NATIONAL QUALITY FORUM
Driving measurable health improvements together

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

TECHNICAL REPORT
MARCH 4, 2021

This report is funded by the Centers for Medicare & Medicaid Services under contract HHSM-500-2017-00060I Task Order HHSM-500-T0001.

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Contents

Executive Summary

The National Quality Forum (NQF) Behavioral Health and Substance Use (BHSU) Standing Committee concerns itself with healthcare quality measures focused on the treatment and prevention of mental and behavioral health conditions, including those associated with substance use disorders (SUDs). This Standing Committee oversees the measurement portfolio used to advance accountability and quality in the delivery of behavioral health and substance use services. There are 46 such behavioral health measures that have been endorsed by NQF. The background and description of NQF's most recent BHSU Standing Committee meeting as well as previous meetings are available on NQF's project webpage.

During the Spring 2020 measure evaluation period, the Behavioral Health and Substance Use Standing Committee reviewed measures within two primary topic areas: appropriate follow-up care for psychiatric conditions and tobacco use among adolescents. The Standing Committee evaluated one newly submitted measure and two measures undergoing maintenance review against NQF's standard evaluation criteria. The Standing Committee recommended one measure for endorsement, and did not recommend two measures. The Consensus Standards Approval Committee (CSAC) upheld the Standing Committee's recommendations.

Endorsed Measures:

- **NQF 0108** Follow-Up Care for Children Prescribed ADHD Medication (National Committee for Quality Assurance (NCQA))

Measures Not Endorsed:

- **NQF 2803** Tobacco Use and Help with Quitting Among Adolescents (NCQA)
- **NQF 3572** Follow-Up After Psychiatric Hospitalization (Mathematica)

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

Introduction

The field of behavioral health is focused on the connection between behaviors and the health and well-being of the body and mind. Behavioral health comprises both mental health as well as SUDs, and represents a critical worldwide healthcare focus. A comprehensive annual report of behavioral health prevalence data is found in the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Survey on Drug Use and Health (NSDUH). Results from the 2019 NSDUH indicated that, in the U.S., 19.2 million persons aged 18 or older suffered from an apparent SUD (not including tobacco dependence), and 51.5 million persons aged 18 or older suffered from a mental illness. These numbers jointly suggest that substantive behavioral health disease was evident in at least 61.2 million adult Americans in 2019 or roughly 24 percent of the adult population. This rate is consistent with other epidemiologic studies that have previously revealed the prevalence of behavioral health conditions in the U.S.[1]

Behavioral healthcare refers to a continuum of services for individuals at risk of or suffering from mental or addictive disorders—challenges broadly ranging from mood and anxiety disorder, to learning disabilities and substance abuse or dependence (including tobacco dependence). In the United States, over 61 million adults suffer from a discernable behavioral health disorder.[2] This includes more than 11 million persons with the most serious forms of mental illness such as schizophrenia, bipolar disorder, and major depression. Also, over 9.5 million adults suffer simultaneously from a mental illness and an SUD. Behavioral disorders cause considerable pain and dysfunction in the U.S. population, so much so that it represents the leading cause of death and disability when compared to other major illness clusters such as cancers, circulatory disease (heart disease, stroke, arteriosclerosis), injuries, and kidney disease.[1]

The NSDUH from 2019 further discusses an important concern about behavioral healthcare in this country. Only 10.3 percent of persons aged 12 and older with a SUD reported receiving treatment during that year and only 44.8 percent of persons aged 18 and older with any mental illness reported receiving care for that condition. These gaps in behavioral health pathology and treatment represent unmet needs among those with behavioral health conditions.[2]

Attention-deficit/hyperactivity disorder (ADHD) is one of the most common mental disorders affecting both children and adults. This disorder is characterized by inattention, excessive movement not fitting to the setting, and impulsivity. It is estimated that 8.4 percent of children and adolescents have ADHD with a reduced incidence of 2.5 percent among adults.[3,4(p)] The disorder manifests in boys at nearly twice the rate of girls.[4]

Tobacco use and addiction is also a key part of behavioral health.[5] Beyond the known physical risks associated with tobacco use, research demonstrates that individuals with behavioral health conditions are more likely to smoke and to do so more heavily.[6] Nearly half of all tobacco related deaths occur among those with behavioral health conditions.[7] Additional research has suggested that smoking can exacerbate mental health symptoms and complicate treatment.[8] Moreover, smoking cessation has been shown to improve mental health and substance use disorder recovery outcomes.[9,10]

Opioid overdose deaths have recently become a particular concern in the U.S., and data compiled by the U.S. Centers for Disease Control and Prevention placed such deaths at nearly 47,000 in 2018 alone.[11] U.S. suicides in 2018 approached that number,[12] and deaths attributable to alcohol use (overdose, accidents, cirrhosis, cancers) numbered approximately 88,000 per annum, according to the 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).[13] Finally, mental illness strongly correlates with premature death by an average of eight years for all mental illnesses and 25 years for the most serious forms. The causes for this premature mortality are multifactorial including tobacco use, suicide, poor self-advocacy, and risk of victimization, but a least one study found that 95 percent of these premature deaths are from medical causes.[14]

There are deep challenges posed by behavioral health illnesses. Such illnesses are typically cycling, chronic, and serious. Nonetheless, there exist many evidence-based approaches to prevent such illnesses and to treat persons and families impacted by them.[15–17] Applications of these strategies are

neither easy nor universal; however, they are made challenging by the complexity and uncertainty of the underlying pathology and by stigma that shrouds a category of diseases that often negatively impact social functioning.[18–21] Accordingly, quality measurement and quality improvement tools are essential to assessing and improving quality of behavioral health care and patients' outcomes.

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 for serious mental illnesses (e.g., schizophrenia, mania, major depression), dysthymia, anxiety, ADHD and other learning and 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 46 measures: 39 process measures, six outcome and resource use measures, and one composite measure (see Table 1).

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

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

	Process	Outcome/Resource Use	Composite
Alcohol and Drug Use	6	0	1
Care Coordination	4	0	0
Depression	5	4	0
Medication Use	10	0	0
Experience of Care	2	0	0
Tobacco	4	0	0
Physical Health	8	2	0
Total	39	6	1

Behavioral Health and Substance Use Measure Evaluation

On June 15 and 17, 2020 the Behavioral Health and Substance Use Standing Committee evaluated one new measure and two measures undergoing maintenance review against NQF's standard measure evaluation criteria.

Table 2. Behavioral Health and Substance Use Measure Evaluation Summary

	Maintenance	New	Total
Measures Reviewed	2	1	3
Measures Endorsed	1	0	1
Measures Not Endorsed	1	1	2

Comments Received Prior to Standing Committee Evaluation

NQF accepts comments on endorsed measures on an ongoing basis through the Quality Positioning System (QPS). In addition, NQF solicits comments for a continuous 16-week period during each evaluation cycle via an online tool located on the project webpage. For this evaluation cycle, the commenting period opened on April 3, 2020 and closed on June 5, 2020. As of June 5, no comments were submitted to be shared with the Standing Committee prior to the measure evaluation meeting(s) (Appendix F).

Comments Received After Standing Committee Evaluation

The continuous 16-week public commenting period with NQF member support closed on August 25, 2020. Following the Standing Committee's evaluation of the measures under review, NQF received three comments from three NQF member organizations pertaining to the draft report and to the measures under review. All comments for each measure under review have been summarized in Appendix A.

Throughout the 16-week continuous public commenting period, NQF members had the opportunity to express their support ("support" or "do not support") for each measure submitted for endorsement consideration to inform the Standing Committee's recommendations. Two NQF members provided their expression of support.

Overarching Issue

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

Use of Telemedicine in Follow-Up Care

The Standing Committee noted that two of the measures under discussion had follow-up care as a significant portion of the measure focus. Moreover, the Standing Committee noted that some measure specifications related to follow-up care stipulated that it was permissible to be conducted via telemedicine, but some were required to be performed in person. This posed a concern for the Standing Committee, especially considering the COVID-19 pandemic and the challenges and risks associated with in-person follow-up care that could reasonably be conducted through telemedicine. The Standing Committee urged the measure developers to consider measure re-specification that permits both long-term and short-term use of telemedicine, as appropriate.

Summary of Measure Evaluation

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

0108 Follow-Up Care for Children Prescribed ADHD Medication (ADD) (NCQA): Endorsed

Description: Percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which is within 30 days of when the first ADHD medication was dispensed. An Initiation Phase Rate and Continuation and Maintenance Phase Rate are reported; **Measure Type**: Process; **Level of Analysis**: Health Plan; **Setting of Care**: Outpatient Services; **Data Source**: Claims

The measure was recommended for continued endorsement by the Standing Committee. The Standing Committee began the review with a summary of the measure and the evidence submission. The Standing Committee noted that the developer cited systematic reviews of American Academy of Pediatrics (AAP) clinical practice guidelines (strong recommendation; grade B evidence) for the treatment of ADHD in children and adolescents. It was noted that the measure requires fewer visits than the current AAP guidelines for prescribing ADHD medication and follow-up visits. The Standing Committee noted that the measure requires the first follow-up visit to be in person, but subsequent ones may be performed via telemedicine.

The Standing Committee questioned whether it was in fact necessary to have the first follow-up visit in person especially considering the current COVID-19 pandemic. It questioned the evidence supporting the 30-day timeframe and its linkage to improved outcomes and noted barriers to meeting this requirement; the developer responded that the clinical guidelines support the 30-day period and pointed to consensus from their expert panel. The Standing Committee agreed that the measure addresses a high priority, as ADHD is one of the most prevalent behavioral health diseases in children. The Standing Committee urged the developer and NQF to incorporate telehealth further into this and other measures. For the discussion related to performance gap, the Standing Committee was concerned that the measure only reports data from the last three years, but over the course of the past six years, the measure statistics have not changed much at all. The Standing Committee discussed whether the lack of change in the 90th percentile, 75th percentile, etc., over the last several years means this measure might not actually be measuring the correct parameters for management of ADHD. In the discussion of the reliability criterion, the Standing Committee discussed that the measure's performance fell below a 0.7 threshold on the commercial plan data for the mean signal-to-noise reliability, with the developer also pointing out that the reliability performance data for Medicaid plans was well above this level. For validity, the Standing Committee observed that the submitted analysis and results indicated moderate correlations between NQF #0108 and external measures of quality. The Standing Committee also discussed the exclusions, noting that patients who are admitted to inpatient settings are excluded from the denominator. The Standing Committee expressed concerns that such patients might be admitted due to poor follow-up. The Committee did not express concerns related to feasibility, observing that the measure data source of healthcare claims is low burden and generated during the routine delivery of care. The Standing Committee also noted the broad adoption of the measure along

with the feedback loops deployed and did not express concerns associated with usability and use. Following all discussion, the Standing Committee voted to recommend this measure to the CSAC for continued endorsement.

2803 Tobacco Use and Help with Quitting Among Adolescents (NCQA): Not Endorsed

Description: The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user; **Measure Type**: Process; **Level of Analysis**: Clinician : Group/Practice; **Setting of Care**: Outpatient Services; **Data Source**: Claims, Electronic Health Records

This measure did not pass on evidence, a must-pass criterion, and the measure was not recommended for endorsement. The discussion of the measure during the initial evaluation began with a review of its description and a presentation of the evidence submitted by the developer. The Standing Committee noted that the evidence submitted was graded and based on the United States Preventative Services Task Force (USPSTF) recommendations. The Standing Committee focused on two recommendations from the USPSTF related to adolescent smoking cessation. First, counseling has been shown to be effective in treatment of adolescent smokers. Therefore, adolescent smokers should be provided with counseling interventions to aid them in quitting smoking. This recommendation was given USPSTF's "Grade B Strength of Evidence—some evidence from randomized clinical trials supported the recommendation, but the scientific support was not optimal. For instance, few randomized trials existed, the trials that did exist were somewhat inconsistent, or the trials were not directly relevant to the recommendation." Second, clinicians should ask pediatric and adolescent patients about tobacco use and provide a strong message regarding the importance of total abstinence. The USPSTF concluded that the evidence was insufficient to recommend for or against routine screening for tobacco use or interventions to prevent and treat tobacco use and dependence in children or adolescents (I grade).

The Standing Committee was especially concerned with the evidence supporting the first recommendation, noting the USPSTF conclusions for routine screening for tobacco use and interventions to prevent tobacco use, resulting in consensus not being reached on evidence. For the performance gap, the Standing Committee noted that mean performance was relatively high, but also with a large standard deviation. The Standing Committee agreed that a gap in performance remains. The Standing Committee turned to a discussion on the scientific acceptability properties of the measure, noting a fairly strong signal-to-noise score level reliability result and expressing no concerns. The Standing Committee acknowledged a moderate correlation between NQF #2803 and external measures of quality in the validity discussion. The Standing Committee did not express concerns related to feasibility, observing that the measure data source is low burden and generated during the routine delivery of care. The Committee also noted the adoption of the measure in the Merit-based Incentive Payment System (MIPS) along with the feedback loops deployed and did not express concerns associated with usability and use. The Committee noted a need to revisit this measure to achieve consensus on evidence and potentially vote on overall endorsement during the post-comment meeting.

In the discussion of evidence during the post-comment web meeting on September 21, 2020 the NQF staff reviewed the previous Standing Committee deliberations and concerns related to the strength of the evidence from the USPSTF review of adolescent smoking cessation and prevention interventions.

Staff also reviewed the NQF evidence algorithm in light of concerns raised that the recommendations from guidelines related to the measure focus were in one instance lacking more substantial evidence than expert opinion. Staff noted that there is still a pathway to endorsement through an exception to evidence and reviewed the NQF evidence criteria and voting process. Some Standing Committee members expressed concerns that the expert opinion recommendation from the USPSTF for cessation interventions did not have enough evidence to warrant the added burden for clinicians. Others noted that the harms associated with the interventions were low and that the burden to clinicians was not especially high.

3572 Follow-Up After Psychiatric Hospitalization (Mathematica): Not Endorsed

Description: The Follow-Up After Psychiatric Hospitalization (FAPH) measure assesses the percentage of inpatient discharges with a principal diagnosis of mental illness or substance use disorder (SUD) for which the patient received a follow-up visit for treatment of mental illness or SUD at seven- and 30-days post-discharge. Patients must be six years of age or older on the discharge date and enrolled in Medicare Parts A and B during the month of the discharge date and at least one month after the discharge date to be included in the measure. Please see Appendix D for a full description of this measure; **Measure Type**: Process; **Level of Analysis**: Facility; **Setting of Care**: Inpatient/Hospital; **Data Source**: Claims, Enrollment Data

This measure did not pass on validity, a must-pass criterion, and the measure was not recommended for endorsement. During the initial review of the measure, the evidence submission was presented to the Standing Committee for consideration. It noted that the developer responded to a call from the Standing Committee to incorporate SUDs alongside other behavioral health conditions inside of a comparable measure of follow-up after psychiatric hospitalization. Nonetheless, one Standing Committee member questioned why these were not presented as two different rates in the measure. It was pointed out that people with psychiatric conditions often have comorbid SUDs that warrant a combination of the rates; separating them may not be possible. The Standing Committee also questioned the strength of the literature that demonstrates that there is clear improvement in outcomes associated with follow-up appointments. The Standing Committee noted several articles that indicate the strength of follow-up interventions that were not included in the developer's evidence summary. The Standing Committee reviewed the performance gap summary and agreed that there was an adequate gap in performance to warrant a national measure. In the discussion of reliability, the Standing Committee noted good signal-to-noise analysis results. During the discussion on validity, it was noted that the developer's analysis used a known-group validity analysis. The Standing Committee expressed concern that readmissions and deaths within 30 days post discharge were not included since follow-up is to prevent readmission and death, especially for opiate use disorder. The developer noted that those who died within 30 days represented 0.15 percent of the study sample, and those who were readmitted represented 35 percent of the sample. There were also concerns that the measure population focus may not be the most appropriate, the Medicaid population would be more at risk, and Medicare Advantage beneficiaries are excluded. The measure was considered by the Standing Committee to be feasible, noting its reliance on claims data. The Standing Committee had limited discussion on use and usability given that the measure has yet to be implemented.

During the post-comment web meeting on September 21, 2020, NQF staff reviewed the Standing Committee's previous discussion on validity for NQF 3572, noting the concern raised during the initial measure evaluation meeting that 35 percent of the measure sample was excluded due to admission or transfer. It was noted that the Standing Committee had a significant concern related to the validity of the measure where the population that could have potentially had a poor outcome as a result of not receiving follow up was excluded from the measure. It was also noted that a comparable NQF-endorsed NCQA follow up measure also has the same exclusion criteria, suggesting this measure is appropriately harmonized with other follow up measures. The measure developer noted that of the 35 percent of exclusions due to readmission or transfer, 19 percent were discharged to home and then readmitted, and 16 percent were transferred to another facility. The Standing Committee reaffirmed a strong concern associated with this particular exclusion.

Related to the comment from Intermountain Healthcare, one Standing Committee member noted that there may be more burden to add more conditions such as dementia, but it is worth ensuring that there is adequate treatment and follow-up.

Measures Withdrawn

Seven measures previously endorsed by NQF have been withdrawn by the developer during the endorsement evaluation process. Endorsement for these measures has been removed. Any of these measures may be resubmitted by the developer for endorsement in the future, with new testing and updated data, and would be assigned new numbers and move through the endorsement process as brand-new measures.

Table 3. Measures Withdrawn

Measure	Reason for withdrawal
0027 Medical Assistance with Smoking and Tobacco Use Cessation	The measure developer is facing unique challenges with the data and cannot support maintenance of endorsement.
2599 Alcohol Screening and Follow-up for People with Serious Mental Illness	The measure developer reports that the measure has not been implemented in programs; thus, there is no performance data to support maintenance of endorsement.
2600 Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence	The measure developer reports that the measure has not been implemented in programs; thus, there is no performance data to support maintenance of endorsement.
2601 Body Mass Index Screening and Follow-Up for People with Serious Mental Illness	The measure developer reports that the measure has not been implemented in programs; thus, there is no performance data to support maintenance of endorsement.
2602 Controlling High Blood Pressure for People with Serious Mental Illness	The measure developer reports that the measure has not been implemented in programs; thus, there is no performance data to support maintenance of endorsement.
2603 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Testing	The measure developer reports that the measure has not been implemented in programs; thus, there is no

Measure	Reason for withdrawal
	performance data to support maintenance of endorsement.
2604 Diabetes Care for People with Serious Mental Illness: Medical Attention for Nephropathy	The measure developer reports that the measure has not been implemented in programs; thus, there is no performance data to support maintenance of endorsement.

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Appendix A: Details of Measure Evaluation

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

Vote totals may differ between measure criteria and between measures as Standing Committee members often have to join calls late or leave calls early. NQF ensures that a quorum is maintained for all live voting. All voting outcomes are calculated using the number of Standing Committee members present for that vote as the denominator.

Endorsed Measures

0108 Follow-Up Care for Children Prescribed ADHD Medication

Submission | Specifications

Description: Percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which is within 30 days of when the first ADHD medication was dispensed. An Initiation Phase Rate and Continuation and Maintenance Phase Rate are reported.

Numerator Statement: Among children newly prescribed ADHD medication, those who had timely and continuous follow-up visits.

Denominator Statement: Children 6-12 years of age newly prescribed ADHD medication.

Exclusions: Children who had an acute inpatient encounter for mental health or chemical dependency following the Index Prescription Start Date

Children with a diagnosis of narcolepsy: Many of the medications used to identify patients for the denominator of this measure are also used to treat narcolepsy. Children with narcolepsy who are pulled into the denominator are then removed by the narcolepsy exclusion.

