eligible encounter.

Exceptions are used to remove a patient from the denominator of a performance measure when the patient does not receive a therapy or service AND that therapy or service would not be appropriate due to patient-specific reasons. The patient would otherwise meet the denominator criteria. Exceptions are not absolute, and are based on clinical judgment, individual patient characteristics, or patient preferences. The PCPI exception methodology uses three categories of reasons for which a patient may be removed from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For measure Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling, exceptions may include medical reason(s) (eg, limited life expectancy, other medical reasons). Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement.

For Registry:

Report Quality Data Code:

G9623 - Documentation of medical reason(s) for not screening for unhealthy alcohol use (e.g., limited life expectancy, other medical reasons)

Risk Adjustment

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

No risk adjustment or risk stratification

2599 Alcohol Screening and Follow-up for People with Serious Mental Illness

No risk adjustment or risk stratification

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

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

2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

No risk adjustment or risk stratification

Stratification

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.

2599 Alcohol Screening and Follow-up for People with Serious Mental Illness

Not applicable.

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

Location of detox is used as a stratification variable in analyses. If an inpatient hospital claim had an ICD-9/ICD-10 detoxification procedure code or a UB revenue code indicating detoxification, hospital inpatient treatment is assigned as the location of detox. In addition, hospital inpatient treatment is also assigned if a non-inpatient claim contains a HCPCS code indicating hospital inpatient detox. The remaining detox location assignments are very straightforward. Whenever possible, use of the HCPCS codes to determine location is most desired as it reflects the more precise detoxification location. The other stayover treatment location is designed to capture detox location from non-inpatient claims that do not contain a HCPCS code. A list of value sets for the measure is attached in the Excel workbook provided for question S.2b.

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

Not applicable.

2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

Consistent with CMS' Measures Management System Blueprint and recent national recommendations put forth by the IOM and NQF, the PCPI encourages the collection of race and ethnicity data as well as the results of this measure to be stratified by race, ethnicity, administrative sex, and payer.

Type Score

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

Rate/proportion better quality = higher score

2599 Alcohol Screening and Follow-up for People with Serious Mental Illness

Rate/proportion better quality = higher score

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

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

2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

Rate/proportion better quality = higher score

Algorithm

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.

2599 Alcohol Screening and Follow-up for People with Serious Mental Illness

Step 1: Determine the eligible population.

Step 1A: Identify all patients 18 years of age or older with a serious mental illness

Step 1B: Exclude patients from step 1A who have a diagnosis of unhealthy alcohol use during the first 9 months of the year prior to the measurement year.

Step 2: Identify Numerator.

Step 2A: Identify the date of screening for unhealthy alcohol use during the measurement year or the year prior within the medical chart

Step 2B: Identify the unhealthy alcohol screening result within the medical chart. If negative for unhealthy alcohol use, stop.

Step 2C: If positive for unhealthy alcohol use, identify the date of any follow-up care occurring within three months of screening.

Step 3: Calculate the rate by adding the number of patients with a negative screening for unhealthy alcohol use (from step 2B) plus the number of patients with positive screening for unhealthy alcohol use and those who received follow-up care (from step 2C) and divide this by the number of patients calculated to be in the eligible population (those remaining after Step 1B is complete.)

3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) 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 enrolled Medicaid beneficiaries ages 18-64 years who have any detoxification (withdrawal management) in inpatient hospital, residential addiction treatment program, or ambulatory detoxification (withdrawal management) discharge from January 1 to December 15 of the measurement year and are enrolled the month of detoxification and the following month. Age is calculated as of January 1 of the measurement year.

Step 1B: Overall: Among the Medicaid beneficiaries in Step 1A, identify all detoxification discharges using all inpatient, outpatient and ambulatory claims files or tables that contain HCPCS or ICD-9/ICD-10 procedure codes and UB revenue codes. If more than one detoxification in a year, treat each detoxification as a separate observation, e.g., an inpatient hospital detoxification in January and an ambulatory detoxification in July, counts as two observations.

Step 1B.1: Multiple detox claims that are within 1-2 days are combined into a single detox episode. Accordingly, sort the inpatient, outpatient and ambulatory detox discharges by Beneficiary ID and service dates to ensure the discharges from these multiple data sources are in chronological order. Then combine close-proximity episodes while retaining all clinical fields from each episode.

