Continuity of Care After Medically Managed Withdrawal from Alcohol and/or Drugs (NQF 3312)

Technical Specifications and Resource Manual

April 2019

Center for Medicaid and CHIP Services
Centers for Medicare & Medicaid Services

This page left blank for double-sided copying.

ACKNOWLEDGMENTS

The Continuity after medically managed withdrawal from alcohol and/or drugs measure was developed by Mathematica Policy Research under the Quality Measure Development and Maintenance for Centers for Medicare & Medicaid Services (CMS) Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees contract HHSM-500-2013-13011I, Task Order #HHSM-500-T0004.

For Proprietary Codes:

Limited proprietary coding is contained in the Measure specifications for user convenience. Users of proprietary code sets should obtain all necessary licenses from the owners of the code sets. Mathematica disclaims all liability for use or accuracy of any CPT or other codes contained in the specifications. Professional organizations frequently update their codes. We recommend that states seek input from their clinical experts to identify current codes.

Level II HCPCS codes in these specifications are approved and maintained jointly by the Alpha-Numeric Panel (consisting of CMS, the Health Insurance Association of America and the Blue Cross and Blue Shield Association.)

The International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) is published by the World Health Organization (WHO). ICD-10-CM is an official Health Insurance Portability and Accountability Act standard.

TABLE OF CONTENTS

I. BACKGROUND

These technical specifications focus on a measure for adult Medicaid beneficiaries, ages 18–64, who are discharged from a medically managed withdrawal episode during the measurement year. Specifically, this manual is for the following measure:

- NQF 3312: Percentage of discharges from a medically managed withdrawal episode for adult Medicaid beneficiaries, ages 18–64, that was followed by a treatment service for substance use disorder (including the prescription or receipt of a medication to treat a substance use disorder (pharmacotherapy)) within 7 or 14 days after discharge. This measure is reported across all medically managed withdrawal settings.

This measure was developed for the CMS Medicaid Innovation Accelerator Program (IAP) area for promoting follow-up care after stabilization in medically managed withdrawal to improve quality of care for beneficiaries with a substance use disorder. This measure can be used by states, providers, and other stakeholders for quality improvement purposes.

The measure steward is CMS and this measure is constructed from Medicaid administrative and claims data. The technical specifications in Chapter III of this manual provide additional details of the measure.

II. DATA COLLECTION

To support consistency in reporting NQF 3312, this chapter provides general guidelines for data collection, preparation, and reporting. The technical specifications are presented in Chapter III and provide detailed information on how to calculate the measure.

Data Collection and Preparation for Reporting

- **Version of specifications**. This manual includes the most applicable version of the measure specifications available to CMS as of April 2019.
- **Value Set**. This measure specification references value sets used for calculating the measure. A value set is the complete set of codes used to identify a service or condition included in a measure. See the posted required value sets.
- **Data collection time frames for measure**. This measure requires a data collection period of 12 months in total, from January 1 to December 31 of the measurement year.
- **Continuous enrollment**. This refers to the time frame during which a beneficiary must be eligible for benefits to be included in the measure denominator. This measure requires enrollment during the month of discharge from medically managed withdrawal and the following month to be included in the denominator.
- **Allowable gap**. Some measures specify an allowable gap that can occur during continuous enrollment. This measure does not have an allowable gap.
- **Retroactive eligibility.** This refers to the time between the actual date when Medicaid became financially responsible for a member and the date when it received notification of the new member's eligibility. This measure does not apply retroactive eligibility.
- **Anchor date**. Some measures include an anchor date, which is the date that an individual must be enrolled and have the required benefit to be eligible for the measure. This measure does not have an anchor date.
- **Date specificity**. A date must be specific enough to determine that an event occurred during the time frame in the measure. There are instances when documentation of the year alone is adequate; e.g., most optional exclusions and measures look for events in the "measurement year or the year prior to the measurement year." Terms such as "recent," "most recent," or "at a prior visit" are not acceptable.
- **Reporting unit**. The reporting unit is the state.
- **Eligible population for measurement**. The measure includes fee-for-service (FFS) and managed care (MC) Medicaid beneficiaries who satisfy measure-specific eligibility criteria (e.g., age, benefit, and event).
- **Members with partial benefits.** States should include only the Medicaid beneficiaries who are eligible to receive the services assessed in the numerator. If a