Children using hospice services during the measurement year. Children in hospice may not be able to receive the necessary follow-up care.

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: Health Plan

Setting of Care: Outpatient Services

Type of Measure: Process

Data Source: Claims

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

Measure Steward: NCQA

STANDING COMMITTEE MEETING June 15, 2020; June 17, 2020

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

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

1a. Evidence: **H-0; M-14; L-5; I-1**; 1b. Performance Gap: **H-2; M-17; L-1; I-0**;

Rationale:

- Developer presents evidence from 2019 update of AAP ADHD guideline, ADHD: Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of ADHD in Children and Adolescents
    - Key Action Statement (KAS) 1: The pediatrician or other primary care clinicians (PCC) should initiate an evaluation for ADHD for any child or adolescent age four years to the 18th birthday who presents with academic or behavioral problems and symptoms of inattention, hyperactivity, or impulsivity. Grade B: Strong Recommendation
    - KAS 4: ADHD is a chronic condition; therefore, the PCC should manage children and adolescents with ADHD in the same manner that they would children and youth with special

0108 Follow-Up Care for Children Prescribed ADHD Medication

health care needs, following the principles of the chronic care model and the medical home. Grade B: Strong Recommendation
    - KAS 5b: For elementary and middle school-aged children (age 6 years to the 12th birthday) with ADHD, the PCC should prescribe FDA-approved medications for ADHD, along with parent training in behavior management (PTBM) and/or behavioral classroom intervention (preferably both PTBM and behavioral classroom interventions). Educational interventions and individualized instructional supports, including school environment, class placement, instructional placement, and behavioral supports, are a necessary part of any treatment plan and often include an individualized education plan (IEP) or a rehabilitation plan (504 plan). Grade A: Strong Recommendation
    - The developer states: "Numerous (>100) studies related to the care for patients with ADHD have been published since the publication of this guideline, none of which contradict the need for appropriate follow-up once treatment with medication begins."
- It was noted that the measure requires fewer visits than the current AAP guidelines for prescribing ADHD medication and follow-up visits.
- The Standing Committee noted that the measure requires the first follow-up visit to be in person, but subsequent ones may be performed via telemedicine.
    - The Standing Committee questioned whether it was in fact necessary to have the first follow-up visit in person especially considering the current COVID-19 pandemic.
    - The Standing Committee questioned the evidence supporting the 30-day timeframe and its linkage to improved outcomes and noted barriers to meeting this requirement. The developer said the clinical guidelines support the 30-day period and pointed to consensus from their expert panel.
    - The Standing Committee urged the developer and NQF to incorporate telehealth further into this and other measures.
- For the discussion related to performance gap, the Standing Committee was concerned that the measure only reports data from the last three years, but over the course of the past six years, the measure statistics have not changed much at all.
- The Standing Committee discussed whether the lack of change in the 90th percentile, 75th percentile, etc., over the last several years means this measure might not actually be measuring the correct parameters for management of ADHD.

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

<u>Rationale</u>:

- Developer performed reliability testing using a signal-to-noise analysis with the beta-binomial methodology and provided updated testing just prior to review that was not included in the preliminary analysis.
- Analysis included the point estimate of mean signal-to-noise reliability, its standard error, and the 95 percent confidence interval (CI) for the *Follow-Up Care for Children Prescribed ADHD Medication – Initiation Phase* measure for commercial and Medicaid plans overall and stratified by the denominator size (distribution of the number of eligible members per plan).
    - Overall, for commercial plans, the reliability estimate is 0.737, and the 95 percent CI is 0.718, 0.757, indicating good reliability.
    - Stratified analyses show that reliability exceeded 0.70 for plans with a large denominator (Tercile 2: reliability=0.76; Tercile 3: reliability=0.91).
    - Overall, for Medicaid plans, the reliability estimate is 0.947 and the 95 percent CI is 0.937, 0.958, indicating very good reliability. Results from the stratified analyses show that reliability exceeds 0.70 for all terciles.
- Analysis also included the *Follow-Up Care for Children Prescribed ADHD Medication – Continuation and Maintenance Phase* measure.

0108 Follow-Up Care for Children Prescribed ADHD Medication
- Overall, for commercial plans, the estimated mean signal-to-noise reliability is 0.626, and the 95 percent CI is 0.602, 0.649.   - The estimated mean signal-to-noise reliability exceeds the threshold of 0.70 for commercial plans with a larger denominator (Tercile 3: reliability=0.822).   - Overall, for Medicaid plans, the estimated mean signal-to-noise reliability is 0.889 and the 95 percent CI is 0.875, 0.903.   - The stratified analyses also exceed the 0.70 threshold for all three terciles for Medicaid plans and have narrow confidence intervals, indicating very good reliability.   - In the discussion of the reliability criterion, the Standing Committee noted that the measure's performance fell below a 0.7 threshold on the commercial plan data for the mean signal-to-noise reliability, with the developer also pointing out that the reliability performance data for Medicaid plans was well above this level.   - Statistical results from Pearson's Correlation analysis comparing the measure's two rates: - Commercial: 0.78   - Medicaid: 0.89   - Statistical results from Pearson's Correlation analysis comparing the measure with Use of First-line Psychosocial Care for Children and Adolescents on Antipsychotics: - Commercial: Initiation: 0.26; Continuation and Maintenance: 0.14   - Medicaid: Initiation: 0.31; Continuation and Maintenance: 0.30   - For validity, the Standing Committee observed that the analysis submitted indicated moderate correlations between NQF #0108 and external measures of quality.   - The Standing Committee also discussed the exclusions, noting that patients who are admitted to in-patient settings are excluded from the denominator. The Standing Committee expressed concerns that such patients might be admitted due to poor follow-up.
3. Feasibility: H-6; M-11; L-2; I-0 *(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/ unintended consequences identified; 3d. Data collection strategy can be implemented)* Rationale: The Standing Committee did not express concerns related to feasibility, observing that the measure data source of healthcare claims is low burden and generated during the routine delivery of care.
4. Usability and Use: The maintenance measure meets the use subcriterion *(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)* 4a. Use**: Pass-21; No Pass-0**; 4b. Usability: **H-1; M-11; L-7; I-0** Rationale: The Standing Committee also noted the broad adoption of the measure along with the feedback loops deployed and did not express concerns associated with usability and use.
5. Related and Competing Measures   No competing measures noted.
6. Standing Committee Recommendation for Endorsement: Yes-13; No-6 The Standing Committee recommended the measure for endorsement.
7. Public and Member Comment   No measure-specific comments were submitted for this measure
8. Consensus Standards Approval Committee (CSAC) Vote to Uphold Standing Committee Recommendation (November 17-18, 2020): Yes-11; No-0 **CSAC Decision:** Approved for Endorsement
10. Appeals: No appeals were received.

Measures Not Endorsed

2803 Tobacco Use and Help with Quitting Among Adolescents

Submission | | Specifications

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

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

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

Exclusions: N/A

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: Clinician : Group/Practice

Setting of Care: Outpatient Services

Type of Measure: Process

Data Source: Claims, Electronic Health Records

This measure is currently in use as a MIPS Clinical Quality Measure under the Quality Payment Program. The source of the data are electronic health records. The data are collected using electronic health record (EHR) data abstraction, and is reported by individual clinicians, groups, or third-party intermediaries on behalf of individual clinicians or groups.

Measure Steward: NCQA

STANDING COMMITTEE MEETING June 15, 2020; June 17, 2020

1. Importance to Measure and Report: The measure was consensus not reached on the importance criteria

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

1a. Evidence: **H-0; M-10; L-3; I-7**; 1b. Performance Gap: **H-5; M-15; L-1; I-0;**

Rationale:

- The Standing Committee noted that the evidence submitted was graded and based on the USPSTF recommendations.
- The Standing Committee focused on two recommendations from the USPSTF related to adolescent smoking cessation.
    - First, counseling has been shown to be effective in treatment of adolescent smokers. Therefore, adolescent smokers should be provided with counseling interventions to aid them in quitting smoking. This recommendation was given USPSTF's "Grade B Strength of Evidence—some evidence from randomized clinical trials supported the recommendation, but the scientific support was not optimal. For instance, few randomized trials existed, the trials that did exist were somewhat inconsistent, or the trials were not directly relevant to the recommendation."
    - Second, clinicians should ask pediatric and adolescent patients about tobacco use and provide a strong message regarding the importance of totally abstaining from tobacco use. USPSTF offed a Grade C Strength of Evidence for this recommendation, stating that it should be "reserved for important clinical situations in which the Panel achieved consensus on the recommendation in the absence of relevant randomized controlled trials."
- The panel was especially concerned with the evidence supporting the first recommendation, resulting in consensus not being reached on evidence.
- For the performance gap, the Standing Committee noted that mean performance was relatively high, but also with a fairly large standard deviation.
- The Standing Committee agreed that a gap in performance still remains.

Post Comment Call Vote: Evidence: **H-0; M-4; L-3; I-9**, Insufficient Evidence with Exception: **Yes-7; No-10**

Rationale:

2803 Tobacco Use and Help with Quitting Among Adolescents

- Evidence of counseling interventions to aid adolescent smokers in quitting smoking was given USPSTF's Grade I Statement Strength of Evidence. The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of primary care--feasible interventions for the cessation of tobacco use among school-aged children and adolescents.
- The recommendation that primary care clinicians provide interventions to prevent initiation of tobacco use was given USPSTF's Grade B Strength of Evidence – some evidence from randomized clinical trials supported the recommendation but the scientific support was not optimal.

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-4; M-16; L-1; I-0**; 2b. Validity: **H-1; M-15; L-2; I-0**

Rationale:

- Developer performed reliability testing using a signal-to-noise analysis with the beta-binomial methodology and provided updated testing just prior to review that was not included in the preliminary analysis.
  - The mean signal-to-noise reliability using the current methodology is 0.985, which is slightly lower than the estimate using the former methodology (0.996).
  - The current estimate is close to 1, indicating very good reliability.
  - Estimates of mean signal-to-noise reliability for the terciles of the eligible population ranged from 0.965 to 0.997 and have narrow confidence intervals, indicating very good reliability.
- The Standing Committee noted a strong signal-to-noise score level reliability result and expressed no concerns.
- Pearson correlation coefficient determined for this measure and Help Quitting Among Adolescents and Unhealthy Alcohol Use: Screening and Brief Counseling. Pearson correlation coefficient at the Group/Practice level was 0.37 ($p<0.0001$).
- The Standing Committee acknowledged a moderate correlation between measure NQF #2803 and external measures of quality in the validity discussion.

3. Feasibility: H-3; M-17; L-0; I-0

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

Rationale:

- The Standing Committee did not express concerns related to feasibility, observing that the measure data source is low burden and generated during the routine delivery of care

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

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

4a. Use**: Pass-21; No Pass-0**; 4b. Usability: **H-2; M-18; L-0; I-0**

Rationale:

- The Standing Committee also noted the adoption of the measure in MIPS along with the feedback loops deployed and did not express concerns associated with usability and use.

5. Related and Competing Measures

- No competing measures noted.

6. Standing Committee Recommendation for Endorsement: N/A

Rationale:

- This measure did not pass the re-vote on evidence, a must-pass criterion, and the measure will not be endorsed.

7. Public and Member Comment

- No measure-specific comments were submitted for this measure

2803 Tobacco Use and Help with Quitting Among Adolescents

8. Consensus Standards Approval Committee (CSAC) Vote to Uphold Standing Committee Recommendation (November 17-18, 2020): Yes-10; No-1

CSAC Decision: Not Approved for Continued Endorsement

9. Appeals: No appeals were received.

3572 Follow-Up After Psychiatric Hospitalization

Submission | Specifications

Description: The *Follow-Up After Psychiatric Hospitalization* (FAPH) measure assesses the percentage of inpatient discharges with principal diagnosis of mental illness or substance use disorder (SUD) for which the patient received a follow-up visit for treatment of mental illness or SUD at seven- and 30-days post-discharge. Patients must be six years of age or older on the discharge date and enrolled in Medicare Parts A and B during the month of the discharge date and at least one month after the discharge date to be included in the measure.

The FAPH measure is not completely new, but is rather an expansion of the existing Inpatient Psychiatric Facility Quality Reporting (IPFQR) program measure, *IPFQR Follow-Up After Hospitalization for Mental Illness (FUH*), which was adapted from the National Quality Forum (NQF)-endorsed Healthcare Effectiveness Data and Information Set (HEDIS®) measure with the same name (NQF #0576). During the 2017 comprehensive review of NQF #0576, the NQF Behavioral Health Standing Committee (BHSC) recommended expanding the measure population to include patients hospitalized for drug and alcohol disorders, because these patients also require follow-up care after they are discharged. In 2018, the Centers for Medicare & Medicaid Services (CMS) created the new FAPH measure, which expanded the IPFQR FUH measure population to include patients with principal substance use disorder (SUD) diagnoses to address the NQF BHSC recommendation and the CMS Meaningful Measures priority to promote treatment of SUD. In addition to including patients with SUD diagnoses, the FAPH measure also broadens the measure population to include patients with additional principal mental illness diagnoses like dementia, which are not currently included in the HEDIS® FUH and IPFQR FUH measures. By including dementia in the measure population, FAPH aligns with the IPFQR program's *30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF Readmission)* measure, which also includes dementia in its measure population. Eligible inpatient psychiatric facility (IPF) discharges with a primary diagnosis of dementia account for 7.31 percent of discharges among IPFs with at least 40 discharges and 7.55 percent of discharges among all IPFs.

While the FAPH measure mostly differs from FUH in the expansion of the measure population to include SUD and other mental health diagnoses, the FAPH measure does include some additional differences. Specifically, the FAPH measure differs from the FUH measure by:

- Simplifying the exclusion of admission or transfer to acute or non-acute inpatient facilities within 30 days after discharge by aligning with the HEDIS® Inpatient Stay Value Set used in both the HEDIS® FUH and HEDIS® FUA measures to identify acute and non-acute inpatient stays. A discharge will be excluded from the FAPH measure if it is followed by an admission or transfer with one of the codes in the value set.
- Removing the exclusion in the FUH measure that used inpatient discharge status codes to identify discharges to or transfers to other healthcare institutions, to better align with the intent of the HEDIS® FUH and HEDIS® FUA measures. These two HEDIS® measures exclude only admissions or transfers that have a claim indicating that the admission or transfer actually occurred. If the patient was not actually discharged to or transferred to other healthcare institutions, they should have had the opportunity to obtain outpatient follow-up care after discharge from the hospital and should not be excluded from the denominator. The FAPH measure likewise only excludes cases in which discharge or transfer to another facility actually occurred.
- Allowing mental illness or SUD diagnoses in any position on the follow-up visit claim to count toward the numerator rather than requiring it to be in the primary position.
- Not limiting the provider type for the follow-up visit as long as it is billed with a diagnosis of mental illness or SUD. The most frequent provider types were family or general practice physicians, internal medicine physicians, nurse practitioners, and physician assistants. This change aligns with integrated care models that

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aim to treat the whole patient and recognizes in areas where there are shortages of mental health or SUD providers, other types of providers are often the only choice for follow-up treatment.

Two rates are reported:

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

The performance period used to identify cases in the denominator is 12 months. Data from the performance period and 30 days after the performance period are used to identify follow-up visits in the numerator.

Numerator Statement: The numerator includes discharges from a psychiatric facility that are followed by an outpatient visit for treatment of mental illness or SUD within seven and 30 days

Denominator Statement: The denominator includes discharges paid under the IPF prospective payment system (PPS) during the performance period for Medicare fee-for-service (FFS) patients with a principal diagnosis of mental illness or SUD.

Exclusions: The denominator excludes IPF discharges for patients:

- Admitted or transferred to acute and non-acute inpatient facilities within the 30-day follow-up period because admission or transfer to other institutions may prevent an outpatient follow-up visit from taking place.

- Who were discharged against medical advice (AMA) because the IPF may have limited opportunity to complete treatment and prepare for discharge. Defined as Discharge Status Code '7' (AMA).

- Who died during the 30-day follow-up period because patients who expire may not have the opportunity for an outpatient follow-up visit. Defined as Discharge Status Code '20' (expired).

- Who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began because patients in hospice may require different follow-up services (refer to the Hospice Codes tab on the FAPH_codes.xlsx workbook).

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: Facility

Setting of Care: Inpatient/Hospital

Type of Measure: Process

Data Source: Claims, Enrollment Data

CMS will calculate the measure outcome using Part A and Part B claims data that are received by Medicare for payment purposes. CMS will calculate the measure by linking Medicare fee-for-service (FFS) claims submitted by IPFs and subsequent outpatient providers for Medicare FFS IPF discharges.

Measure Steward: CMS

STANDING COMMITTEE MEETING June 15, 2020; June 17, 2020

1. Importance to Measure and Report: <u>The measure meets the importance criteria</u>

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

1a. Evidence **M-18; L-2; I-1**; 1b. Performance Gap: **H-12; M-9; L-0; I-0;**

<u>Rationale</u>:

- Developer cites three studies that found that readmission rates for those with psychiatric diagnoses are lower for patients who receive follow-up visits within 30 days of discharge.
    - A 2017 study found that receipt of a follow-up visit within 30 days of hospital discharge lowered the risk of readmission for days 31 to 120 post-discharge for patients with schizophrenia or bipolar disorder (Marcus et al.).
    - A 2018 study found that among patients discharged with schizophrenia, psychiatric readmission rates on days 31-180 were lower if the patient saw a primary care physician or psychiatrist within 30 days of discharge (Kurdyak et al.).
    - A 2019 study looked at results of a program for military veterans discharged from an IPF that included inpatient/outpatient care coordination, phone calls from clinicians within seven days of discharge, and group dialectical behavior therapy treatment sessions (Wray et al.).

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- Developer points to evidence that inpatient psychiatric facilities can influence rates of follow-up care for patients hospitalized for mental illness or SUD and suggests that the following interventions have been shown effective in the literature:
    - Following up with letters or telephone calls
    - Discussing barriers to attending the first outpatient post-discharge appointment
    - Serving as a contact for questions or concerns between discharge and outpatient appointment
    - Establishing a case management plan before discharge
    - Involvement between family members and inpatient staff (Agarin et al. 2015, Batscha et al. 2011, Dixon et al. 2009, Haseldin et al. 2019).
- The Standing Committee questioned the strength of the literature summarized by the developer that demonstrates that there is clear improvement in outcomes associated with follow-up appointments. Other Standing Committee members noted several articles that indicate the strength of follow-up interventions that were not included in the developer's evidence summary.
- The Standing Committee noted that the developer responded to a call from the Standing Committee to incorporate SUD alongside other behavioral health conditions inside of a comparable measure of follow-up after psychiatric hospitalization. It was pointed out that people with psychiatric conditions often have comorbid SUDs that warrant a combination of the rates; separating them may not be possible.
- The Standing Committee reviewed the performance gap summary and agreed that there was an adequate gap in performance to warrant a national measure.
- Developer offered analysis of disparities data by sex, SUD diagnosis, dual status, race, and level of urbanization for each of the rates.