Step 1C: Detox location assignment: hospital inpatient, inpatient residential addiction, outpatient residential outpatient addiction, other stayover treatment and ambulatory detoxification. Use HCPCs detox procedure codes to assign detox location whenever possible; revenue center detox will map to the hospital inpatient location when the revenue codes appear on an inpatient claim or table. They will map to other stayover treatment when the revenue codes appear on a non-inpatient claim. If there is more than 1 detox location when episodes are combined, assign the location using the first claim's location. If there is a TIE between a detox 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: Overall: From the denominator in Step 1B, identify those discharges from detoxification 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). 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, the specification 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 detox 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. 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 detox through day 7 or 14.

Step 2A.3: Co-occurring events: Continuity service flags and pharmacotherapy flags are reset to zero if an overdose diagnosis code appears on the SAME claim as the continuity service. Further, outpatient continuity is also reset to zero if an emergency department visit occurs on the same day. If an inpatient continuity claim has an emergency department visit, 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 detox location by dividing the respective number of discharges by each location with a qualifying continuity service (Step 2A) by the denominator (Step 1C).

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).

2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

To calculate performance rates:

1. Find the patients who meet the initial population (ie, the general group of patients that a set of performance measures is designed to address).

2. From the patients within the initial population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial population and denominator are identical.

3. From the patients within the denominator, find the patients who meet the numerator criteria (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator

4. From the patients who did not meet the numerator criteria, determine if the provider has documented that the patient meets any criteria for exception when denominator exceptions have been specified [for this measure: medical reason(s) (eg, limited life expectancy, other medical reasons)]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the exception rate (ie, percentage with valid exceptions) should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.

If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure.

Submission items

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

2599 Alcohol Screening and Follow-up for People with Serious Mental Illness

5.1 Identified measures: 2152 : Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

5a.1 Are specs completely harmonized?

5a.2 If not completely harmonized, identify difference, rationale, impact: This measure was adapted from the existing provider-level measure (NQF #2152: Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling) for use at the health plan level for the high risk subpopulation of people with serious mental illness. The measure is harmonized and has been reviewed with the original measure stewards and developers. The differences between the existing measure and the proposed serious mental illness subpopulation measure were developed with expert input and are described here. -The population focus: This measure focuses on people with serious mental illness, who are at a higher risk of unhealthy alcohol use than the general population and have demonstrated disparities in care -What counts as follow-up and the number of events for follow-up: This measure requires two events of counseling, raising expectations for the intensity of service for the serious mental illness population compared to the original measure for the general population, and is reasonably achievable, particularly in the health plan context. USPSTF recommendation supports multi-contact counseling which seems to have the best evidence of effectiveness. -In addition, the existing measure (NQF #2152) is reported at the provider level and is focused on follow-up conducted at time of screening making a single event sufficient. However, at the health plan level, there is opportunity/responsibility for follow-up care beyond the visit. We believe our measure focused on screening patients with SMI for unhealthy alcohol use and capturing more intensive evidence-based follow-up care for a vulnerable population contributes to the national quality agenda.

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

3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) 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.

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.

2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

5.1 Identified measures:

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact: The related measures listed in 5.1b were developed after our measure. The NCQA measure focuses on a specific sub-population (people with serious mental illness) and is intended for use at the health plan level. In the TJC measures, screening and intervention are separate measures. Additionally, the TJC measures are intended for use at the hospital level. PCPI was contacted by these measure stewards respectively while the measures were developed, and they are currently harmonized to the extent feasible.

Appendix F: Pre-Evaluation Comment

Comment received as of January 18, 2019.

Topic	Commenter	Comment
0004: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (National Committee for Quality Assurance)	Submitted by Louisiana State Office of Behavioral Health	It's an excellent measure. However, it is limited by losing a significant amount of relevant data because it excludes multiple ASAM residential treatment levels of care. Many states and other entities would benefit greatly with more accurate data if that observation was considered by the reviewing committee to include residential levels of care in the next update of that measure.

National Quality Forum
1030 15th St NW, Suite 800
Washington, DC 20005
http://www.qualityforum.org

ISBN 978-1-68248-122-6