member is not eligible to receive the services assessed in the measure, the member should not be included in the denominator for the measure. Individuals receiving medically managed withdrawal services should be eligible to receive follow-up services for substance use disorders (SUD) including the prescription or receipt of a medication to treat a substance use disorder. Each state should assess the specific benefit packages of the beneficiaries in their state.

- **Aggregating information for state-level reporting**. To obtain a state-level rate for a measure that is developed from the rates of multiple units of measurement (such as multiple managed care organizations [MCOs]), the state should calculate a weighted average of the individual rates. How much any one entity (e.g., individual MCOs) will contribute to the weighted average is based on the size of its eligible population for the measure. This means that reporting units with larger eligible populations will contribute more toward the rate than those with smaller eligible populations.
- **Age criteria.** This measure applies to Medicaid FFS and managed care beneficiaries who are ages 18–64 as of the first date of the measurement period (January 1).
- **Exclusions**. This measure does not apply any exclusions. However, states may require exclusions as appropriate for their SUD programs and recipients.
- **Representativeness of data**. States should use the most complete data available and ensure that the rates reported are representative of the entire eligible population for the measure.
- **Data collection methods**. The data for this measure are collected from Medicaid administrative claims and eligibility files.
- **Sampling**. The denominator for this measure includes all FFS and managed care Medicaid beneficiaries ages 18–64 who meet the denominator criteria. The measure does not require a separate sampling methodology.
- **Small numbers**. If a measure has a denominator that is less than 11, the state may choose not report the measure due to small numbers.
- **Risk adjustment.** This measure does not require risk adjustment.

III. TECHNICAL SPECIFICATIONS

This chapter presents the technical specifications for the measure of continuity of care after medically managed withdrawal from alcohol and/or drugs. The specification includes a description of the measure and information about the eligible population, key definitions, data collection method(s), instructions for calculating the measure, and any other relevant measure information.

NQF 3312: CONTINUTIY OF CARE FOR MEDICAID BENEFICIARIES AFTER MEDICALLY MANAGED WITHDRAWAL FROM ALCOHOL AND/OR DRUGS

Centers for Medicare & Medicaid Services

A. DESCRIPTION

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

Data Collection Method: Administrative

Guidance for Reporting:

- Two rates are reported: follow-up within 7 days and within 14 days after discharge from medically managed withdrawal.
- The denominator for this measure should be the same for the 7-day rate and the 14-day rate.
- The 14-day follow-up rate should be greater than (or equal to) the 7-day follow-up rate.
- This measure is reported across all medically managed withdrawal settings.
- This measure uses the following administrative claims or encounter data and pharmacy claims:
    - State Medicaid Management Information System (MMIS), MSIS, or T-MSIS files: eligible (EL), inpatient (IP), other services (OT), long-term care (LT), and drug (RX) files.
    - The other services file contains facility and individual provider services data. Most notably, it may contain both residential and other stayover service claims data as claims are assigned to claims file types based upon the category of service provided.
    - The inpatient file only contains inpatient hospital, sterilization, abortion, and religious non-medical health care institution claims.

The following coding systems are used in this measure: Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), International Classification of Diseases (ICD-10-CM and ICD-10-PCS), National Drug Codes (NDC), and Uniform Billing (UB) Revenue Codes. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Follow-up period	7-days and 14-days after discharge from medically managed withdrawal.
Measurement period	January 1 to December 15 of the measurement year.