2. Scientific Acceptability of Measure Properties: <u>The Committee did not reach consensus on the scientific acceptability criteria</u> (2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-2; M-15; L-4; I-0**; 2b. Validity: **H-0; M-10; L-8; I-2**

<u>Rationale</u>:

- Measure developer tested score level reliability using a beta-binomial signal-to-noise analysis.
- Mean reliability for the mean was 0.87. Less than 5 percent of data was below 0.73 with minimum values at 0.68 for both measure rates.
- In the discussion of reliability, the Standing Committee noted good signal-to-noise analysis results.
- Measure validity was assessed using known-group validity.
    - A measure is considered to exhibit known-group validity if the measure score could be used to discriminate between subgroups of patients known to have differences in the measure rates based on findings from the literature.
    - Known-groups validity was investigated by evaluating differences in mean FAPH facility scores among predefined groups of patients based on the evidence from peer-reviewed studies examining post-psychiatric hospitalization follow-up in the community.
- Developer hypothesized lower measure performance according to the literature for
    - Male patients (Marcus et al, 2017);
    - Patients with an SUD diagnosis (Marcus et al, 2017; Fontanella et al, 2016);
    - Patients with limited resources, measured in this data by dual Medicare-Medicaid status (Anderson and Kurdyak, 2017);
    - Black patients (Carson et al, 2014; Marcus et al, 2017; Fontanella, 2016);
    - Patients living in rural areas (Anderson and Kurdyak, 2017)
    - Consistent with the literature, results were lower on the FAPH measure rates for men, patients with a SUD diagnosis, dual Medicare and Medicaid status, and for black patients.
- Developer's results did not have a strong effect size by urbanicity, though this may have been confounded by a number of factors latent in the data used.
- The Standing Committee expressed a number of validity concerns:
    - With exclusions, the Standing Committee was concerned that readmissions and deaths within 30 days post discharge were not included since follow-up is to prevent readmission and death, especially for opiate use disorder.

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- The developer noted that those who died within 30 days represented 0.15 percent of the study sample, and those who were readmitted represented 35 percent of the sample.
- There were also concerns that the measure population focus may not be the most appropriate, noting that the Medicaid population would be more at risk and also noting the exclusion of Medicare Advantage beneficiaries.

Post Comment Call Vote: Validity **H-1; M-4; L-11; I-0**

Rationale:

- There were concerns that exclusions may impact the validity of the measure since the measure excludes those who have undesirable outcomes that could be due to lack of follow-up.
  - The Standing Committee noted that follow-up is to prevent readmission and death, especially for opiate use disorder
  - Developer noted that those who died within 30 days represented 0.15 percent of the study sample, and those who are readmitted represented 35 percent of the sample
- Medicaid population focus may not be the most appropriate, as they would be more at risk. And Medicare Advantage beneficiaries are excluded

3. Feasibility: H-5; M-17; L-0; I-0

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

Rationale:

- The measure was considered by the Standing Committee to be feasible, noting its reliance on claims data.

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

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

4a. Use**: Pass-19; No Pass-3**; 4b. Usability: **H-2; M-12; L-7; I-1**

Rationale:

- The Standing Committee had limited discussion on use and usability given that the measure has yet to be implemented.

5. Related and Competing Measures

- No competing measures noted.

6. Standing Committee Recommendation for Endorsement: N/A

Rationale:

- This measure did not pass the re-vote on validity, a must-pass criterion, and the measure will not be endorsed.

7. Public and Member Comment

- Comment by **Intermountain Healthcare**: Intermountain Healthcare notes that the expansion to include additional diagnosis like dementia is likely to negatively impact the FUH focus from mental health and substance use diagnosis that can positively be impacted by both inpatient and outpatient behavioral health follow up. Additionally, dementia is not likely to be impacted by the same sort of treatment and is likely to overwhelm limited resources. This expansion would not be beneficial for this population who needs targeted intervention.
- Comment by **The American Geriatrics Society (AGS)**: The American Geriatrics Society (AGS) wishes to acknowledge how important this measure is, and how much these updates to the original are really needed in the current healthcare climate. Additionally, it is very difficult to take such a heterogenous group of disorders and attempt to simplify and clarify a well scripted measure that can be easily reported by healthcare systems. It is clear that a deep level of thought and perceptive analysis went into the measure draft as it stands. Here are our specific comments on the measure:

  1) Grouping psychiatric admissions with SUD admissions may be permissible for now, especially if there is a plan to evaluate the subgroups to see if they might otherwise warrant separation. Another possible

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partition would be that specifically around opioid substance use disorder, given its increasing prevalence and very unique circumstances regarding follow up care. It really seems to differ from other types of SUD and psychiatric disorders and the difficulty that healthcare systems seem to face in helping this group (1) agree to treatment and when they do, (2) help them access follow-up at the appropriate clinics where they can receive methadone or suboxone for their treatment. Additionally, these follow-ups, for purposes of prescribing such medications, do require in-person visits as opposed to the other conditions. 2) From a geriatrics perspective, we are heartened to see psychiatric admissions for dementia included in this quality measure. This group of patients will continue to expand and psychiatric care has been difficult for many to access. Many of these patients may be homebound, further limiting access. We believe that expanding the qualifying visits to telehealth will help healthcare systems to meet this measure and help fill this very needed gap in healthcare. 3) This group of disorders both psychiatric and SUD (except for opioid SUD) are very amenable to telephonic and telehealth follow-ups and we agree that they should qualify. They are also very often treated by various members of the healthcare team, and we agree with expanding the clinical assessor type (PA, NP etc.)
8. Consensus Standards Approval Committee (CSAC) Vote to Uphold Standing Committee Recommendation (November 17-18, 2020): Yes-11; No-0 **CSAC Decision:** Not Approved for Initial 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 February 20, 2020
0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Qualified Health Plan (QHP) Quality Rating System (QRS) Medicaid
0004e	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (eMeasure)	MIPS Medicaid Promoting Interoperability Program for Eligible Professionals
0028	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	MIPS Medicare Shared Savings Program (MSSP)
0028e	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (eMeasure)	MIPS Medicaid Promoting Interoperability Program
0104	Adult Major Depressive Disorder: Suicide Risk Assessment	None
0104e	Adult Major Depressive Disorder: Suicide Risk Assessment (eMeasure)	MIPS Medicaid Promoting Interoperability Program
0105	Antidepressant Medication Management (AMM)	Marketplace QRS Medicaid
0105e	Antidepressant Medication Management (AMM) (eMeasure)	None
0108	Follow-Up Care for Children Prescribed ADHD Medication (ADD)	Medicaid
0108e	Follow-Up Care for Children Prescribed ADHD Medication (ADD) (eMeasure)	MIPS Medicaid Promoting Interoperability Program
0576	Follow-Up After Hospitalization for Mental Illness (FUH)	MIPS Inpatient Psychiatric Facility Quality Reporting Marketplace QRS Medicaid
0640	HBIPS-2 Hours of physical restraint use	Inpatient Psychiatric Facility Quality Reporting
0641	HBIPS-3 Hours of seclusion use	Inpatient Psychiatric Facility Quality Reporting
0710e	Depression Remission at Twelve Months (eMeasure)	MIPS Medicaid Promoting Interoperability Program
0711	Depression Remission at Six Months	None
0712e	Depression Utilization of the PHQ-9 Tool (eMeasure)	None
1365	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment	None

[a] Per CMS Measures Inventory Tool as of January 29, 2021

NQF #	Title	Federal Programs: Finalized or Implemented as of February 20, 2020
1365e	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment (eMeasure)	MIPS Medicaid Promoting Interoperability Program
1884	Depression Response at Six Months – Progress Towards Remission	None
1885	Depression Response at 12 Months – Progress Towards Remission	None
1879	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	MIPS Medicaid
1932	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	Medicaid
1933	Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)	None
1934	Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)	None
2152	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	MIPS
2597	Substance Use Screening and Intervention Composite	None
2605	Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence	None
2606	Diabetes Care for People with Serious Mental Illness: Blood Pressure Control (<140/90 mm Hg)	None
2607	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	Medicaid
2608	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Control (<8.0%)	None
2609	Diabetes Care for People with Serious Mental Illness: Eye Exam	None
2800	Metabolic Monitoring for Children and Adolescents on Antipsychotics	Medicaid
2801	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	Medicaid
2806	Pediatric Psychosis: Screening for Drugs of Abuse in the Emergency Department	Prospective Payment System-Exempt Cancer Hospital Quality Reporting

NQF #	Title	Federal Programs: Finalized or Implemented as of February 20, 2020
3205	Medication Continuation Following Inpatient Psychiatric Discharge	Inpatient Psychiatric Facility Quality Reporting
3175	Continuity of Pharmacotherapy for Opioid Use Disorder	MIPS Program
3312	Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) from Alcohol and/or Drugs	Medicaid
3313	Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic	Medicaid
3317	Medication Reconciliation on Admission	None
3332	Psychosocial Screening Using the Pediatric Symptom Checklist-Tool (PSC-Tool)	None
3400	Use of pharmacotherapy for opioid use disorder (OUD)	Medicaid
3453	Continuity of care after inpatient or residential treatment for substance use disorder (SUD)	Medicaid
3488	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	Medicaid
3489	Follow-Up After Emergency Department Visit for Mental Illness	Medicaid
3539e	Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting	None
3541	Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO)	Marketplace QRS

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

STANDING COMMITTEE

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Appendix D: Measure Specifications (Tabular)

	0108 Follow-Up Care for Children Prescribed ADHD Medication (ADD): Specifications
Steward	NCQA
Description	Percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which is within 30 days of when the first ADHD medication was dispensed. An Initiation Phase Rate and Continuation and Maintenance Phase Rate are reported.
Type	Process
Data Source	Claims This measure is based on administrative claims collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from Health Management Organizations and Preferred Provider Organizations via NCQA's online data submission system.
Level	Health Plan
Setting	Outpatient Services
Numerator Statement	Among children newly prescribed ADHD medication, those who had timely and continuous follow-up visits.
Numerator Details	RATE 1. INITIATION PHASE NUMERATOR An outpatient, intensive outpatient, or partial hospitalization follow-up visit with a practitioner with prescribing authority within 30 days after the earliest prescription dispensing date for a new ADHD medication. Any of the following code combinations billed by a practitioner with prescribing authority meet criteria: • An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set). • An outpatient visit (BH Outpatient Value Set). • An observation visit (Observation Value Set). • A health and behavior assessment/intervention (Health and Behavior Assessment/Intervention Value Set). • An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set). • An intensive outpatient encounter or partial hospitalization (Partial Hospitalization/Intensive Outpatient Value Set). • A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set). Note: Do not count a visit on the Index Prescription Start Date as the Initiation Phase visit. Do not count visits billed with a telehealth modifier (Telehealth Modifier Value Set) or billed with a telehealth POS code (Telehealth POS Value Set). RATE 2. CONTINUATION AND MAINTENANCE PHASE NUMERATOR Children who are numerator compliant for Rate 1. Initiation Phase, AND have documentation of at least two follow-up visits on different dates of service with any practitioner from 31-300 days (nine months) after the earliest prescription dispensing date for a new ADHD medication. One of the two visits (during days 31-300) may be a telephone visit (Telephone Visits Value Set) with any practitioner. Identify follow-up visits using the code combinations below, then identify telehealth visits by the presence of a telehealth modifier (Telehealth Modifier Value Set) or the presence of a telehealth POS code (Telehealth POS Value Set) on the claim. Any of the following code combinations identify follow-up visits: • An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set).

	0108 Follow-Up Care for Children Prescribed ADHD Medication (ADD): Specifications
	• An outpatient visit (BH Outpatient Value Set). • An observation visit (Observation Visit Value Set). • A health and behavior assessment/intervention (Health and Behavior Assessment/Intervention Value Set). • An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set). • An intensive outpatient encounter or partial hospitalization (Partial Hospitalization/Intensive Outpatient Value Set). • A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set). • A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set). • A telephone visit (Telephone Visits Value Set).
Denominator Statement	Children 6-12 years of age newly prescribed ADHD medication.
Denominator Details	RATE 1. INITIATION PHASE DENOMINATOR Children age 6 as of March 1 of the measurement year; 12 years as of February 28 of the measurement year who were dispensed a new ADHD medication during the 12-month Intake Period (Table ADD-A). Patients must have all of the following: (1) A 120-day (4-month) negative medication history on or before the Index Prescription Date. The Index Prescription Start Date is the dispensing date of the earliest ADHD prescription in the Intake Period with a Negative Medication History. (2) Continuous enrollment for 120 days prior to the Index Prescription Start Date through 30 days after the Index Prescription Start Date. (3) Exclude patients who had an acute inpatient encounter for mental health or chemical dependency during the 30 days after the Index Prescription Start Date. An acute inpatient encounter in combination with any of the following meet criteria: A principal mental health diagnosis (Mental Health Diagnosis Value Set). A principal diagnosis of chemical dependency (Chemical Dependency Value Set) Due to the extensive volume of codes associated with identifying the denominator for this measure, we are attaching a separate file with code value sets. See code value sets located in question S.2b. ADHD MEDICATIONS LIST CNS stimulants: Amphetamine-dextroamphetamine, dexmethylphenidate, dextroamphetamine, lisdexamfetamine, methamphetamine, methylphenidate Alpha-2 receptor agonists: Clonidine, guanfacine Miscellaneous: Atomoxetine --- RATE 2. CONTINUATION AND MAINTENANCE PHASE DENOMINATOR Children who meet the eligible population criteria for Rate 1. Initiation Phase who have been continuously enrolled in the organization for 120 days (4 months) prior to the Index Prescription Start Date and 300 days (10 months) after the Index Prescription Start Date. Patients must have all of the following: (1) The patient must have filled a sufficient number of prescriptions to provide continuous treatment for at least 210 days out of the 300-day period after the Index Prescription Start Date. The definition of “continuous medication treatment” allows gaps in medication treatment, up to a total of 90 days during the 300-day (10-month) period. (This period spans the Initiation Phase (one1 month) and the C&M Phase (9 months).)

	0108 Follow-Up Care for Children Prescribed ADHD Medication (ADD): Specifications
	Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication. Regardless of the number of gaps, the total gap days may be no more than 90. The organization should count any combination of gaps (e.g., one washout gap of 14 days and numerous weekend drug holidays). (2) Exclude patients who had an acute inpatient encounter for mental health or chemical dependency during the 300 days (10 months) after the Index Prescription Start Date. An acute inpatient encounter in combination with any of the following meet the criteria: A principal mental health diagnosis (Mental Health Diagnosis Value Set). A principal diagnosis of chemical dependency (Chemical Dependency Value Set).
Exclusions	Children who had an acute inpatient encounter for mental health or chemical dependency following the Index Prescription Start Date Children with a diagnosis of narcolepsy: Many of the medications used to identify patients for the denominator of this measure are also used to treat narcolepsy. Children with narcolepsy who are pulled into the denominator are then removed by the narcolepsy exclusion. Children using hospice services during the measurement year. Children in hospice may not be able to receive the necessary follow-up care.
Exclusion details	Exclude from the denominator for both rates, children who had an acute inpatient encounter for mental health or chemical dependency during the 30 days after the Index Prescription Start Date Exclude from the denominator for both rates, children with a diagnosis of narcolepsy (Narcolepsy Value Set) any time during their history through December 31 of the measurement year Exclude from the denominator for both rates 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 members may be identified using various methods, which may include but are not limited to enrollment data, medical record or claims/encounter data (Hospice Value Set).
Risk Adjustment	No risk adjustment or risk stratification
Stratification	N/A
Type Score	Rate/proportion better quality = higher score
Algorithm	INITIATION PHASE: ELIGIBLE POPULATION Step 1: Identify all children in the specified age range (Children 6-12 years of age: 6 as of March 1 of the measurement year; 12 years as of February 28 of the measurement year) who were dispensed an ADHD medication (ADHD Medications List) during the 12-month Intake Period. Step 2: Test for negative medication history. For each member identified in step 1, test each ADHD prescription for a negative medication history. The Index Prescription Start Date is the dispensing date of the earliest ADHD prescription in the Intake Period with a negative medication history. Step 3: Calculate continuous enrollment. Patients must be continuously enrolled for 120 days (4 months) prior to the Index Prescription Start Date through 30 days after the Index Prescription Start Date. Step 4: Exclude patients who had an acute inpatient encounter for mental health or chemical dependency during the 30 days after the Index Prescription Start Date. An acute inpatient encounter (Acute Inpatient Value Set) in combination with any of the following

	0108 Follow-Up Care for Children Prescribed ADHD Medication (ADD): Specifications
	meet criteria: A principal mental health diagnosis (Mental Health Diagnosis Value Set) AND/OR A principal diagnosis of chemical dependency (Chemical Dependency Value Set). Step 5: Determine the number of patients in the eligible population with an outpatient, intensive outpatient, or partial hospitalization follow-up visit with a practitioner with prescribing authority within 30 days after the Index Prescription Start Date. Any of the following code combinations billed by a practitioner with prescribing authority meet criteria: • An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set). • An outpatient visit (BH Outpatient Value Set). • An observation visit (Observation Value Set). • A health and behavior assessment/intervention (Health and Behavior Assessment/Intervention Value Set). • An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set). • An intensive outpatient encounter or partial hospitalization (Partial Hospitalization/Intensive Outpatient Value Set). • A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set). Note: Do not count a visit on the Index Prescription Start Date as the Initiation Phase visit. Do not count visits billed with a telehealth modifier (Telehealth Modifier Value Set) or billed with a telehealth POS code (Telehealth POS Value Set). Step 6: Calculate a rate (number of children receiving a follow-up visit with a prescriber within 30 days of the Index Prescription Start Date). --- CONTINUATION AND MAINTENANCE PHASE: ELIGIBLE POPULATION Step 1: Identify all patients who meet the eligible population criteria for Rate 1—Initiation Phase. Step 2: Calculate continuous enrollment. Patients must be continuously enrolled in the organization for 120 days (four months) prior to the Index Prescription Start Date and 300 days (10 months) after the Index Prescription Start Date. Step 3: Calculate the continuous medication treatment. Using the patients in step 2, determine if the member filled a sufficient number of prescriptions to provide continuous treatment for at least 210 days out of the 300-day period after the Index Prescription Start Date. The definition of “continuous medication treatment” allows gaps in medication treatment for up to a total of 90 days during the 300-day (10-month) period. (This period spans the Initiation Phase (one month) and the C&M Phase (nine months].) Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication. Regardless of the number of gaps, the total gap days may be no more than 90. The organization should count any combination of gaps (e.g., one washout gap of 14 days and numerous weekend drug holidays). Step 4: Exclude patients who had an acute inpatient encounter for mental health or chemical dependency during the 300 days (10 months) after the Index Prescription Start Date. An acute inpatient encounter in combination with any of the following meet criteria: A principal mental health diagnosis (Mental Health Diagnosis Value Set). A principal diagnosis of chemical dependency (Chemical Dependency Value Set). Step 5: Identify all patients in the eligible population who meet the following criteria: (1) Numerator compliant for Rate 1—Initiation Phase, and (2) At least two follow-up visits on different dates of service from 31-300 days (9 months) after the Index Prescription Start Date with any practitioner.

