Project Title:

Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) Funding Opportunity: Measure Development for the Quality Payment Program (Mental Health/Substance Use Care).

Project Overview:

The Centers for Medicare & Medicaid Services (CMS) has entered a cooperative agreement with the American Psychiatric Association (APA) and the National Committee for Quality Assurance (NCQA) to develop provider-level measures for mental health and substance use. The cooperative agreement name is MACRA/Measure Development for the Quality Payment Program. The *cooperative agreement* number is #1V1CMS331640-02-00.

Date:

Information included is current on December 20, 2019

1. Measure Name (Measure Title De.2.)

Improvement or maintenance of functioning for all individuals seen for mental health and/or substance use care

2. Descriptive Information

2.1 Measure Type (NQF Submission Form De.1.)

Outcome

2.2 Brief Description of Measure (NQF Submission Form De.3.)

The percentage of individuals aged 18 and older with mental and/or substance use disorder who demonstrated an improvement in functioning (or maintained baseline level of functioning) based on results from the 12-item World Health Organization Disability Assessment Schedule (WHODAS 2.0) six months (+/- 30 days) after a baseline visit.

2.3 If Paired or Grouped (NQF Submission Form De.4.)

Not applicable.

3. Measure Specifications

3.1 Measure-specific Web Page (NQF Submission Form S.1.)

Not applicable.

3.2 If this is an eCQM (NQF Submission Form S.2a.)

Not applicable.

3.3 Data Dictionary, Code Table, or Value Sets (NQF Submission Form S.2b.)

See Appendix A for data elements. Appendix A will be updated following measure testing.

3.4 For Instrument-Based Measure (NQF Submission Form S.2c)

See Appendix B for copy of instrument.

3.5 For Endorsement Maintenance (NQF Submission Form S.3.1. and S.3.2.)

Not applicable.

3.6 Numerator Statement (NQF Submission Form S.4.)

Individuals who demonstrated an improvement in functioning (or maintained baseline level of functioning) as demonstrated by results of a follow-up assessment using the WHODAS 2.0 six months (+/- 30 days) after the baseline assessment during the measurement period.

3.7 Numerator Details (NQF Submission Form S.5.)

Improvement or maintenance: To be determined. This section will be updated following measure testing

Follow-up Assessment: Follow-up assessment using the WHODAS 2.0 will occur at a separate encounter from the baseline assessment. This assessment will be administered six months (+/- 30 days) after the baseline assessment within the 12-month measurement period. If there are multiple assessments during the measurement period, the assessment that will be counted as the follow-up is the last assessment completed during the six months (+/- 30 days) after the baseline assessment.

WHODAS 2.0: The 12-item World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0) tool assesses changes in functioning for all mental health and substance use individuals. The domains covered in the tool are communication and understanding, mobility, self-care, social functioning, life activities (work and home), and participation in society. Response options include None, Mild, Moderate, Severe, and Extreme or cannot do. Cutoff scores for level of functioning and meaningful change will be determined during testing.

Baseline Assessment: Defined in denominator details (Section 3.9)

Measurement Period: A standard 12-month calendar year

3.8 Denominator Statement (NQF Submission Form S.6.)

Individuals aged 18 and older with a mental and/or substance use disorder and an encounter with a baseline assessment completed using the WHODAS 2.0 during the denominator identification period.

3.9 Denominator Details (NQF Submission Form S.7.)

Codes Used to Identify Diagnoses (ICD Code): Mental, Behavioral and Neurodevelopmental disorders – F01-F99

Codes Used to Identify Encounter Type (CPT or HCPCS): 59400, 59510, 59610, 59618, 90791, 90792, 90832, 90834, 90837, 92625, 96116, 96121, 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96146, 96150, 96151, 97165, 97166, 97167, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316,

99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99339, 99340, 99483, 99484, 99492, 99493, 99384, 99385, 99386, 99387, 99394, 99395, 99396, 99397, G0101, G0402, G0438, G0439, G0444

Baseline Assessment: The encounter when the individual first completes the WHODAS 2.0 will be counted as the baseline assessment. If there are multiple assessments during the measurement period, the assessment that will be counted as the baseline is the first assessment completed during the denominator identification period.

Denominator Identification Period: The period in which individuals can have an encounter with a baseline assessment using the WHODAS 2.0. The denominator encounter period is the 10-month window starting on August 1 of the year prior to the measurement year and ending on June 1 of the measurement year.

This section will be updated following measure testing.

3.10 Denominator Exclusions (NQF Includes "Exception" in the "Exclusion" Field) (NQF Submission Form S.8.)

To be determined. This section will be updated following measure testing.