C. ELIGIBLE POPULATION

Age	18–64 years. Age is calculated as of January 1 of the measurement year.
Continuous enrollment	Beneficiaries must be enrolled in Medicaid during the month of discharge from medically managed withdrawal and the following month.
Allowable gap	No gaps in enrollment.
Anchor date	None.
Benefits	Medical and chemical dependency (inpatient and outpatient). Note: Medicaid beneficiaries with medically managed withdrawal-only chemical dependency benefits do not meet these criteria.
Exclusions	• None.
Event/diagnosis	Beneficiaries with at least one discharge from medically managed withdrawal during the year January 1 to December 15. <u>Step 1: Identify denominator</u> • Step 1A: Eligible population: Identify Medicaid beneficiaries ages 18–64 who have any medically managed withdrawal in inpatient hospital, residential addiction treatment program, or ambulatory medically managed withdrawal from January 1 to December 15 of the measurement year and are enrolled the month of medically managed withdrawal and the following month. Age is calculated as of January 1 of the measurement year. • Step 1B: Among the Medicaid beneficiaries in Step 1A, identify all discharges from medically managed withdrawal using all inpatient, outpatient, and ambulatory claims files or tables that contain HCPCS or ICD-10 procedure codes and UB revenue codes (see NQF 3312 – Tab 1-2 for code lists). If more than one discharge from medically managed withdrawal in a year, treat each discharge from medically managed withdrawal as a separate episode, e.g., an inpatient hospital medically managed withdrawal in January and an ambulatory medically managed withdrawal in July counts as two episodes. o Step 1B.1: Multiple medically managed withdrawal claims that are up to 2 days apart are combined into a

	single episode. Sort the inpatient, outpatient, and ambulatory discharge from medically managed withdrawals by Beneficiary ID and service dates to ensure the discharges from these multiple data sources are in chronological order. Then combine claims that are up to 2 days apart while retaining all clinical fields from each episode. • Step 1C: Identify appropriate location of medically managed withdrawal services: hospital inpatient, inpatient residential addiction, outpatient residential outpatient addiction, other stayover treatment, and ambulatory medically managed withdrawal. Use HCPCS medically managed withdrawal procedure codes to assign medically managed withdrawal location whenever possible; revenue center medically managed withdrawal will map to the hospital inpatient location when the revenue codes appear on an inpatient claim or table (see posted value set: NQF 3312 – Tab 2). Revenue center medically managed withdrawal will map to other stayover treatment when the revenue codes appear on a non-inpatient claim. If there is more than 1 medically managed withdrawal location when episodes are combined, assign the location using the first claim's location. If there is a tie between a medically managed withdrawal episode being identified via revenue center codes and a more specific category using HCPCS on the same claim, the HCPCS location prevails. <u>Step 2: Identify numerator</u> • Step 2A: From the denominator in Step 1B, identify those discharges from medically managed withdrawal in any setting with a qualifying continuity service within 7 or 14 days after discharge. o Step 2A.1: Identify SUD continuity services: Continuity services are assigned using clinical claims billing information (e.g., diagnosis, procedure, revenue codes; see posted value sets NQF 3312 – Tab 2-8). The measure includes all claims files or data tables that contain clinical fields (e.g., inpatient hospital, outpatient, other ambulatory, and long-term care). SUD diagnoses can be in any position – primary or secondary – for continuity services. Since multiple claims files or tables could each contain a continuity claim, this calls for creating continuity variables separately within each file type or table, sorting the files or tables by beneficiary ID and service dates, then putting them together in order to assign the set of variables that are “First” to occur relative to the