	0108 Follow-Up Care for Children Prescribed ADHD Medication (ADD): Specifications
	One of the two visits (during days 31-300) may be a telephone visit (Telephone Visits Value Set) with any practitioner. Any of the following code combinations identify follow-up visits: • An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set). • An outpatient visit (BH Outpatient Value Set). • An observation visit (Observation Visit Value Set). • A health and behavior assessment/intervention (Health and Behavior Assessment/Intervention Value Set). • An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set). • An intensive outpatient encounter or partial hospitalization (Partial Hospitalization/Intensive Outpatient Value Set). • A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set). • A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set). • A telephone visit (Telephone Visits Value Set). Step 6: Calculate a rate (number of children receiving two follow-up visits with any practitioner from 31-300 days after the Index Prescription Start Date). ADDITIONAL EXCLUSION: Exclude from the denominator, for both rates, patients with a diagnosis of narcolepsy (Narcolepsy Value Set) any time during their history through December 31 of the measurement year NOTE (1) Patients who have multiple overlapping prescriptions should count the overlap days once toward the days supply (whether the overlap is for the same drug or for a different drug). (2) Organizations may have different methods for billing intensive outpatient encounters and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the period required for the rate (e.g., within 30 days after or from 31-300 days after the Index Prescription Start Date). 123834| 140881| 135810

	2803 Tobacco Use and Help with Quitting Among Adolescents: Specifications
Steward	NCQA
Description	The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user.
Type	Process
Data Source	Claims, Electronic Health Records This measure is currently in use as a MIPS Clinical Quality Measure under the Quality Payment Program. The source of the data are electronic health records. The data are collected using EHR data abstraction and is reported by individual clinicians, groups, or third-party intermediaries on behalf of individual clinicians or groups.
Level	Clinician : Group/Practice

	2803 Tobacco Use and Help with Quitting Among Adolescents: Specifications
Setting	Outpatient Services
Numerator Statement	Patients who were screened for tobacco use at least once within 18 months (during the measurement period or the six months prior to the measurement period) AND who received tobacco cessation counseling intervention if identified as a tobacco user.
Numerator Details	Documentation that the adolescent is currently not a tobacco user OR Documentation that the adolescent is a tobacco user AND any of the following: -Advice given to quit smoking or tobacco use -Counseling on the benefits of quitting smoking or tobacco use (e.g., "5-A" Framework) -Assistance with or referral to external smoking or tobacco cessation support programs (e.g., telephone counseling 'quit line') -Current enrollment in smoking or tobacco use cessation program
Denominator Statement	All patients aged 12-20 years with a visit during the measurement period
Denominator Details	Patient age is 12-20 years on date of encounter
Exclusions	N/A
Exclusion details	N/A
Risk Adjustment	No risk adjustment or risk stratification
Stratification	N/A
Type Score	Rate/proportion better quality = higher score
Algorithm	1. Start with Denominator 2. Check Patient Age: a. If patient's age is 12-20 years on date of encounter equals No during the measurement period, do not include in Eligible Population. Stop Processing. b. If patient;s age is 12-20 years on date of encounter equals Yes during the measurement period, proceed to check Encounter Performed. 3. Check Encounter Performed: a. If Encounter as Listed in the Denominator equals No, do not include in Eligible Population. Stop Processing. b. If Encounter as Listed in the Denominator equals Yes, include in Eligible Population. 4. Denominator Population: a. Denominator Population is all Eligible Patients in the Denominator. 5. Start Numerator 6. Check Patient Documented as Tobacco User AND Received Tobacco Cessation Intervention if Identified as a Tobacco User: a. If Patient Documented as Tobacco User AND Received Tobacco Cessation Intervention if identified as a Tobacco User equals Yes, include in Data Completeness Met and Performance Met. b. If Patient Documented as Tobacco User AND Received Tobacco Cessation Intervention if identified as a Tobacco User equals No, proceed to check Currently a Tobacco Non-User. 7. Check Currently a Tobacco Non-User: a. If Currently a Tobacco Non-User equals Yes, include in Data Completeness Met and Performance Met. b. If Currently a Tobacco Non-User equals No, proceed to check Tobacco Assessment or Tobacco Cessation Intervention Not Performed, Reason Not Given.

	2803 Tobacco Use and Help with Quitting Among Adolescents: Specifications
	8. Check Tobacco Assessment or Tobacco Cessation Intervention Not Performed, Reason Not Given: a. If Tobacco Assessment or Tobacco Cessation Intervention Not Performed, Reason Not Given equals Yes, include in the Data Completeness Met and Performance Not Met. b. If Tobacco Assessment or Tobacco Cessation Intervention Not Performed, Reason Not Given equals No, proceed to check Data Completeness Not Met. 9. Check Data Completeness Not Met: a. If Data Completeness Not Met, the Quality Data Code or equivalent was not submitted 123834

	3572 Follow-Up After Psychiatric Hospitalization (FAPH): Specifications
Steward	CMS
Description	*The Follow-Up After Psychiatric Hospitalization (FAPH)* measure assesses the percentage of inpatient discharges with principal diagnosis of mental illness or substance use disorder (SUD) for which the patient received a follow-up visit for treatment of mental illness or SUD at seven- and 30-days post-discharge. Patients must be six years of age or older on the discharge date and enrolled in Medicare Parts A and B during the month of the discharge date and at least one month after the discharge date to be included in the measure. FAPH is not a completely new measure, but is rather an expansion of the existing Inpatient Psychiatric Facility Quality Reporting (IPFQR) program measure, *IPFQR Follow-Up After Hospitalization for Mental Illness (FUH)*, which was adapted from the National Quality Forum (NQF)-endorsed *Healthcare Effectiveness Data and Information Set (HEDIS®)* measure with the same name (NQF #0576). During the 2017 comprehensive review of NQF #0576, the NQF Behavioral Health Standing Committee (BHSC) recommended expanding the measure population to include patients hospitalized for drug and alcohol disorders, because these patients also require follow-up care after they are discharged. In 2018, the Centers for Medicare & Medicaid Services (CMS) created the new FAPH measure, which expanded the IPFQR FUH measure population to include patients with principal substance use disorder (SUD) diagnoses to address the NQF BHSC recommendation and the CMS Meaningful Measures priority to promote treatment of SUDs. In addition to including patients with SUD diagnoses, the FAPH measure also broadens the measure population to include patients with additional principal mental illness diagnoses like dementia, which are not currently included in the HEDIS® FUH and IPFQR FUH measures. By including dementia in the measure population, FAPH aligns with the IPFQR program's *30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF Readmission)* measure, which also includes dementia in its measure population. Eligible IPF discharges with a primary diagnosis of dementia account for 7.31 percent of discharges among IPFs with at least 40 discharges and 7.55 percent of discharges among all IPFs. While the FAPH measure mostly differs from FUH in the expansion of the measure population to include SUD and other mental health diagnoses, the FAPH measure does include some additional differences. Specifically, the FAPH measure differs from the FUH measure by: • Simplifying the exclusion of admission or transfer to acute or non-acute inpatient facilities within 30 days after discharge by aligning with the HEDIS® Inpatient Stay Value Set used in both the HEDIS® FUH and HEDIS® FUA measures to identify acute and non-acute inpatient stays. A discharge will be excluded from the FAPH measure if it is followed by an admission or transfer with one of the codes in the value set. • Removing the exclusion in the FUH measure that used inpatient discharge status codes to identify discharges or transfers to other healthcare institutions, to better align with the intent of the HEDIS® FUH and HEDIS® FUA measures. These two HEDIS® measures

	3572 Follow-Up After Psychiatric Hospitalization (FAPH): Specifications
	exclude only admissions or transfers that have a claim indicating that the admission or transfer actually occurred. If the patient was not actually discharged or transferred to other healthcare institutions, they should have had the opportunity to obtain outpatient follow-up care after discharge from the hospital and should not be excluded from the denominator. The FAPH measure likewise only excludes cases in which discharge or transfer to another facility actually occurred. • Allowing mental illness or SUD diagnoses in any position on the follow-up visit claim to count toward the numerator rather than requiring it to be in the primary position. • Not limiting the provider type for the follow-up visit as long as it is billed with a diagnosis of mental illness or SUD. The most frequent provider types were family or general practice physicians, internal medicine physicians, nurse practitioners, and physician assistants. This change aligns with integrated care models that aim to treat the whole patient and recognizes in areas where there are shortages of mental health or SUD providers, other types of providers are often the only choice for follow-up treatment. Two rates are reported: - The percentage of discharges for which the patient received follow-up within seven days of discharge - The percentage of discharges for which the patient received follow-up within 30 days of discharge The performance period used to identify cases in the denominator is 12 months. Data from the performance period and 30 days after the performance period are used to identify follow-up visits in the numerator.
Type	Process
Data Source	Claims, Enrollment Data CMS will calculate the measure outcome using Part A and Part B claims data that are received by Medicare for payment purposes. CMS will calculate the measure by linking Medicare fee-for-service (FFS) claims submitted by IPFs and subsequent outpatient providers for Medicare FFS IPF discharges.
Level	Facility
Setting	Inpatient/Hospital
Numerator Statement	The numerator includes discharges from a psychiatric facility that are followed by an outpatient visit for treatment of mental illness or SUD within seven and 30 days.
Numerator Details	Numerator qualifying visits include outpatient visits, intensive outpatient encounters, or partial hospitalization and are defined by the Current Procedural Terminology (CPT) (defined in the Visit Codes tab on the FAPH_codes.xlsx workbook), Healthcare Common Procedure Coding System (HCPCS) (defined in the Visit Codes tab on the FAPH_codes.xlsx workbook), and Uniform Billing (UB) Revenue codes (defined in the Revenue Codes tab on the FAPH_codes.xlsx workbook). Data from the 12-month performance period and 30 days after the performance period are used to identify outpatient visits. The type of visits that qualify as outpatient follow-up (defined in the Outpatient Codes tab on the FAPH_codes.xlsx workbook) must be paired with one of the qualifying diagnoses used to define the denominator (defined in the Diagnosis Codes tab on the FAPH_codes.xlsx workbook). The qualifying diagnosis can be in any position on the claim. Provider type is not considered when determining qualifying outpatient visit. Outpatient visit claims with the GT telehealth modifier count as outpatient visits. Claims with codes for emergency room visits do not count toward the numerator. Emergency room visits are defined by UB revenue, CPT, Berenson-Eggers type of service (BETOS), and Place of Service codes (refer to the ED Codes tab on the FAPH_codes.xlsx workbook). All codes required to calculate the measure are included in the FAPH_Codes.xlsx workbook.

	3572 Follow-Up After Psychiatric Hospitalization (FAPH): Specifications
Denominator Statement	The denominator includes discharges paid under the IPF prospective payment system (PPS) during the performance period for Medicare fee-for-service (FFS) patients with a principal diagnosis of mental illness or SUD.
Denominator Details	The measure includes IPF discharges during the 12-month measurement period for which the patient was: - Discharged with a principal diagnosis of mental illness or substance use disorder that would necessitate outpatient follow-up care. Defined using ICD-10-CM diagnosis codes and claim type 60 (refer to the Diagnosis Codes tab on the FAPH_codes.xlsx workbook). - Discharged alive to ensure they are eligible for follow-up care. Defined as any Discharge Status Code other than '20' (expired). - Enrolled in Medicare Parts A and B during the month of the discharge date and at least one month after the discharge date to ensure data are available to capture the index admission and follow-up visits. Defined as having continuous (no gaps) Medicare Part A and Part B coverage with no Health Maintenance Organization (HMO). Therefore, the Entitlement Buy-in Indicator must be '3' or 'C' and the HMO indicator must be '0' for both the month of discharge and the month following the discharge month for the IPF stay to qualify as continuous FFS. - Six years of age or older on the date of discharge because follow-up treatment for mental illness or SUD may not always be recommended for younger children. Defined using date of birth and discharge date from the CMS denominator file.
Exclusions	The denominator excludes IPF discharges for patients: - Admitted or transferred to acute and non-acute inpatient facilities within the 30-day follow-up period because admission or transfer to other institutions may prevent an outpatient follow-up visit from taking place. - Who were discharged against medical advice (AMA) because the IPF may have limited opportunity to complete treatment and prepare for discharge. Defined as Discharge Status Code '7' (AMA). - Who died during the 30-day follow-up period because patients who expire may not have the opportunity for an outpatient follow-up visit. Defined as Discharge Status Code '20' (expired). - Who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began because patients in hospice may require different follow-up services (refer to the Hospice Codes tab on the FAPH_codes.xlsx workbook).
Exclusion details	- Those admitted or transferred to acute and non-acute inpatient facilities within the 30-day follow-up period are defined using UB revenue codes (defined in the Readmission Codes tab on the FAPH_codes.xlsx workbook). - Those who were discharged against medical advice (AMA) are defined using Discharge Status Code '07' 2/12/2020 NQF: Follow-Up After Psychiatric Hospitalization - Those who died during the 30-day follow-up period are defined using the Medicare Enrollment File - Those who use hospice services or elect to use a hospice benefit any time during the measurement year are defined using hospice codes (defined in the Hospice codes tab on the FAPH_codes.xlsx workbook)
Risk Adjustment	No risk adjustment or risk stratification
Stratification	Not applicable
Type Score	Rate/proportion better quality = higher score

	3572 Follow-Up After Psychiatric Hospitalization (FAPH): Specifications
Algorithm	The performance period used to identify cases in the denominator is 12 months. Data from the performance period and 30 days after the performance period are used to identify follow-up visits in the numerator. The performance period begins on July 1. Identify the denominator using the following criteria: 1. Enrolled in Medicare Parts A and B during the month of the discharge date and at least one month after the discharge date to ensure data are available to capture the index admission and follow-up visits 2. Have a principal diagnosis of mental illness or substance use disorder (SUD) (as defined in on the Diagnosis Codes tab of the FAPH_Codes.xlsx and in Table A.4 and Table A.3 of the measure specifications) 3. Discharged alive (any discharge status other than '20') 4. Six years of age or older on the date of discharge 5. Discharged from an IPF with eligible claim types '60' or with CMS Certification Number that meets at least one of the following criteria: a. Last 4 digits of the CMS Certification Number (CCN) is 4000–4499 (Psychiatric Hospital excluded from Inpatient Prospective Payment System) b. 3rd digit of CCN is 'S' (distinct part Psychiatric Unit in an acute care hospital) c. 3rd digit of CCN 'M' (Psychiatric Unit in a CAH) 2/12/2020 NQF: Follow-Up After Psychiatric Hospitalization www.qualityforum.org/Print_Measure_Submission.aspx?SubmissionID=3572&projectID=2368/18 6. Exclude the following patients from the denominator: a. Admitted or transferred to acute and non-acute inpatient facilities within the 30-day follow-up period b. Discharged against medical advice (AMA) c. Used hospice services or elect to use a hospice benefit any time during the measurement period. Identify the numerator using the following criteria: 1. Identify treatment by an outpatient visit for mental illness or SUD within seven nd 30 day of discharge using the visit type codes in the FAPH_Code.xlsx workbook 2. Exclude claims with codes for emergency room visits outlined in the FAPH_Code.xlsx workbook The measure rate is the numerator / denominator. A higher score indicates better quality. 147129

Appendix D: Measure Specifications (Narrative)

0108 Follow-Up Care for Children Prescribed ADHD Medication (ADD): Specifications

STEWARD

NCQA

DESCRIPTION

Percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which is within 30 days of when the first ADHD medication was dispensed.

An Initiation Phase Rate and Continuation and Maintenance Phase Rate are reported.

TYPE

Process

DATA SOURCE

Claims

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

LEVEL

Health Plan

SETTING

Outpatient Services

NUMERATOR STATEMENT

Among children newly prescribed ADHD medication, those who had timely and continuous follow-up visits.

NUMERATOR DETAILS

RATE 1. INITIATION PHASE NUMERATOR

An outpatient, intensive outpatient or partial hospitalization follow-up visit with a practitioner with prescribing authority within 30 days after the earliest prescription dispensing date for a new ADHD medication. Any of the following code combinations billed by a practitioner with prescribing authority meet criteria:

• An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set).

• An outpatient visit (BH Outpatient Value Set).

• An observation visit (Observation Value Set).

• A health and behavior assessment/intervention (Health and Behavior Assessment/Intervention Value Set).

• An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set).

• An intensive outpatient encounter or partial hospitalization (Partial Hospitalization/Intensive Outpatient Value Set).

• A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set).

Note: Do not count a visit on the Index Prescription Start Date as the Initiation Phase visit. Do not count visits billed with a telehealth modifier (Telehealth Modifier Value Set) or billed with a telehealth POS code (Telehealth POS Value Set).

RATE 2. CONTINUATION AND MAINTENANCE PHASE NUMERATOR

Children who are numerator compliant for Rate 1 AND have documentation of at least two follow-up visits on different dates of service with any practitioner from 31-300 days (9 months) after the earliest prescription dispensing date for a new ADHD medication.

One of the two visits (during days 31–300) may be a telephone visit (Telephone Visits Value Set) with any practitioner. Identify follow-up visits using the code combinations below, then identify telehealth visits by the presence of a telehealth modifier (Telehealth Modifier Value Set) or the presence of a telehealth POS code (Telehealth POS Value Set) on the claim.

Any of the following code combinations identify follow-up visits:

• An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set).

• An outpatient visit (BH Outpatient Value Set).

• An observation visit (Observation Visit Value Set).

• A health and behavior assessment/intervention (Health and Behavior Assessment/Intervention Value Set).

• An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set).

• An intensive outpatient encounter or partial hospitalization (Partial Hospitalization/Intensive Outpatient Value Set).

• A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set).

• A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set).

• A telephone visit (Telephone Visits Value Set).

DENOMINATOR STATEMENT

Children 6-12 years of age newly prescribed ADHD medication.

DENOMINATOR DETAILS

RATE 1. INITIATION PHASE DENOMINATOR

Children age 6 as of March 1 of the measurement year; 12 years as of February 28 of the measurement year who were dispensed a new ADHD medication during the 12-month Intake Period (Table ADD-A). Patients must have all of the following:(1) A 120-day (4-month) negative medication history on or before the Index Prescription Date. The Index Prescription Start Date is the dispensing date of the earliest ADHD prescription in the Intake Period with a negative medication history.

(2) Continuous enrollment for 120 days prior to the Index Prescription Start Date through 30 days after the Index Prescription Start Date.

(3) Exclude patients who had an acute inpatient encounter for mental health or chemical dependency during the 30 days after the Index Prescription Start Date. An acute inpatient encounter in combination with any of the following meet criteria:

A principal mental health diagnosis (Mental Health Diagnosis Value Set).

A principal diagnosis of chemical dependency (Chemical Dependency Value Set)

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

ADHD MEDICATIONS LIST

CNS stimulants: Amphetamine-dextroamphetamine, dexmethylphenidate, dextroamphetamine, lisdexamfetamine, methamphetamine, methylphenidate

Alpha-2 receptor agonists: Clonidine, guanfacine

Miscellaneous: Atomoxetine

RATE 2. CONTINUATION AND MAINTENANCE PHASE DENOMINATOR

Children who meet the eligible population criteria for Rate 1. Initiation Phase who have been continuously enrolled in the organization for 120 days (4 months) prior to the Index Prescription Start Date and 300 days (10 months) after the Index Prescription Start Date. Patients must have all of the following:

(1) The patient must have filled a sufficient number of prescriptions to provide continuous treatment for at least 210 days out of the 300-day period after the Index Prescription Start Date. The definition of “continuous medication treatment” allows gaps in medication treatment, up to a total of 90 days during the 300-day (10-month) period. (This period spans the Initiation Phase (one month) and the C&M Phase (nine months).)

Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.

Regardless of the number of gaps, the total gap days may be no more than 90. The organization should count any combination of gaps (e.g., one washout gap of 14 days and numerous weekend drug holidays).

(2) Exclude patients who had an acute inpatient encounter for mental health or chemical dependency during the 300 days (10 months) after the Index Prescription Start Date. An acute inpatient encounter in combination with any of the following meet criteria:

A principal mental health diagnosis (Mental Health Diagnosis Value Set).

A principal diagnosis of chemical dependency (Chemical Dependency Value Set).

EXCLUSIONS

Children who had an acute inpatient encounter for mental health or chemical dependency following the Index Prescription Start Date

Children with a diagnosis of narcolepsy: Many of the medications used to identify patients for the denominator of this measure are also used to treat narcolepsy. Children with narcolepsy who are pulled into the denominator are then removed by the narcolepsy exclusion.

Children using hospice services during the measurement year. Children in hospice may not be able to receive the necessary follow-up care.

EXCLUSION DETAILS

Exclude from the denominator for both rates, children who had an acute inpatient encounter for mental health or chemical dependency during the 30 days after the Index Prescription Start Date

Exclude from the denominator for both rates, children with a diagnosis of narcolepsy (Narcolepsy Value Set) any time during their history through December 31 of the measurement year

Exclude from the denominator for both rates 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 members may be identified using various methods, which may include but are not limited to enrollment data, medical record or claims/encounter data

(Hospice Value Set).

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

N/A

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

INITIATION PHASE: ELIGIBLE POPULATION

Step 1: Identify all children in the specified age range (Children 6-12 years of age: 6 as of March 1 of the measurement year; 12 years as of February 28 of the measurement year) who were dispensed an ADHD medication (ADHD MEDICATIONS LIST) during the 12-month Intake Period.

Step 2: Test for negative medication history. For each member identified in step 1, test each ADHD prescription for a negative medication history. The Index Prescription Start Date is the dispensing date of the earliest ADHD prescription in the Intake Period with a negative medication history.

Step 3: Calculate continuous enrollment. Patients must be continuously enrolled for 120 days (4 months) prior to the Index Prescription Start Date through 30 days after the Index Prescription Start Date.

Step 4: Exclude patients who had an acute inpatient encounter for mental health or chemical dependency during the 30 days after the Index Prescription Start Date. An acute inpatient encounter (Acute Inpatient Value Set) in combination with any of the following meet criteria: A principal mental health diagnosis (Mental Health Diagnosis Value Set) AND/OR A principal diagnosis of chemical dependency (Chemical Dependency Value Set).

Step 5: Determine the number of patients in the eligible population with an outpatient, intensive outpatient or partial hospitalization follow-up visit with a practitioner with prescribing authority, within 30 days after the Index Prescription Start Date. Any of the following code combinations billed by a practitioner with prescribing authority meet criteria:

- An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set).
- An outpatient visit (BH Outpatient Value Set).
- An observation visit (Observation Value Set).

• A health and behavior assessment/intervention (Health and Behavior Assessment/Intervention Value Set).

• An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set).

• An intensive outpatient encounter or partial hospitalization (Partial Hospitalization/Intensive Outpatient Value Set).

• A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set).

Note: Do not count a visit on the Index Prescription Start Date as the Initiation Phase visit. Do not count visits billed with a telehealth modifier (Telehealth Modifier Value Set) or billed with a telehealth POS code (Telehealth POS Value Set).

Step 6: Calculate a rate (number of children receiving a follow-up visit with a prescriber within 30 days of the Index Prescription Start Date).

CONTINUATION AND MAINTENANCE PHASE: ELIGIBLE POPULATION

Step 1: Identify all patients who meet the eligible population criteria for Rate 1—Initiation Phase.

Step 2: Calculate continuous enrollment. Patients must be continuously enrolled in the organization for 120 days (4 months) prior to the Index Prescription Start Date and 300 days (10 months) after the Index Prescription Start Date.

Step 3: Calculate the continuous medication treatment. Using the patients in step 2, determine if the member filled a sufficient number of prescriptions to provide continuous treatment for at least 210 days out of the 300-day period after the Index Prescription Start Date. The definition of “continuous medication treatment” allows gaps in medication treatment, up to a total of 90 days during the 300-day (10-month) period. (This period spans the Initiation Phase (one month) and the C&M Phase (nine months).) Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication. Regardless of the number of gaps, the total gap days may be no more than 90. The organization should count any combination of gaps (e.g., one washout gap of 14 days and numerous weekend drug holidays).

Step 4: Exclude patients who had an acute inpatient encounter for mental health or chemical dependency during the 300 days (10 months) after the Index Prescription Start Date. An acute inpatient encounter in combination with any of the following meet criteria:

A principal mental health diagnosis (Mental Health Diagnosis Value Set).

A principal diagnosis of chemical dependency (Chemical Dependency Value Set).

Step 5: Identify all patients in the eligible population who meet the following criteria:

(1) Numerator compliant for Rate 1—Initiation Phase, and

(2) At least two follow-up visits on different dates of service from 31-300 days (9 months) after the Index Prescription Start Date with any practitioner.

One of the two visits (during days 31-300) may be a telephone visit (Telephone Visits Value Set) with any practitioner. Any of the following code combinations identify follow-up visits:

• An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set).

• An outpatient visit (BH Outpatient Value Set).

• An observation visit (Observation Visit Value Set).

• A health and behavior assessment/intervention (Health and Behavior Assessment/Intervention Value Set).

• An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set).

• An intensive outpatient encounter or partial hospitalization (Partial Hospitalization/Intensive Outpatient Value Set).

• A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set).

• A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set).

• A telephone visit (Telephone Visits Value Set).

Step 6: Calculate a rate (number of children receiving two follow-up visits with any practitioner from 31-300 days after the Index Prescription Start Date).

ADDITIONAL EXCLUSION:

Exclude from the denominator for both rates, patients with a diagnosis of narcolepsy (Narcolepsy Value Set) any time during their history through December 31 of the measurement year

NOTE

(1) Patients who have multiple overlapping prescriptions should count the overlap days once toward the days supply (whether the overlap is for the same drug or for a different drug).

(2) Organizations may have different methods for billing intensive outpatient encounters and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the period required for the rate (e.g., within 30 days after or from 31-300 days after the Index Prescription Start Date). 123834| 140881| 135810

2803 Tobacco Use and Help with Quitting Among Adolescents: Specifications

STEWARD

NCQA

DESCRIPTION

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

TYPE

Process

DATA SOURCE

Claims, Electronic Health Records

This measure is currently in use as a MIPS Clinical Quality Measure under the Quality Payment Program. The source of the data are electronic health records. The data are collected using EHR data abstraction, and is reported by individual clinicians, groups, or third-party intermediaries on behalf of individual clinicians or groups.

LEVEL

Clinician : Group/Practice

SETTING

Outpatient Services

NUMERATOR STATEMENT

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

NUMERATOR DETAILS

Documentation that the adolescent is currently not a tobacco user

OR

Documentation that the adolescent is a tobacco user AND any of the following:

-Advice given to quit smoking or tobacco use

-Counseling on the benefits of quitting smoking or tobacco use (e.g., “5-A” Framework)

-Assistance with or referral to external smoking or tobacco cessation support programs (e.g., telephone counseling ‘quit line’)

-Current enrollment in smoking or tobacco use cessation program

DENOMINATOR STATEMENT

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

DENOMINATOR DETAILS

Patient age is 12-20 years on date of encounter

EXCLUSIONS

N/A

EXCLUSION DETAILS

N/A

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

N/A

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

1. Start with Denominator

2. Check Patient Age:

a. If patient’s age is 12-20 years on date of encounter equals No during the measurement period, do not include in Eligible Population. Stop Processing.

b. If patient's age is 12-20 years on date of encounter equals Yes during the measurement period, proceed to check Encounter Performed.

3. Check Encounter Performed:

a. If Encounter as Listed in the Denominator equals No, do not include in Eligible Population. Stop Processing.

b. If Encounter as Listed in the Denominator equals Yes, include in Eligible Population.

4. Denominator Population:

a. Denominator Population is all Eligible Patients in the Denominator.

5. Start Numerator

6. Check Patient Documented as Tobacco User AND Received Tobacco Cessation Intervention if Identified as a Tobacco User:

a. If Patient Documented as Tobacco User AND Received Tobacco Cessation Intervention if identified as a Tobacco User equals Yes, include in Data Completeness Met and Performance Met.

b. If Patient Documented as Tobacco User AND Received Tobacco Cessation Intervention if identified as a Tobacco User equals No, proceed to check Currently a Tobacco Non-User.

7. Check Currently a Tobacco Non-User:

a. If Currently a Tobacco Non-User equals Yes, include in Data Completeness Met and Performance Met.

b. If Currently a Tobacco Non-User equals No, proceed to check Tobacco Assessment or Tobacco Cessation Intervention Not Performed, Reason Not Given.

8. Check Tobacco Assessment or Tobacco Cessation Intervention Not Performed, Reason Not Given:

a. If Tobacco Assessment or Tobacco Cessation Intervention Not Performed, Reason Not Given equals Yes, include in the Data Completeness Met and Performance Not Met.

b. If Tobacco Assessment or Tobacco Cessation Intervention Not Performed, Reason Not Given equals No, proceed to check Data Completeness Not Met.

9. Check Data Completeness Not Met:

a. If Data Completeness Not Met, the Quality Data Code or equivalent was not submitted 123834

3572 Follow-Up After Psychiatric Hospitalization (FAPH): Specifications

STEWARD

CMS

DESCRIPTION

The *Follow-Up After Psychiatric Hospitalization (FAPH)* measure assesses the percentage of inpatient discharges with principal diagnosis of mental illness or substance use disorder (SUD) for which the patient received a follow-up visit for treatment of mental illness or SUD at seven- and 30-days post-discharge. Patients must be six years of age or older on the discharge date and enrolled in Medicare Parts A and B during the month of the discharge date and at least one month after the discharge date to be included in the measure.

The FAPHmeasure is not a completely new measure, but is rather an expansion of the existing Inpatient Psychiatric Facility Quality Reporting (IPFQR) program measure, *IPFQR Follow-Up After Hospitalization for Mental Illness* (FUH), which was adapted from the National Quality Forum (NQF)-endorsed *Healthcare Effectiveness Data and Information Set (HEDIS®)* measure with the same name (NQF #0576). During the 2017 comprehensive review of NQF #0576, the NQF Behavioral Health Standing Committee (BHSC) recommended expanding the measure population to include patients hospitalized for drug and alcohol disorders, because these patients also require follow-up care after they are discharged. In 2018, the Centers for Medicare & Medicaid Services (CMS) created the new FAPH measure, which expanded the IPFQR FUH measure population to include patients with principal substance use disorder (SUD) diagnoses to address the NQF BHSC recommendation and the CMS Meaningful Measures priority to promote treatment of SUDs. In addition to including patients with SUD diagnoses, the FAPH measure also broadens the measure population to include patients with additional principal mental illness diagnoses like dementia, which are not currently included in the HEDIS® FUH and IPFQR FUH measures. By including dementia in the measure population, FAPH aligns with the IPFQR program's *30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF Readmission)* measure, which also includes dementia in its measure population. Eligible IPF discharges with a primary diagnosis of dementia account for 7.31 percent of discharges among IPFs with at least 40 discharges and 7.55 percent of discharges among all IPFs.

While the FAPH measure mostly differs from FUH in the expansion of the measure population to include SUD and other mental health diagnoses, the FAPH measure does include some additional differences:

- Simplifying the exclusion of admission or transfer to acute or non-acute inpatient facilities within 30 days after discharge by aligning with the HEDIS® Inpatient Stay Value Set used in both the HEDIS® FUH and HEDIS® FUA measures to identify acute and non-acute inpatient stays. A discharge will be excluded from the FAPH measure if it is followed by an admission or transfer with one of the codes in the value set.
- Removing the exclusion in the FUH measure that used inpatient discharge status codes to identify discharges or transfers to other healthcare institutions to better align with the intent of the HEDIS® FUH and HEDIS® FUA measures. These two HEDIS® measures exclude only admissions or transfers that have a claim indicating that the admission or transfer actually occurred. If the patient was not actually discharged or transferred to other healthcare institutions, they should have had the opportunity to obtain outpatient follow-up care after discharge from the hospital and should not be excluded from the denominator. The FAPH measure likewise only excludes cases in which discharge or transfer to another facility actually occurred.
- Allowing mental illness or SUD diagnoses in any position on the follow-up visit claim to count toward the numerator rather than requiring it to be in the primary position.
- Not limiting the provider type for the follow-up visit as long as it is billed with a diagnosis of mental illness or SUD. The most frequent provider types were family or general practice physicians, internal medicine physicians, nurse practitioners, and physician assistants. This change aligns with integrated care models that aim to treat the whole patient and recognizes in areas where there are shortages of mental health or SUD providers, other types of providers are often the only choice for follow-up treatment.

Two rates are reported:

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

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

The performance period used to identify cases in the denominator is 12 months. Data from the performance period and 30 days after the performance period are used to identify follow-up visits in the numerator.

TYPE

Process

DATA SOURCE

Claims, Enrollment Data

CMS will calculate the measure outcome using Part A and Part B claims data that are received by Medicare for payment purposes. CMS will calculate the measure by linking Medicare fee-for-service (FFS) claims submitted by IPFs and subsequent outpatient providers for Medicare FFS IPF discharges.

LEVEL

Facility

SETTING

Inpatient/Hospital

NUMERATOR STATEMENT

The numerator includes discharges from a psychiatric facility that are followed by an outpatient visit for treatment of mental illness or SUD within seven and 30 days.

NUMERATOR DETAILS

Numerator qualifying visits include outpatient visits, intensive outpatient encounters, or partial hospitalization and are defined by the Current Procedural Terminology (CPT) (defined in the Visit Codes tab on the FAPH_codes.xlsx workbook), Healthcare Common Procedure Coding System (HCPCS) (defined in the Visit Codes tab on the FAPH_codes.xlsx workbook), and Uniform Billing (UB) Revenue codes (defined in the Revenue Codes tab on the FAPH_codes.xlsx workbook). Data from the 12-month performance period and 30 days after the performance period are used to identify outpatient visits. The type of visits that qualify as outpatient follow-up (defined in the Outpatient Codes tab on the FAPH_codes.xlsx workbook) must be paired with one of the qualifying diagnoses used to define the denominator (defined in the Diagnosis Codes tab on the FAPH_codes.xlsx workbook). The qualifying diagnosis can be in any position on the claim. Provider type is not considered when determining qualifying outpatient visit. Outpatient visit claims with the GT telehealth modifier count as outpatient visits.

Claims with codes for emergency room visits do not count toward the numerator. Emergency room visits are defined by UB revenue, CPT, Berenson-Eggers type of service (BETOS), and Place of Service codes (refer to the ED Codes tab on the FAPH_codes.xlsx workbook).

All codes required to calculate the measure are included in the FAPH_Codes.xlsx workbook.

DENOMINATOR STATEMENT

The denominator includes discharges paid under the IPF prospective payment system (PPS) during the performance period for Medicare fee-for-service (FFS) patients with a principal diagnosis of mental illness or SUD.

DENOMINATOR DETAILS

The measure includes IPF discharges during the 12-month measurement period for which the patient was subject to the following:

- Discharged with a principal diagnosis of mental illness or substance use disorder that would necessitate outpatient follow-up care. Defined using ICD-10-CM diagnosis codes and claim type 60 (refer to the Diagnosis Codes tab on the FAPH_codes.xlsx workbook).

- Discharged alive to ensure they are eligible for follow-up care. Defined as any Discharge Status Code other than '20' (expired).

- Enrolled in Medicare Parts A and B during the month of the discharge date and at least one month after the discharge date to ensure data are available to capture the index admission and follow-up visits. Defined as having continuous (no gaps) Medicare Part A and Part B coverage with no Health Maintenance Organization (HMO). Therefore, the Entitlement Buy-in Indicator must be '3' or

'C' and the HMO indicator must be '0' for both the month of discharge and the month following the discharge month for the IPF stay to qualify as continuous FFS.

- Six years of age or older on the date of discharge because follow-up treatment for mental illness or SUD may not always be recommended for younger children. Defined using date of birth and discharge date from the CMS denominator file.

EXCLUSIONS

The denominator excludes IPF discharges for patients:

- Admitted or transferred to acute and non-acute inpatient facilities within the 30-day follow-up period because admission or transfer to other institutions may prevent an outpatient follow-up visit from taking place.

- Who were discharged against medical advice (AMA) because the IPF may have limited opportunity to complete treatment and prepare for discharge. Defined as Discharge Status Code '7' (AMA).

- Who died during the 30-day follow-up period because patients who expire may not have the opportunity for an outpatient follow-up visit. Defined as Discharge Status Code '20' (expired).

- Who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began because patients in hospice may require different follow-up services (refer to the Hospice Codes tab on the FAPH_codes.xlsx workbook).

EXCLUSION DETAILS

- Those admitted or transferred to acute and non-acute inpatient facilities within the 30-day follow-up period are defined using UB revenue codes. (defined in the Readmission Codes tab on the FAPH_codes.xlsx workbook)

- Those who were discharged against medical advice (AMA) are defined using Discharge Status Code '07'

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- Those who died during the 30-day follow-up period are defined using the Medicare Enrollment File

- Those who use hospice services or elect to use a hospice benefit any time during the measurement year are defined using hospice codes (defined in the Hospice codes tab on the FAPH_codes.xlsx workbook)

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

Not applicable

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

The performance period used to identify cases in the denominator is 12 months. Data from the performance period and 30 days after the performance period are used to identify follow-up visits in the numerator. The performance period begins on July 1. Identify the denominator using the following criteria:

1. Enrolled in Medicare Parts A and B during the month of the discharge date and at least one month after the discharge date to ensure data are available to capture the index admission and follow-up visits

2. Have a principal diagnosis of mental illness or substance use disorder (SUD) (as defined in on the Diagnosis Codes tab of the FAPH_Codes.xlsx and in Table A.4 and Table A.3 of the measure specifications)

3. Discharged alive (any discharge status other than '20')

4. Six years of age or older on the date of discharge

5. Discharged from an IPF with eligible claim types '60' or with CMS Certification Number that meets at least one of the following criteria:

a. Last four digits of the CMS Certification Number (CCN) is 4000–4499 (Psychiatric Hospital excluded from Inpatient Prospective Payment System)

b. Third digit of CCN is 'S' (distinct part Psychiatric Unit in an acute care hospital)

c. Third digit of CCN 'M' (Psychiatric Unit in a CAH) 2/12/2020 NQF: Follow-Up After Psychiatric Hospitalization
www.qualityforum.org/Print_Measure_Submission.aspx?SubmissionID=3572&projectID=2368/18

6. Exclude the following patients from the denominator:

a. Admitted or transferred to acute and non-acute inpatient facilities within the 30-day follow-up period

b. Discharged against medical advice (AMA)

c. Used hospice services or elect to use a hospice benefit any time during the measurement period.

Identify the numerator using the following criteria:

1. Identify treatment by an outpatient visit for mental illness or SUD within seven and 30 day of discharge using the visit type codes in the FAPH_Code.xlsx workbook

2. Exclude claims with codes for emergency room visits outlined in the FAPH_Code.xlsx workbook

The measure rate is the numerator / denominator. A higher score indicates better quality. 147129

Appendix E: Related and Competing Measures (Narrative)

Comparison of NQF 2803 and NQF 0027, 0028, 2600

Steward

2803: Tobacco Use and Help with Quitting Among Adolescents

NCQA

0027: Medical Assistance With Smoking and Tobacco Use Cessation

NCQA

0028: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

PCPI Foundation

2600: Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence

NCQA

Description

2803: Tobacco Use and Help with Quitting Among Adolescents

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

0027: Medical Assistance With Smoking and Tobacco Use Cessation

The three components of this measure assess different facets of providing medical assistance with smoking and tobacco use cessation:

Advising Smokers and Tobacco Users to Quit: A rolling average represents the percentage of patients 18 years of age and older who were current smokers or tobacco users and who received advice to quit during the measurement year.

Discussing Cessation Medications: A rolling average represents the percentage of patients 18 years of age and older who were current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year.

Discussing Cessation Strategies: A rolling average represents the percentage of patients 18 years of age and older who were current smokers or tobacco users and who discussed or were provided cessation methods or strategies during the measurement year.

0028: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user.

Three rates are reported:

a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months

b. Percentage of patients aged 18 years and older who were identified as a tobacco user who received tobacco cessation intervention

c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user

2600: Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence

The percentage of patients 18 years and older with a serious mental illness or alcohol or other drug dependence who received a screening for tobacco use and follow-up for those identified as a current tobacco user. Two rates are reported.