	medically managed withdrawal episode discharge date. Continuity services have to occur the day after discharge through day 7 or 14. ○ Step 2A.2: Identify pharmacotherapy which may occur in multiple files or tables (see posted value sets: NQF 3312 – Tab 9-10). For example, one claims file or data source may contain injectables, another claims file or table data source may contain oral medications. Consequently, pharmacotherapy variables are created separately in each source, the data sources are then sorted by beneficiary ID and service dates, then multiple pharmacotherapy data sources are put together so they will be in chronological order to assign "First" variables. Pharmacotherapy services could be provided on the same day as the discharge from medically managed withdrawal through day 7 or 14. ○ Step 2A.3: Co-occurring events: Emergency department visits, even with an SUD diagnosis, do not count as continuity. Also, other continuity services, e.g., an outpatient visit that occur on the same day as an emergency department visit with an SUD diagnosis do not count as continuity. If an overdose diagnosis code appears on the same claim as the continuity service, then the service does not count as continuity. If an inpatient continuity claim has an emergency department visit meaning that the beneficiary was admitted through the emergency department, it is allowed to remain a continuity service. <u>Step 3: Calculate rate</u> • Step 3A: Calculate the overall 7- or 14-day continuity rates by dividing the number of discharges with a qualifying continuity service (Step 2A) by the denominator (Step 1B). • Step 3B: Calculate the rates separately for each medically managed withdrawal location by dividing the respective number of discharges by each location with a qualifying continuity service (Step 2A) by the denominator (Step 1C).
Care settings	Ambulatory care: Clinician Office/Clinic, ambulatory care: outpatient rehabilitation, behavioral health/psychiatric: inpatient, behavioral health/psychiatric: outpatient, hospital/acute care facility, other (residential addiction program, outpatient addiction program).

D. ADMINISTRATIVE SPECIFICATIONS

Denominator

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

Eligible population meets the following conditions:

- Medicaid beneficiaries ages 18–64 with at least one discharge from medically managed withdrawal during the year January 1 to December 15.
- Enrolled in Medicaid during the month of discharge from medically managed withdrawal and the following month.
- The denominator is based on discharges, not individuals. A beneficiary may have more than one qualifying medically managed withdrawal episode.
- Medically managed withdrawal is identified using a combination of HCPCS codes, UB Revenue codes, and ICD-10 procedure codes. A list of codes to identify medically managed withdrawal is posted in the value sets: Table NQF 3312 – Tabs 1-2). States will likely need to modify the specifications to include their state-specific codes.

Numerator

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

The numerator includes individuals with any of the following within 7 or 14 days after discharge from medically managed withdrawal:

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

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

SUD diagnoses are used to identify procedures connected to SUD diagnoses. SUD diagnoses are identified through ICD-10 codes (see posted value set: NQF 3312 – Tab 3).

Procedures are defined using a combination of HCPCS codes, UB Revenue Codes, and ICD-10 procedure codes (see posted value sets: NQF 3312 – Tabs 4-8).

Pharmacotherapy includes naltrexone (short or long acting), acamprosate, or disulfiram for alcohol dependence treatment and buprenorphine for opioid dependence treatment, as well HCPCS codes to identify procedures related to injecting drugs (e.g., long-acting injectable naltrexone) (see posted value sets: NQF 3312 – Tabs 9-10).

Code lists for this measure are in the posted value sets. States may need to adapt the list of codes to include state-specific codes.

E. ADDITIONAL NOTES

If an inpatient hospital claim has an ICD-10 medically managed withdrawal procedure code or a UB revenue code indicating medically managed withdrawal, hospital inpatient treatment is assigned as the location of medically managed withdrawal. In addition, hospital inpatient treatment is also assigned if a non-inpatient claim contains a HCPCS code indicating hospital inpatient medically managed withdrawal. The remaining medically managed withdrawal location assignments are very straightforward. Whenever possible, use of the HCPCS codes to determine location is most desired as it reflects the more precise medically managed withdrawal location. The other stayover treatment location is designed to capture medically managed withdrawal location from non-inpatient claims that do not contain a HCPCS code.

F. OPTIONAL STRATIFICATIONS

Some states may want to calculate continuity rates by medically managed withdrawal location. To identify medically managed withdrawal location, please refer to Section C, Step 1C. Briefly, location of medically managed withdrawal can include hospital inpatient, inpatient residential addiction, other stayover treatment, and ambulatory medically managed withdrawal.

States may also be interested in calculating continuity rates when pharmacotherapy is the type of continuity received. To identify the extent to which continuity is established through pharmacotherapy, identify episodes that have a pharmacotherapy flag (Section C, Step 2A.2) only, but not a continuity service (Section C, Step 2A.1) within 7 or 14 days.