Rate 1: The percentage of patients 18 years and older with a diagnosis of serious mental illness who received a screening for tobacco use and follow-up for those identified as a current tobacco user.

Rate 2: The percentage of adults 18 years and older with a diagnosis of alcohol or other drug dependence who received a screening for tobacco use and follow-up for those identified as a current tobacco user.

Note: The proposed health plan measure is adapted from an existing provider-level measure for the general population (NQF #0028 *Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention*). This measure is currently stewarded by the AMA-PCPI and used in the Physician Quality Reporting System.

Type

2803: Tobacco Use and Help with Quitting Among Adolescents

Process

0027: Medical Assistance With Smoking and Tobacco Use Cessation

Process

0028: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Process

2600: Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence

Process

Data Source

2803: Tobacco Use and Help with Quitting Among Adolescents

Claims, Electronic Health Records This measure is currently in use as a MIPS Clinical Quality Measure under the Quality Payment Program. The source of the data are electronic health records. The data are collected using E.H.R data abstraction, and is reported by individual clinicians, groups, or third-party intermediaries on behalf of individual clinicians or groups.

No data collection instrument provided No data dictionary

0027: Medical Assistance With Smoking and Tobacco Use Cessation

Instrument-Based Data CAHPS Health Plan Survey 5.0H, Adult Version; Medicare CAHPS

http://www.ahrq.gov/cahps/index.html

Available at measure-specific web page URL identified in S.1 No data dictionary

0028: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Claims, Registry Data Not applicable.

No data collection instrument provided No data dictionary NQF0028_CMS138v5_ValueSets_Details-637262743113954447-637267092102947208.xlsx

2600: Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence

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 medical record documentation collected in the course of providing care to patients.

No data collection instrument provided Attachment 2600_Tobacco_Use_Screening_for_People_With_Mental_Illness_Value_Set-636583544493466623.xlsx

Level

2803: Tobacco Use and Help with Quitting Among Adolescents

Clinician : Group/Practice

0027: Medical Assistance With Smoking and Tobacco Use Cessation

Health Plan, Integrated Delivery System

0028: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Clinician : Group/Practice, Clinician : Individual

2600: Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence

Health Plan

Setting

2803: Tobacco Use and Help with Quitting Among Adolescents

Outpatient Services

0027: Medical Assistance With Smoking and Tobacco Use Cessation

Other, Outpatient Services In addition to clinician visits, some respondents may recall contacts with an “other health provider” (the wording used in the survey question), which may include contacts with nurses or health plan staff.

0028: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Home Care, Other, Outpatient Services Occupational therapy evaluation, speech and hearing evaluation, ophthalmological services visit

2600: Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence

Outpatient Services

Numerator Statement

2803: Tobacco Use and Help with Quitting Among Adolescents

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

0027: Medical Assistance With Smoking and Tobacco Use Cessation

Advising Smokers and Tobacco Users to Quit:

Patients who indicated that they received advice to quit smoking or using tobacco from their doctor or health provider

Discussing Cessation Medications:

Patients who indicated that their doctor or health provider recommended or discussed smoking or tobacco cessation medications

Discussing Cessation Strategies:

Patients who indicated their doctor or health provider discussed or provided smoking or tobacco cessation methods and strategies other than medication

0028: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Population 1:

Patients who were screened for tobacco use at least once within 24 months

Population 2:

Patients who received tobacco cessation intervention

Population 3:

Patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation intervention if identified as a tobacco user

2600: Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence

Rate 1: Screening for tobacco use in patients with serious mental illness during the measurement year or year prior to the measurement year and received follow-up care if identified as a current tobacco user.

Rate 2: Screening for tobacco use in patients with alcohol or other drug dependence during the measurement year or year prior to the measurement year and received follow-up care if identified as a current tobacco user.

Numerator Details

2803: Tobacco Use and Help with Quitting Among Adolescents

Documentation that the adolescent is currently not a tobacco user

OR

Documentation that the adolescent is a tobacco user AND any of the following:

-Advice given to quit smoking or tobacco use

-Counseling on the benefits of quitting smoking or tobacco use (e.g., “5-A” Framework)

-Assistance with or referral to external smoking or tobacco cessation support programs (e.g., telephone counseling ‘quit line’)

-Current enrollment in smoking or tobacco use cessation program

0027: Medical Assistance With Smoking and Tobacco Use Cessation

For the commercial product line:

- Advising Smokers and Tobacco Users to Quit:

The number of patients in the denominator who indicated that they received advice to quit smoking or tobacco use from a doctor or other health provider by answering “Sometimes” or “Usually” or “Always” to CAHPS question 36: “In the last 12 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?”

- Discussing Smoking Cessation Medications:

The number of patients in the denominator who indicated that their doctor or health provider recommended or discussed cessation medications to assist with quitting smoking or using tobacco by answering “Sometimes” or “Usually” or “Always” to CAHPS question Q37: “In the last 12 months, how often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco? Examples of medication are: nicotine gum, patch, nasal spray, inhaler, or prescription medication.”

- Discussing Cessation Strategies:

The number of patients in the denominator who indicated that their doctor or health provider discussed or provided cessation methods and strategies other than medication to assist with quitting smoking or using tobacco by answering “Sometimes” or “Usually” or “Always” to CAHPS question Q38: “In the last 12 months, how often did your doctor or health provider discuss or provide methods and strategies other than medication to assist you with quitting smoking or using tobacco? Examples of methods and strategies are: telephone helpline, individual or group counseling, or cessation program.”

Response options for all questions:

Never, Sometimes, Usually, Always

For the Medicaid product line:

- Advising Smokers and Tobacco Users to Quit:

The number of patients in the denominator who indicated that they received advice to quit smoking or tobacco use from a doctor or other health provider by answering “Sometimes” or “Usually” or “Always” to CAHPS question Q33: “In the last 6 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?”

- Discussing Smoking Cessation Medications:

The number of patients in the denominator who indicated that their doctor or health provider recommended or discussed medication to assist with quitting smoking or using tobacco by answering “Sometimes” or “Usually” or “Always” to CAHPS question Q34: “In the last 6 months, how often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco? Examples of medication are: nicotine gum, patch, nasal spray, inhaler, or prescription medication.”

- Discussing Cessation Strategies:

The number of patients in the denominator who indicated that their doctor or health provider discussed or provided methods and strategies other than medication to assist with quitting smoking or using tobacco by answering “Sometimes” or “Usually” or “Always” to CAHPS question Q35: “In the last 6 months, how often did your doctor or

health provider discuss or provide methods and strategies other than medication to assist you with quitting smoking or using tobacco? Examples of methods and strategies are: telephone helpline, individual or group counseling, or cessation program."

Response options for all questions:

Never, Sometimes, Usually, Always

For the Medicare product line:

- Advising Smokers or Tobacco Users to Quit

The number of patients in the denominator who indicated that they received advice to quit smoking or using tobacco from a doctor or other health provider by answering "Sometimes" or "Usually" or "Always" to CAHPS question Q55 : "In the last 6 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?"

Response options for all questions:

Never, Sometimes, Usually, Always, I had no visits in the last 6 months

0028: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

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

Definitions:

Tobacco Use - Includes any type of tobacco

Tobacco Cessation Intervention - Includes brief counseling (3 minutes or less), and/or pharmacotherapy Note: For the purpose of this measure, brief counseling (e.g., minimal and intensive advice/counseling interventions conducted both in person and over the phone) qualifies for the numerator. Written self-help materials (e.g., brochures, pamphlets) and complementary/alternative therapies do not qualify for the numerator. Brief counseling also may be of longer duration or be performed more frequently, as evidence shows there is a dose-response relationship between the intensity of counseling provided (either length or frequency) and tobacco cessation rates (U.S. Preventive Services Task Force, 2015).

Numerator Note:

To satisfy the intent of this measure, a patient must have at least one tobacco use screening during the 24-month period. If a patient has multiple tobacco use screenings during the 24-month period, only the most recent screening, which has a documented status of tobacco user or tobacco non-user, will be used to satisfy the measure requirements.

If a patient uses any type of tobacco (i.e., smokes or uses smokeless tobacco), the expectation is that they should receive tobacco cessation intervention: either counseling and/or pharmacotherapy.

This measure defines tobacco cessation counseling as lasting 3 minutes or less. Services typically provided under CPT codes 99406 and 99407 satisfy the requirement of tobacco cessation intervention, as these services provide tobacco cessation counseling for 3-10 minutes. If a patient received these types of services, submit G-code G9906 (for population criteria 1) and CPT Category II code 4004F (for population criteria 3).

Population 1:

Report quality data code:

G9902: Patient screened for tobacco use AND identified as a tobacco user

OR

G9903: Patient screened for tobacco use AND identified as a tobacco non-user

Population 2:

Report quality data code:

G9906: Patient identified as a tobacco user received tobacco cessation intervention (counseling and/or pharmacotherapy)

Population 3:

Report CPT Category II code:

4004F: Patient screened for tobacco use AND received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user

OR

1036F: Current tobacco non-user

2600: Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence

Tobacco Use Screening:

MEDICAL RECORD:

Patients who had screening for tobacco use documented any time during the year prior to the measurement year or during the first 9 months of the measurement year.

Tobacco Use Definition:

'Tobacco Use' is defined to include any type of tobacco.

Follow-up:

ADMINISTRATIVE: Patients who received follow-up care within three months of screening if identified as a tobacco user. Follow-up care is defined as:

1) Two events of counseling (see Tobacco Cessation Counseling Value Set), on different dates, for tobacco use with the provider who did the screening or another provider including health plan clinical case managers (participation in community-based programs such as quit lines or non-clinical support activities can count as counseling if documented in the health record (referrals alone do not count)).

2) One event of counseling (see Tobacco Cessation Counseling Value Set) and one event of medication fill (see Tobacco Cessation Medication Value Set) or use for tobacco cessation.

MEDICAL RECORD: Patients who received follow-up care within three months of screening if identified as a tobacco user. Follow-up care is defined as:

1) Two events of counseling, on different dates, for tobacco use with the provider who did the screening or another provider including health plan clinical case managers (participation in community-based programs such as quit lines or non-clinical support activities can count as counseling if documented in the health record (referrals alone do not count)).

One event of counseling and one event of medication fill or use for tobacco cessation.

Denominator Statement

2803: Tobacco Use and Help with Quitting Among Adolescents

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

0027: Medical Assistance With Smoking and Tobacco Use Cessation

Patients 18 years and older who responded to the CAHPS survey and indicated that they were current smokers or tobacco users during the measurement year or in the last 6 months for Medicaid and Medicare.

0028: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Population 1:

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

Population 2:

All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period who were screened for tobacco use and identified as a tobacco user

Population 3:

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

2600: Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence

Rate 1: 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.

Rate 2: All patients 18 years of age or older as of December 31 of the measurement year with any diagnosis of alcohol or other drug dependence during the measurement year.

Denominator Details

2803: Tobacco Use and Help with Quitting Among Adolescents

Patient Age is 12-20 years on date of encounter

0027: Medical Assistance With Smoking and Tobacco Use Cessation

In order to be included in the denominator for each rate, patients must answer both the question about current cigarette/tobacco use and the relevant numerator question (eg, for the Advising Smokers and Tobacco Users to Quit rate, patients must answer the question about current cigarette/tobacco use and the question about how often they were advised to quit by a doctor or other health provider).

For the commercial product line:

- Advising Smokers and Tobacco Users to Quit

The number of patients who responded to the survey and indicated that they were current smokers or tobacco users by answering “Every day” or “Some days” to CAHPS question 35 and by answering Q36 with any response (“Never” or “Sometimes” or “Usually” or “Always”).

Q35: “Do you now smoke cigarettes or use tobacco every day, some days, or not at all?”

Response options for Q35: “Every day”, “Some days”, “Not at all”, “Don´t know”

Q36: “In the last 12 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?”

Response options for Q36: “Never”, “Sometimes”, “Usually”, “Always”

- Discussing Cessation Medications

The number of patients who responded to the survey and indicated that they were current smokers or tobacco users by answering “Every day” or “Some days” to CAHPS question Q35 and by answering Q37 with any response (“Never” or “Sometimes” or “Usually” or “Always”).

Q35: “Do you now smoke cigarettes or use tobacco every day, some days, or not at all?”

Response options for Q35: “Every day”, “Some days”, “Not at all”, “Don´t know”

Q37: “In the last 12 months, how often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco? Examples of medication are: nicotine gum, patch, nasal spray, inhaler, or prescription medication.”

Response options for Q37: “Never” OR “Sometimes” OR “Usually” OR “Always”

- Discussing Cessation Strategies

The number of patients who responded to the survey and indicated that they were current smokers or tobacco users by answering “Every day” or “Some days” to CAHPS question Q35 and by answering Q38 with any response (“Never” or “Sometimes” or “Usually” or “Always”).

Q35: “Do you now smoke cigarettes or use tobacco every day, some days, or not at all?”

Response options for Q435: “Every day”, “Some days”, “Not at all”, “Don´t know”

Q38: “In the last 12 months, how often did your doctor or health provider discuss or provide methods and strategies other than medication to assist you with quitting smoking or using tobacco? Examples of methods and strategies are: telephone helpline, individual or group counseling, or cessation program.”

Response options for Q38: “Never”, “Sometimes”, “Usually”, “Always”

For the Medicaid product line:

- Advising Smokers and Tobacco Users to Quit

The number of patients who responded to the survey and indicated that they were current smokers or tobacco users by answering “Every day” or “Some days” to CAHPS question Q32 and by answering Q33 with any response (“Never” or “Sometimes” or “Usually” or “Always”).

Q32: “Do you now smoke cigarettes or use tobacco every day, some days, or not at all?”

Response options for Q32: “Every day”, “Some days”, “Not at all”, “Don´t know”

Q33: “In the last 6 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?”

Response options for Q33: “Never”, “Sometimes”, “Usually”, “Always”

- Discussing Cessation Medications

The number of patients who responded to the survey and indicated that they were current smokers or tobacco users by answering “Every day” or “Some days” to CAHPS question

Q32 and by answering Q34 with any response (“Never” or “Sometimes” or “Usually” or “Always”).

Q32: “Do you now smoke cigarettes or use tobacco every day, some days, or not at all?”

Response options for Q32: “Every day”, “Some days”, “Not at all”, “Don´t know”

Q34: “In the last 6 months, how often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco? Examples of medication are: nicotine gum, patch, nasal spray, inhaler, or prescription medication.”

Response options for Q34: “Never”, “Sometimes”, “Usually”, “Always”

- Discussing Cessation Strategies

The number of patients who responded to the survey and indicated that they were current smokers or tobacco users by answering “Every day” or “Some days” to CAHPS question Q32 and by answering Q35 with any response (“Never” or “Sometimes” or “Usually” or “Always”).

Q32: “Do you now smoke cigarettes or use tobacco every day, some days, or not at all?”

Response options for Q32: “Every day”, “Some days”, “Not at all”, “Don´t know”

Q35: “In the last 6 months, how often did your doctor or health provider discuss or provide methods and strategies other than medication to assist you with quitting smoking or using tobacco? Examples of methods and strategies are: telephone helpline, individual or group counseling, or cessation program.”

Response options for Q35: “Never”, “Sometimes”, “Usually”, “Always”

For the Medicare product line:

- Advising Smokers or Tobacco Users to Quit

The number of patients who responded to the survey and indicated that they were current smokers or tobacco users by answering “Every day” or “Some days” to CAHPS question Q54, had one or more visits during the last 6 months, and by answering Q55 with any response (“Never” or “Sometimes” or “Usually” or “Always”).

Q54: “Do you now smoke cigarettes or use tobacco every day, some days, or not at all?”

Response options for Q54: “Not at all”, “Some days”, “Every day”, “Don’t know”

Q55: “In the last 6 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?”

Response options for Q55: “Never”, “Sometimes”, “Usually”, “Always”, “I had no visits in the last 6 months”

The Medicare results for the Advising Smokers and Tobacco Users to Quit Rate requires a minimum denominator of at least 30 responses.

0028: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Time Period for Data Collection: 12 consecutive months

Definitions:

Tobacco Use - Includes any type of tobacco

Denominator Note:

The denominator of submission criteria 2 is a subset of the resulting numerator for submission criteria 1, as submission criteria 2 is limited to assessing if patients identified as tobacco users received an appropriate tobacco cessation intervention. For all patients,

submission criteria 1 and 3 are applicable, but submission criteria 2 will only be applicable for those patients who are identified as tobacco users. Therefore, data for every patient that meets the age and encounter requirements will only be submitted for submission criteria 1 and 3, whereas data submitted for submission criteria 2 will be for a subset of patients who meet the age and encounter requirements, as the denominator has been further limited to those who were identified as tobacco users.

Population 1:

Patients aged >= 18 years on date of encounter

AND

At least two patient encounters during the performance period (CPT): 90791, 90792, 90832, 90834, 90837, 90845, 92002, 92004, 92012, 92014, 92521, 92522, 92523, 92524, 92540, 92557, 92625, 96150, 96151, 96152, 97165, 97166, 97167, 97168, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

WITHOUT

Telehealth Modifier: GQ, GT, 95, POS 02

OR

At least one preventive encounter 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

Population 2:

Patients aged >= 18 years on date of encounter

AND

All eligible instances when (G9902) Patient screened for tobacco use AND identified as a tobacco user that are utilized in submission of Performance Met Patient Screened for Tobacco Use, Identified as a Tobacco User in the numerator for population one

AND

At least two patient encounters during the performance period (CPT): 90791, 90792, 90832, 90834, 90837, 90845, 92002, 92004, 92012, 92014, 92521, 92522, 92523, 92524, 92540, 92557, 92625, 96150, 96151, 96152, 97165, 97166, 97167, 97168, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

WITHOUT

Telehealth Modifier: GQ, GT, 95, POS 02

OR

At least one preventive encounter 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

Population 3:

Patients aged >= 18 years on date of encounter

AND

At least two patient encounters during the performance period (CPT): 90791, 90792, 90832, 90834, 90837, 90845, 92002, 92004, 92012, 92014, 92521, 92522, 92523, 92524, 92540, 92557, 92625, 96150, 96151, 96152, 97165, 97166, 97167, 97168, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

WITHOUT

Telehealth Modifier: GQ, GT, 95, POS 02

OR

At least one preventive encounter 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

2600: Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence

Age: 18 years and older

Benefit: Medical

Continuous Enrollment: No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the 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).

Serious Mental Illness 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 Non-acute Inpatient Value Set with one of the following diagnoses:

- Schizophrenia Value Set

o Bipolar Disorder Value Set

• BH Non-acute Inpatient Value Set with BH Non-acute Inpatient POS Value Set and one of the following diagnoses:

- Schizophrenia Value Set
- Bipolar Disorder Value Set

Alcohol or Other Drug Dependence Diagnosis Criteria: Identify patients with alcohol or other drug as those who met at least one of the following criteria during the measurement year:

• An outpatient visit, intensive outpatient visit, or partial hospitalization with a diagnosis of AOD. 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 AOD Dependence Value Set.

– IET Visits Group 2 Value Set with IET POS Group 2 Value Set and AOD Dependence Value Set.

• A detoxification visit (Detoxification Value Set).

• An ED visit (ED Value Set) with a diagnosis of AOD (AOD Dependence Value Set).

• An inpatient discharge with a diagnosis of AOD as identified by either of the following:

– An inpatient facility code with a diagnosis of AOD (AOD Dependence Value Set).

– An inpatient facility code with an AOD procedure code (AOD Procedures Value Set).

Exclusions

2803: Tobacco Use and Help with Quitting Among Adolescents

Not applicable0027: Medical Assistance With Smoking and Tobacco Use Cessation

None

0028: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Denominator Exclusions: not applicable

Denominator Exceptions:

Population 1:

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

Population 2:

Documentation of medical reason(s) for not providing tobacco cessation intervention (eg, limited life expectancy, other medical reason)

Population 3:

Documentation of medical reason(s) for not screening for tobacco use OR for not providing tobacco cessation intervention for patients identified as tobacco users (eg, limited life expectancy, other medical reason)

2600: Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence

Not applicable.

Exclusion Details

2803: Tobacco Use and Help with Quitting Among Adolescents

Not applicable

0027: Medical Assistance With Smoking and Tobacco Use Cessation

Not applicable0028: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

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

The PCPI distinguishes between denominator exceptions and denominator exclusions.

Denominator exclusions arise when the clinical action indicated in the numerator is not appropriate for a particular group of patients who otherwise meet the denominator criteria. These are absolute and would be removed from the denominator of a measure in order to determine the eligible population.

Denominator exceptions are used to remove a patient from the denominator when the patient does not receive the action(s) required in the numerator AND that action(s) would not be appropriate due to a patient-specific reason(s). The patient would otherwise meet the denominator criteria. Exceptions are not absolute and are based on provider judgment or individual patient characteristics or preferences. The PCPI methodology includes two categories of exceptions for which a patient may be removed from the denominator of an individual measure: 1) medical OR 2) patient or non-medical reasons. These exception categories are not uniformly relevant across all measures. The denominator exception language may include specific examples of instances that may constitute an exception, which are intended to serve as a guide to providers. Where examples of exceptions are included in the measure language, value sets for these examples are developed and are included in the eCQM.

Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that providers 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

provider's exceptions data to identify practice patterns and opportunities for quality improvement.

Additional details: This measure includes denominator exceptions.

Population 1:

Report quality data code:

G9904: Documentation of medical reason(s) for not screening for tobacco use (e.g., limited life expectancy, other medical reason)

Population 2:

Report quality data code:

G9907: Documentation of medical reason(s) for not providing tobacco cessation intervention (e.g., limited life expectancy, other medical reason)

Population 3:

Append modifier to CPT Category II code or report quality data code:

4004F-1P: Documentation of medical reason(s) for not screening for tobacco use (e.g., limited life expectancy, other medical reason)

OR

G9909: Documentation of medical reason(s) for not providing tobacco cessation intervention if identified as a tobacco user (e.g., limited life expectancy, other medical reason)

2600: Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence

Not applicable.

Risk Adjustment

2803: Tobacco Use and Help with Quitting Among Adolescents

No risk adjustment or risk stratification

0027: Medical Assistance With Smoking and Tobacco Use Cessation

No risk adjustment or risk stratification

0028: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

No risk adjustment or risk stratification

2600: Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence

No risk adjustment or risk stratification

Stratification

2803: Tobacco Use and Help with Quitting Among Adolescents

Not applicable0027: Medical Assistance With Smoking and Tobacco Use Cessation

None

0028: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

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

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

2600: Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence

Not applicable.

Type Score

2803: Tobacco Use and Help with Quitting Among Adolescents

Rate/proportion better quality = higher score

0027: Medical Assistance With Smoking and Tobacco Use Cessation

Rate/proportion better quality = higher score

0028: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Rate/proportion better quality = higher score

2600: Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence

Rate/proportion better quality = higher score

Algorithm

2803: Tobacco Use and Help with Quitting Among Adolescents

1. Start with Denominator

2. Check Patient Age:

a. If patient's Age is 12-20 years on date of encounter equals No during the measurement period, do not include in Eligible Population. Stop Processing.

b. If patient's age is 12-20 Years on date of encounter equals Yes during the measurement period, proceed to check Encounter Performed.

3. Check Encounter Performed:

a. If Encounter as Listed in the Denominator equals No, do not include in Eligible Population. Stop Processing.

b. If Encounter as Listed in the Denominator equals Yes, include in Eligible Population.

4. Denominator Population:

a. Denominator Population is all Eligible Patients in the Denominator.

5. Start Numerator

6. Check Patient Documented as Tobacco User AND Received Tobacco Cessation Intervention if Identified as a Tobacco User:

a. If Patient Documented as Tobacco User AND Received Tobacco Cessation Intervention if identified as a Tobacco User equals Yes, include in Data Completeness Met and Performance Met.

b. If Patient Documented as Tobacco User AND Received Tobacco Cessation Intervention if identified as a Tobacco User equals No, proceed to check Currently a Tobacco Non-User.

7. Check Currently a Tobacco Non-User:

a. If Currently a Tobacco Non-User equals Yes, include in Data Completeness Met and Performance Met.

b. If Currently a Tobacco Non-User equals No, proceed to check Tobacco Assessment or Tobacco Cessation Intervention Not Performed, Reason Not Given.

8. Check Tobacco Assessment or Tobacco Cessation Intervention Not Performed, Reason Not Given:

a. If Tobacco Assessment or Tobacco Cessation Intervention Not Performed, Reason Not Given equals Yes, include in the Data Completeness Met and Performance Not Met.

b. If Tobacco Assessment or Tobacco Cessation Intervention Not Performed, Reason Not Given equals No, proceed to check Data Completeness Not Met.

9. Check Data Completeness Not Met:

a. If Data Completeness Not Met, the Quality Data Code or equivalent was not submitted

0027: Medical Assistance With Smoking and Tobacco Use Cessation

Step 1: Identify the eligible population of commercial, Medicaid and Medicare CAHPS respondents

Step 2: Identify the denominator for each component.

Step 3: Identify the numerator for each component.

Step 4: Calculate the rate as numerator/denominator.

For the commercial and Medicaid product lines, rolling averages are calculated using the formula below.

Rate = (Year 1 Numerator + Year 2 Numerator)/(Year 1 Denominator + Year 2 Denominator)

NCQA calculates a result when the denominator is 100 individuals or more.

If the health plan did not report results in the prior year (Year 1), but reports results for the current year and achieves a denominator of 100 or more, NCQA calculates a rate.

For the Medicare product line, this is collected by the Centers for Medicare & Medicaid Services through the Medicare CAHPS Survey. This is collected on an annual basis.

0028: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Calculating the performance rate:

1. Define the initial population. The initial population is identified through a common set of characteristics that define the overall group of patients—or other unit of measurement — targeted for evaluation

2. Define the denominator by identifying the subset of the initial population that meets the denominator criteria. Note: in some cases, the initial population and denominator are identical

3. Determine the numerator by identifying the subset of the denominator that meets the numerator criteria

4. From the patients who did not meet the numerator criteria, determine if the provider has documented whether each patient represents an exception. Subtract from the denominator those patients that meet the conditions for a denominator exception; although the exception cases are removed from the denominator for the measure calculation, the exception rate (i.e., percentage of patients with valid exceptions) should be calculated and reported along with performance rates to highlight variations in care

5. Calculate the performance rate

A patient not meeting the numerator criteria and without a valid and documented exception represents a quality failure.

2600: Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence

RATE 1: Tobacco Use 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 2: Identify the numerator.

Step 2A: Identify the date of screening for tobacco use during the year prior to the measurement year or during the first 9 months of the measurement year.

Step 2B: Identify the tobacco use screening result. If negative for tobacco use, stop.

Step 2C: If positive for tobacco 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 tobacco use (from Step 2B) plus the number of patients with positive screening for tobacco use 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 1A is complete).

RATE 2: Tobacco Use Screening and Follow-up for People with Alcohol or Other Drug Dependence

Step 1: Determine the eligible population.

Step 1A: Identify all patients 18 years of age or older with alcohol or other drug dependence.

Step 2: Identify the numerator.

Step 2A: Identify the date of screening for tobacco use during the year prior to the measurement year or during the first 9 months of the measurement year.

Step 2B: Identify the tobacco use screening result. If negative for tobacco use, stop. If positive for tobacco use

Step 2C: If positive for tobacco 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 tobacco use (from Step 2B) plus the number of patients with positive screening for tobacco use 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 1A is complete).

Submission items

2803: Tobacco Use and Help with Quitting Among Adolescents

5.1 Identified measures:

#0028 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: While both measures look at tobacco use and cessation counseling, they assess different target populations. NQF #0028 measures tobacco use in adults aged 18 and older. This measure assesses tobacco use in adolescents who are between the ages of 12 and 20. The expected impact on data collection burden due to the overlapping age range of 18-20 is minimal.

5b.1 If competing, why superior or rationale for additive value: N/A—the measures assess different target populations.

0027: Medical Assistance with Smoking and Tobacco Use Cessation

5.1 Identified measures:

#0028 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

#2600 Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence

#2803 Tobacco Use and Help with Quitting Among Adolescents

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: Refer to 5b.1

5b.1 If competing, why superior or rationale for additive value: Answer for 5a.2: Identify differences, rationale, and impact on interpretability and data collection burden:

Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (NQF #0028, stewarded by the AMA-convened Physician Consortium for Performance Improvement (AMA-PCPI)) evaluates the "percentage of patients 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as tobacco user"; "cessation counseling intervention includes brief counseling (3 minutes or less), and/or pharmacotherapy." The denominator includes "patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period"; patients are excluded from the measure if there is "documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy)." It differs from NCQA's measure under review because it: 1) requires screening and intervention once every two years (rather than once every two); 2) includes only those patients who have had at least two visits or at least one preventive visit during the measurement period; and 3) excludes patients with a medical reason for not screening for tobacco use.

Regarding the timing of screening and interventions, the USPSTF recommendation does not provide guidance about the frequency of screening or providing tobacco cessation interventions. Because of the harm caused by tobacco use and the positive outcomes associated with tobacco use cessation, NCQA has decided to assess smoking and tobacco use cessation on an annual basis, rather than biannual basis. Regarding the visit requirement in the encounter, the AMA-PCPI measure is specified for individual clinicians and groups/practices, whereas the NCQA measure is specified for health plans. Because health plans may engage individuals in tobacco cessation outside of clinical visits, we chose not to require visits in the denominator. Lastly, regarding the medical reason exclusion, NCQA does not expect this type of exclusion to have a significant impact at the health plan level; therefore, we do not include this type of exclusion in the NCQA measure.

Tobacco Use and Help with Quitting Among Adolescents (NQF #2803, stewarded by NCQA evaluates the "percentage of adolescents 12 to 20 years of age during the measurement

year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user." There are no exclusions for the measure. It differs from NCQA's measure under review because it: 1) includes an evaluation of whether or not adolescents received tobacco screening; and 2) it focuses on adolescents rather than adults. It is specified for the clinician: group/practice level and EHR only. NCQA's measure under review focuses on evaluating whether patients who are current smokers or tobacco users receive information from their doctor or health provider about recommended cessation interventions. It also reports separate rates for the different recommended cessation interventions (advice, cessation medications, and cessation strategies), whereas the Tobacco Use and Help with Quitting Among Adolescents measure evaluates whether adolescents received any of the following: advice to quit, counseling on the benefits of quitting, assistance with or referral to a cessation support program, or current enrollment in a cessation program.

Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence (NQF #2600, stewarded by the National Committee on Quality Assurance) evaluates the "percentage of patients 18 years and older with a serious mental illness or alcohol or other drug dependence who received a screening for tobacco use and follow-up for those identified as a current tobacco user." There are two rates; rate 1 focuses on patients with a diagnosis of serious mental illness; rate 2 focuses on patients with a diagnosis of alcohol or other drug dependence. This measure is adapted from *Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention* (NQF #0028). There are no exclusions. It is specified at the health-plan level. The differences between NCQA's measure under review and this measure are similar as the differences between NCQA's measure under review and the AMA-PCPI measure, although this measure does not have exclusions. This measure is specified at the health plan measure, as is NCQA's measure under review; however, it focuses on a specific, at-risk population (patients with a serious mental illness or alcohol or other drug dependence).

0028: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

5.1 Identified measures:

#0027: Medical Assistance With Smoking and Tobacco Use Cessation

#1651 TOB-1 Tobacco Use Screening

#1654 TOB - 2 Tobacco Use Treatment Provided or Offered and the subset measure TOB-2a Tobacco Use Treatment

#1656 TOB-3 Tobacco Use Treatment Provided or Offered at Discharge and the subset measure TOB-3a Tobacco Use Treatment at Discharge

#2600 Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence

2803 : Tobacco Use and Help with Quitting Among Adolescents

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: Related measures have differing target populations and/or levels of measurement from the PCPI's Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention measure. #0028 focuses on routine tobacco screening for all adults and tobacco cessation interventions for those who use tobacco products and is intended to assess clinician level performance

towards these objectives. The cessation intervention required by the PCPI measure includes brief counseling and/or pharmacotherapy in light of the strong support for these interventions in the guidelines and the feasibility of implementing these practices as part of routine care. Measure #0027 is a patient survey measure assessing health plan performance and includes one additional component of the cessation intervention beyond our measure (ie, discussion of methods or strategies other than medication). Measures #1651, #1654, and #1656 assess hospital level performance at providing tobacco use and treatment to patients being discharged from hospitals. Measure #2803 is focused on assessing clinical level performance on tobacco cessation counseling among adolescents. Finally, measure #2600 represents an adaptation of the PCPI measure and is limited to a subset of the population of patients with serious mental illness.

5b.1 If competing, why superior or rationale for additive value: No competing measures.

2600: Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence

5.1 Identified measures:

#0028 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact: This measure was adapted from the existing provider-level measure (NQF #0028 *Preventive Care and Screening: Tobacco Use: Screening & Cessation Intervention*) for use at the health plan level for the high risk subpopulation of people with serious mental illness and alcohol or other drug dependence. This measure is harmonized with the existing measure (NQF #0028 *Preventive Care and Screening: Tobacco Use: Screening & Cessation Intervention*) and has been reviewed with the original measure stewards and developers. The differences between the existing measure and the proposed subpopulation measure were developed with expert input and are described here: -The population focus: This measure focuses on people with serious mental illness or alcohol or other drug dependence, who are at a higher risk of tobacco 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 or one event of counseling and one event of medication fill or use for tobacco cessation, raising expectations for the intensity of service for the serious mental illness/alcohol or other drug dependence population compared to the original measure for the general population, and are reasonably achievable, particularly in the health plan context. -USPSTF recommendation concluded that even brief counseling (<3 minutes) is effective, there is a dose-response relationship between quit rates and the number of sessions of counseling; and the combination of counseling and pharmacotherapy is more effective than either component alone. -In addition, the existing measure (NQF #0028) 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 tobacco screening for patients with serious mental illness or alcohol or other drug dependence 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 3572 and NQF 0576, 2605, 3488, 3489

Steward

3572: Follow-up After Psychiatric Evaluation (FAPH)

CMS

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

NCQA

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

NCQA

3488: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence

NCQA

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

NCQA

Description

3572: Follow-up After Psychiatric Evaluation (FAPH)

The Follow-Up After Psychiatric Hospitalization (FAPH) measure assesses the percentage of inpatient discharges with principal diagnosis of mental illness or substance use disorder (SUD) for which the patient received a follow-up visit for treatment of mental illness or SUD at 7- and 30-days post-discharge. Patients must be six years of age or older on the discharge date and enrolled in Medicare Parts A and B during the month of the discharge date and at least one month after the discharge date to be included in the measure.

The FAPH measure is not a completely new measure, but is rather an expansion of the existing Inpatient Psychiatric Facility Quality Reporting (IPFQR) program measure, IPFQR Follow-Up After Hospitalization for Mental Illness (FUH), which was adapted from the National Quality Forum (NQF)-endorsed *Healthcare Effectiveness Data and Information Set (HEDIS®)* measure with the same name (NQF #0576). During the 2017 comprehensive review of NQF #0576, the NQF Behavioral Health Standing Committee (BHSC) recommended expanding the measure population to include patients hospitalized for drug and alcohol disorders, because these patients also require follow-up care after they are discharged. In 2018, the Centers for Medicare & Medicaid Services (CMS) created the new FAPH measure, which expanded the IPFQR FUH measure population to include patients with principal substance use disorder (SUD) diagnoses to address the NQF BHSC recommendation and the CMS Meaningful Measures priority to promote treatment of SUDs. In addition to including patients with SUD diagnoses, the FAPH measure also broadens the measure population to include patients with additional principal mental illness diagnoses like dementia, which are not currently included in the HEDIS® FUH and IPFQR FUH measures. By including dementia in the measure population, FAPH aligns with the IPFQR program's *30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF Readmission)* measure, which also includes dementia in its measure population. Eligible IPF discharges with a primary diagnosis of dementia account for 7.31 percent of discharges among IPFs with at least 40 discharges and 7.55 percent of discharges among all IPFs.

While the FAPH measure mostly differs from FUH in the expansion of the measure population to include SUD and other mental health diagnoses, the FAPH measure does include some additional differences. Specifically, the FAPH measure differs from the FUH measure by:

- Simplifying the exclusion of admission or transfer to acute or non-acute inpatient facilities within 30 days after discharge by aligning with the HEDIS® Inpatient Stay Value Set used in both the HEDIS® FUH and HEDIS® FUA measures to identify acute and non-acute inpatient stays. A discharge will be excluded from the FAPH measure if it is followed by an admission or transfer with one of the codes in the value set.
- Removing the exclusion in the FUH measure that used inpatient discharge status codes to identify discharges to or transfers to other healthcare institutions, to better align with the intent of the HEDIS® FUH and HEDIS® FUA measures. These two HEDIS® measures exclude only admissions or transfers that have a claim indicating that the admission or transfer actually occurred. If the patient was not actually discharged to or transferred to other healthcare institutions, they should have had the opportunity to obtain outpatient follow-up care after discharge from the hospital and should not be excluded from the denominator. The FAPH measure likewise only excludes cases in which discharge or transfer to another facility actually occurred.
- Allowing mental illness or SUD diagnoses in any position on the follow-up visit claim to count toward the numerator rather than requiring it to be in the primary position.
- Not limiting the provider type for the follow-up visit as long as it is billed with a diagnosis of mental illness or SUD. The most frequent provider types were family or general practice physicians, internal medicine physicians, nurse practitioners, and physician assistants. This change aligns with integrated care models that aim to treat the whole patient and recognizes in areas where there are shortages of mental health or SUD providers, other types of providers are often the only choice for follow-up treatment.

Two rates are reported:

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

The performance period used to identify cases in the denominator is 12 months. Data from the performance period and 30 days after the performance period are used to identify follow-up visits in the numerator.

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 or intentional self-harm 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 seven 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 seven- 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 seven 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 seven 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.

3488: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence

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

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

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

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

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

Type

3572: Follow-up After Psychiatric Evaluation (FAPH)

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

3488: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence

Process

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

Process

Data Source

3572: Follow-up After Psychiatric Evaluation (FAPH)

Claims, Enrollment Data CMS will calculate the measure outcome using Part A and Part B claims data that are received by Medicare for payment purposes. CMS will calculate the measure by linking Medicare fee-for-service (FFS) claims submitted by IPFs and subsequent outpatient providers for Medicare FFS IPF discharges.

No data collection instrument provided Attachment FAPH_Codes-637139235239123160.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-636818739976368043.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

3488: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence

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 3488_FUA_Value_Sets_Spring_2019.xlsx

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

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

No data collection instrument provided Attachment 3489_FUM_Value_Sets_Spring_2019.xlsx

Level

3572: Follow-up After Psychiatric Evaluation (FAPH)

Facility

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

3488: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence

Health Plan

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

Health Plan

Setting

3572: Follow-up After Psychiatric Evaluation (FAPH)

Inpatient/Hospital

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

3488: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence

Outpatient Services

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

Outpatient Services

Numerator Statement

3572: Follow-up After Psychiatric Evaluation (FAPH)

The numerator includes discharges from a psychiatric facility that are followed by an outpatient visit for treatment of mental illness or SUD within seven and 30 days.

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.

Seven-Day Follow-Up: A follow-up visit with a mental health practitioner within seven 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 seven 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 seven 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

3488: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence

The numerator consists of two rates:

- 30-day follow-up: A follow-up visit with any practitioner with a principal diagnosis of AOD within 30 days after the ED visit (31 total days). Include visits that occur on the date of the ED visit.
- seven-day follow-up: A follow-up visit with any practitioner with a principal diagnosis of AOD within seven days after the ED visit (eighttotal days). Include visits that occur on the date of the ED visit.

These rates are stratified by age (13-17, 18 and older, total).

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

The numerator consists of two rates:

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

Numerator Details

3572: Follow-up After Psychiatric Evaluation (FAPH)

Numerator qualifying visits include outpatient visits, intensive outpatient encounters, or partial hospitalization and are defined by the Current Procedural Terminology (CPT) (defined in the Visit Codes tab on the FAPH_codes.xlsx workbook), Healthcare Common Procedure Coding System (HCPCS) (defined in the Visit Codes tab on the FAPH_codes.xlsx workbook), and Uniform Billing (UB) Revenue codes (defined in the Revenue Codes tab on the FAPH_codes.xlsx workbook). Data from the 12-month performance period and 30 days after the performance period are used to identify outpatient visits. The type of visits that qualify as outpatient follow-up (defined in the Outpatient Codes tab on the

FAPH_codes.xlsx workbook) must be paired with one of the qualifying diagnoses used to define the denominator (defined in the Diagnosis Codes tab on the FAPH_codes.xlsx workbook). The qualifying diagnosis can be in any position on the claim. Provider type is not considered when determining qualifying outpatient visit. Outpatient visit claims with the GT telehealth modifier count as outpatient visits.

Claims with codes for emergency room visits do not count toward the numerator. Emergency room visits are defined by UB revenue, CPT, Berenson-Eggers type of service (BETOS), and Place of Service codes (refer to the ED Codes tab on the FAPH_codes.xlsx workbook).

All codes required to calculate the measure are included in the FAPH_Codes.xlsx workbook.

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

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

• An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set with a mental health practitioner, with or without a telehealth modifier (Telehealth Modifier Value Set)).

• An outpatient visit (BH Outpatient Value Set with a mental health practitioner, with or without a telehealth modifier (Telehealth Modifier Value Set)).

• An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set with a mental health practitioner, with or without a telehealth modifier (Telehealth Modifier Value Set)).

• An intensive outpatient encounter or partial hospitalization (Partial Hospitalization/Intensive Outpatient Value Set) with a mental health practitioner.

• A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set with a mental health practitioner, with or without a telehealth modifier (Telehealth Modifier Value Set)).

• Electroconvulsive therapy (Electroconvulsive Therapy Value Set) with (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set) with a mental health practitioner.

• A telehealth visit: Visit Setting Unspecified Value Set with Telehealth POS Value Set with a mental health practitioner, with or without a telehealth modifier (Telehealth Modifier Value Set).

• An observation visit (Observation Value Set) with a mental health practitioner.

• Transitional care management services (Transitional Care Management Services Value Set), with a mental health practitioner, with or without a telehealth modifier (Telehealth Modifier 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 seven 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 seven 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).

3488: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence

30-day follow-up: A follow-up visit with any practitioner, with a principal diagnosis of AOD within 30 days after the ED visit (31 total days). Include visits that occur on the date of the ED visit. Any of the following meet criteria for a follow-up visit:

- IET Stand Alone Visits Value Set with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- IET Visits Group 1 Value Set with IET POS Group 1 Value Set and a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), 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 principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- An observation visit (Observation Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set).

- A telephone visit (Telephone Visits Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set).

- An online assessment (Online Assessments Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set).

Seven-day follow-up: A follow-up visit with any practitioner with a principal diagnosis of AOD within seven days after the ED visit (8 total days). Include visits that occur on the date of the ED visit. Any of the following meet criteria for a follow-up visit:

- IET Stand Alone Visits Value Set with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- IET Visits Group 1 Value Set with IET POS Group 1 Value Set and a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), 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 principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- An observation visit (Observation Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set).

- A telephone visit (Telephone Visits Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set).

- An online assessment (Online Assessments Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set).

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

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

- An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- An outpatient visit (BH Outpatient Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set), with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization/Intensive Outpatient Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

- A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set), with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) with (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

- A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set), with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- An observation visit (Observation Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

- An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- An outpatient visit (BH Outpatient Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set), with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization/Intensive Outpatient Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

- A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set), with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder

(Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) with (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

- A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- An observation visit (Observation Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set) with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

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

- An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- An outpatient visit (BH Outpatient Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set), with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization/Intensive Outpatient Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

- A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set), with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) with (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

- A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set), with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- An observation visit (Observation Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

- An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with

any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- An outpatient visit (BH Outpatient Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set), with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization/Intensive Outpatient Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

- A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set), with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) with (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

- A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set), with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- An observation visit (Observation Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

Denominator Statement

3572: Follow-up After Psychiatric Evaluation (FAPH)

The denominator includes discharges paid under the IPF prospective payment system (PPS) during the performance period for Medicare fee-for-service (FFS) patients with a principal diagnosis of mental illness or SUD.

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

Discharges from an acute inpatient setting with a principal diagnosis of mental illness or intentional self-harm 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.

3488: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence

Emergency department (ED) visits with a primary diagnosis of alcohol or other drug abuse or dependence on or between January 1 and December 1 of the measurement year where the member was 13 years or older on the date of the visit.

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

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

Denominator Details

3572: Follow-up After Psychiatric Evaluation (FAPH)

The measure includes IPF discharges during the 12-month measurement period for which the patient was:

- Discharged with a principal diagnosis of mental illness or substance use disorder that would necessitate outpatient follow-up care. Defined using ICD-10-CM diagnosis codes and claim type 60 (refer to the Diagnosis Codes tab on the FAPH_codes.xlsx workbook).

- Discharged alive to ensure they are eligible for follow-up care. Defined as any Discharge Status Code other than '20' (expired).

- Enrolled in Medicare Parts A and B during the month of the discharge date and at least one month after the discharge date to ensure data are available to capture the index admission and follow-up visits. Defined as having continuous (no gaps) Medicare Part A and Part B coverage with no Health Maintenance Organization (HMO). Therefore, the Entitlement Buy-in Indicator must be '3' or

'C' and the HMO indicator must be '0' for both the month of discharge and the month following the discharge month for the IPF stay to qualify as continuous FFS.

- Six years of age or older on the date of discharge because follow-up treatment for mental illness or SUD may not always be recommended for younger children. Defined using date of birth and discharge date from the CMS denominator file.

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

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

To identify acute inpatient discharges:

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

2. Exclude non-acute inpatient stays (Non-acute Inpatient Stay Value Set).

3. Identify the discharge date for the stay.

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

Acute facility readmission or direct transfer:

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

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

2. Exclude non-acute inpatient stays (Non-acute Inpatient Stay Value Set).

3. Identify the admission date for the stay.

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

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

If the readmission/direct transfer to the acute inpatient care setting was for any other principal diagnosis exclude both the original and the readmission/direct transfer discharge.

*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.

3488: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence

Age: 13 years and older as of the date of the ED visit

Benefit: Medical and chemical dependency.

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

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

Event/diagnosis criteria: An ED visit (ED Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set) on or between January 1 and

December 1 of the measurement year where the member was 13 years or older on the date of the visit. The denominator for this measure is based on ED visits, not on members. If a member has more than one ED visit, identify all eligible ED visits between January 1 and December 1 of the measurement year, and do not include more than one visit per 31-day period as described below.

If a member has more than one ED visit in a 31-day period, include only the first eligible ED visit. For example, if a member has an ED visit on January 1, then include the January 1 visit and do not include ED visits that occur on or between January 2 and January 31; then, if applicable, include the next ED visit that occurs on or after February 1. Identify visits chronologically including only one per 31-day period. Note: Removal of multiple visits in a 31-day period is based on eligible visits. Assess each ED visit for exclusions before removing multiple visits in a 31-day period.

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

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

2. Identify the admission date for the stay.

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

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

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

Benefit: Medical and mental health.

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

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

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

If a member has more than one ED visit in a 31-day period, include only the first eligible ED visit. For example, if a member has an ED visit on January 1 then include the January 1 visit and do not include ED visits that occur on or between January 2 and January 31; then, if applicable, include the next ED visit that occurs on or after February 1. Identify visits chronologically including only one per 31-day period. Note: Removal of multiple visits in a 31-day period is based on eligible visits. Assess each ED visit for exclusions before removing multiple visits in a 31-day period.

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

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

2. Identify the admission date for the stay.

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

Exclusions

3572: Follow-up After Psychiatric Evaluation (FAPH)

The denominator excludes IPF discharges for patients:

- Admitted or transferred to acute and non-acute inpatient facilities within the 30-day follow-up period because admission or transfer to other institutions may prevent an outpatient follow-up visit from taking place.

- Who were discharged against medical advice (AMA) because the IPF may have limited opportunity to complete treatment and prepare for discharge. Defined as Discharge Status Code '7' (AMA).

- Who died during the 30-day follow-up period because patients who expire may not have the opportunity for an outpatient follow-up visit. Defined as Discharge Status Code '20' (expired).

- Who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began because patients in hospice may require different follow-up services (refer to the Hospice Codes tab on the FAPH_codes.xlsx workbook).

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 non-acute facility within the 30-day follow-up period regardless of principal diagnosis.

Exclude discharges followed by readmission or direct transfer to an acute facility within the 30-day follow-up period if the principal diagnosis was 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 non-acute 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.

3488: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence

Patients in hospice.

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

Patients in hospice.

Exclusion Details

3572: Follow-up After Psychiatric Evaluation (FAPH)

- Those admitted or transferred to acute and non-acute inpatient facilities within the 30-day follow-up period are defined using UB revenue codes. (defined in the Readmission Codes tab on the FAPH_codes.xlsx workbook)

- Those who were discharged against medical advice (AMA) are defined using Discharge Status Code '07'

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- Those who died during the 30-day follow-up period are defined using the Medicare Enrollment File

- Those who use hospice services or elect to use a hospice benefit any time during the measurement year are defined using hospice codes (defined in the Hospice codes tab on the FAPH_codes.xlsx workbook)

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 non-acute inpatient care setting within the 30-day follow-up period, regardless of principal diagnosis for the readmission. To identify readmissions and direct transfers to a non-acute inpatient care setting:

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

2. Confirm the stay was for non-acute care based on the presence of a non-acute code (Non-acute 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 non-acute inpatient stays (Inpatient Stay Value Set).

2. Exclude non-acute inpatient stays (Non-acute 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

3488: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence

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).

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

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

Risk Adjustment

3572: Follow-up After Psychiatric Evaluation (FAPH)

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

3488: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence

No risk adjustment or risk stratification

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

No risk adjustment or risk stratification

Stratification

3572: Follow-up After Psychiatric Evaluation (FAPH)

Not applicable

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.

3488: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence

This measure is stratified by age:

- Age 13 to 17 years

- Age 18 and older

- Total (sum of the age stratifications)

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

Not applicable.

Type Score

3572: Follow-up After Psychiatric Evaluation (FAPH)

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

3488: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence

Rate/proportion better quality = higher score

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

Rate/proportion better quality = higher score

Algorithm

3572: Follow-up After Psychiatric Evaluation (FAPH)

The performance period used to identify cases in the denominator is 12 months. Data from the performance period and 30 days after the performance period are used to identify follow-up visits in the numerator. The performance period begins on July 1. Identify the denominator using the following criteria:

1. Enrolled in Medicare Parts A and B during the month of the discharge date and at least one month after the discharge date to ensure data are available to capture the index admission and follow-up visits

2. Have a principal diagnosis of mental illness or substance use disorder (SUD) (as defined in on the Diagnosis Codes tab of the FAPH_Codes.xlsx and in Table A.4 and Table A.3 of the measure specifications)

3. Discharged alive (any discharge status other than '20')

4. Six years of age or older on the date of discharge

5. Discharged from an IPF with eligible claim types '60' or with CMS Certification Number that meets at least one of the following criteria:

a. Last four digits of the CMS Certification Number (CCN) is 4000–4499 (Psychiatric Hospital excluded from Inpatient Prospective Payment System)

b. Third digit of CCN is 'S' (distinct part Psychiatric Unit in an acute care hospital)

c. Third digit of CCN 'M' (Psychiatric Unit in a CAH) 2/12/2020 NQF: Follow-Up After Psychiatric Hospitalization www.qualityforum.org/Print_Measure_Submission.aspx?SubmissionID=3572&projectID=236 8/18

6. Exclude the following patients from the denominator:

a. Admitted or transferred to acute and non-acute inpatient facilities within the 30-day follow-up period

b. Discharged against medical advice (AMA)

c. Used hospice services or elect to use a hospice benefit any time during the measurement period.

Identify the numerator using the following criteria:

1. Identify treatment by an outpatient visit for mental illness or SUD within seven and 30 day of discharge using the visit type codes in the FAPH_Code.xlsx workbook

2. Exclude claims with codes for emergency room visits outlined in the FAPH_Code.xlsx workbook

The measure rate is the numerator / denominator. A higher score indicates better quality.

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 7sevendays.

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

Step 3: Calculate the rates.

Step 3A: Calculate the seven-day rate by dividing the number of patients with qualifying follow-up visit within seven 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 seven days.

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

Step 3: Calculate the rates.

Step 3A: Calculate the seven-day rate by dividing the number of patients with qualifying follow-up visit within seven 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).

3488: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or 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 abuse or dependence. Do not include ED visits that result in an inpatient stay, or are followed by an admission to an acute or non-acute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit.

Step 2: Identify the numerator.

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

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

Step 3: Calculate the rates.

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

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

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

Step 1: Determine the eligible population.

Step 1A: Identify patients with who were treated and discharged from an emergency department with a primary diagnosis of mental health. Do not include ED visits that result in an inpatient stay, or are followed by an admission to an acute or non-acute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit.

Step 2: Identify the numerator.

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

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

Step 3: Calculate the rates.

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

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

Submission items

3572: Follow-up After Psychiatric Evaluation (FAPH)

5.1 Identified measures:

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact: As noted in Section 1b.1, the FAPH measure is an expansion of the existing IPFQR FUH measure, which was adapted from the NQF-endorsed HEDIS® FUH measure (NQF #0576). During the 2017 comprehensive review of NQF #0576, the NQF BHSC recommended expanding the IPFQR FUH measure population to include patients hospitalized for drug and alcohol disorders. In 2018, CMS created the FAPH measure by expanding the IPFQR FUH measure population to include patients with principal SUD diagnoses to address the NQF BHSC recommendation and the CMS Meaningful Measures priority to promote treatment of SUDs.

In addition to including patients with SUD diagnoses, the FAPH measure also broadens the measure population to include patients with additional principal mental illness diagnoses like dementia, which are not currently included in the HEDIS® FUH and IPFQR FUH measures. By including dementia in the measure population, FAPH aligns with the IPFQR program's *30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF Readmission)* measure, which also includes dementia in its measure population. Eligible IPF discharges with a primary diagnosis of dementia account for 7.31 percent of discharges among IPFs with at least 40 discharges and 7.55 percent of discharges among all IPFs.

During the development of FAPH, the measure developer conducted a comprehensive reevaluation of the IPFQR FUH measure to ensure that FAPH would capture principal discharge diagnoses related to mental illness or SUD that would require follow-up after discharge from an IPF, that appropriate follow-up visits are captured by the measure numerator, and that measure specifications are harmonized to the extent feasible with existing measures. The measure development team convened an expert workgroup (EWG) to provide subject matter expertise and feedback on existing, similar measures and the FAPH measure. The EWG included a subject matter expert (SME) from NCQA, which is the measure steward of HEDIS® FUH and HEDIS® Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA). The NCQA SME provided input focused on harmonization and alignment between FAPH and the HEDIS® measures. CMS continues to harmonize with NCQA as part of the regular measure maintenance cycle. In addition to including patients with SUD diagnoses, as well as those with additional principal mental illness diagnoses like dementia, the FAPH measure differs from the IPFQR FUH measure by:

- Simplifying the exclusion of admission or transfer to acute or non-acute inpatient facilities within 30 days after discharge by aligning with the HEDIS® Inpatient Stay Value Set used in both the HEDIS® FUH and HEDIS® FUA measures to identify acute and non-acute inpatient stays. A discharge will be excluded from the FAPH measure if it is followed by an admission or transfer with one of the codes in the value set.
- Removing the exclusion identifying discharge to or transfer to other healthcare institutions by using inpatient discharge status codes in the IPFQR FUH measure from the FAPH measure to better align with the intent of the HEDIS® FUH and HEDIS® FUA measure
- Allowing mental illness or SUD diagnoses in any position on the follow-up visit claim to count toward the numerator rather than requiring it to be in the primary position.

- Not limiting the provider type for the follow-up visit if it is billed with a diagnosis of mental illness or SUD. The TEP confirmed that this is aligned with integrated care models that aim to treat the whole patient. They noted that in areas where there are shortages of mental health or SUD providers, other types of providers are often the only choice for follow-up treatment. In analyses using draft specifications before the measure was finalized, the measure developer found that the IPFQR FUH and HEDIS FUH approach requiring the follow-up visit to be with a specific provider type resulted in 104,028 discharges meeting the 30-day numerator criteria whereas the HEDIS Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) approach requiring the follow-up visit to be accompanied by a primary mental illness or SUD diagnosis resulted in 111,504 discharges meeting the 30-day numerator criteria. Among the 10,880 discharges that did not meet the provider-type criteria but that had an appropriate follow-up visit with a primary diagnosis of mental illness or SUD, the most frequent provider types were family or general practice physicians, internal medicine physicians, nurse practitioners, and physician assistants. The Expert Workgroup and TEP agreed that these provider types should be credited by the measure for treating mental illness and SUD. Additionally, the specifications from HEDIS® FUH and HEDIS® FUA helped served as the basis of FAPH. The key features HEDIS® FUH and HEDIS® FUA that served as the basis of FAPH are as follows: HEDIS® FUH:

- Definition of denominator criteria for discharges with principal mental illness - Definition of appropriate outpatient follow-up visits following discharges with mental illness HEDIS® FUA:

- Definition of denominator criteria for discharges with principal SUD
- Definition of appropriate outpatient follow-up visits following discharges with SUD

5b.1 If competing, why superior or rationale for additive value: The NQF BHSC recommended expanding the IPFQR FUH measure population to include patients hospitalized for drug and alcohol disorders, because these patients also require follow-up care after they are discharged. In 2018, CMS created the FAPH measure by expanding the IPFQR FUH measure population to include patients with principal SUD diagnoses to address the NQF BHSC recommendation and the CMS Meaningful Measures priority to promote treatment of SUDs.

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 (seven- 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 (NQF #0576 *Follow-up After Hospitalization for Mental Illness* and NQF #1937 *Follow-up After Hospitalization for Schizophrenia*). 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.

3488: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence

5.1 Identified measures:

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

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

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact: The measure is harmonized with the existing NQF-endorsed measure. The following highlights the differences between the measures: Population focus (denominator): The measure targets patients discharged from the emergency department (not detoxification). Numerator: The measure captures follow-up with a primary alcohol or other drug dependence diagnosis.

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

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

5.1 Identified measures:

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

5a.1 Are specs completely harmonized? Yes

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

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

Appendix F: Pre-Evaluation Comments

There were no comments received as of June 5, 2020.

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