3.11 Denominator Exclusion Details (NQF Includes "Exception" in the "Exclusion" Field) (NQF Submission Form S.9.)

To be determined. This section will be updated following measure testing.

3.12 Stratification Details/Variables (NQF Submission Form S.10.)

Stratifications based on patient and provider characteristics will be determined in testing.

3.13 Risk Adjustment Type (NQF Submission Form S.11.)

Risk adjustments based on patient and provider characteristics will be determined in testing.

3.14 Type of Score (NQF Submission Form S.12.)

Rate/Proportion

3.15 Interpretation of Score (NQF Submission Form S.13.)

Better quality = higher score

3.16 Calculation Algorithm/Measure Logic (NQF Submission Form S.14.)

STEP 1: Initial denominator population. Identify individuals aged 18 and older with a mental health and/or substance use disorder and an encounter with a baseline assessment completed using the WHODAS 2.0 during the denominator identification period as defined in sections 3.8 and 3.9.

STEP 2: Final denominator population. For all individuals included in the denominator in Step 1 above, identify and remove all individuals that meet the exclusion criteria as defined in sections 3.10 and 3.11. (Exclusion criteria will be determined during testing).

STEP 3: Final numerator population. Identify all individuals who demonstrated improvement or maintenance of functioning as demonstrated by results of a follow-up assessment using the WHODAS 2.0 six months (+/- 30 days) after the baseline assessment during the measurement period, as defined in sections 3.6 and 3.7.

STEP 4: Calculate the performance score for the given measurement year as follows:
Year's Performance Score = Year's Final Numerator Population (Step 3) ÷ Year's Final Denominator Population (Step 2)

Note: Steps will be revised to incorporate risk adjustment and/or stratification approach based on results from testing.

3.17 Sampling (NQF Submission Form S.15.)

Proxy responses are not permitted for this measure.

3.18 Survey/Patient-Reported Data (NQF Submission Form S.16.)

To be determined. This section will be updated following measure testing.

3.19 Data Source (NQF Submission Form S.17.)

Registry

3.20 Data Source or Collection Instrument (NQF Submission Form S.18.)

PsychPRO clinical registry

3.21 Data Source or Collection Instrument (Reference) (NQF Submission Form S.19.)

https://www.psychiatry.org/psychiatrists/registry

3.22 Level of Analysis (NQF Submission Form S.20.)

Clinician: Individual
Clinician: Group/Practice

3.23 Care Setting (NQF Submission Form S.21.)

Outpatient
Ambulatory

3.24 Composite Performance Measure (NQF Submission Form S.22.)

Not applicable.

Appendix A: Data Elements for MBC Outcome Measures

Section or Table Name	Data element (DE)	Element Description	Data Type	Measure topic
Patient	patient_unique_ID	Unique ID assigned to the Patient (may or may not be MRN or EMR number)	varchar (50)	All
Patient	patient_gender	Administrative Gender of the patient	varchar (50)	All
Patient	patient_age	Calculated from Patient's dob in years	date	All
Patient	patient_sex	Patient's sex	varchar (50)	All
Patient	patient_guardian	If patient has a guardian who will be assisting with completing patient reported outcome scales (Y/N)	varchar (50)	All
Patient	relationship_to_patient	Guardian's relationship with the patient	varchar (50)	All
Patient	patient_deceased	Whether the patient is deceased (Y/N)	varchar (50)	All
Patient	death_date	If Deceased, Death date of patient	date	All
Encounter	patient_unique_ID	Unique ID assigned to the Patient (may or may not be MRN or EMR number)	varchar (50)	All
Encounter	unique_encounter_code	Unique ID assigned to the encounter	varchar (20)	All
Encounter	encounter_type_code	CPT code used to indicate type of encounter	varchar (100)	All
Encounter	encounter_type_code_desc	Description for CPT code to indicate type of encounter	varchar (500)	All
Encounter	encounter_start_date	Encounter start date or date of patient visit	dateTime	All
Encounter	encounter_start_time	Encounter start time or time of patient visit	dateTime	All
Encounter	encounter_end_date	Encounter end date (same as start date for outpatient visits)	dateTime	All
Encounter	encounter_end_time	Encounter end time (same as start time	dateTime	All

		for outpatient visits)		
Encounter	reason_for_visit	The reason the patient sought treatment	varchar (500)	All
Provider	patient_unique_ID	Unique ID assigned to the Patient (may or may not be MRN or EMR number)	varchar (50)	All
Provider	enc_service_prov_npi	Provider NPI who is attending the patient	varchar (20)	All
Provider	enc_service_prov_locID	LocationId uniquely identify the service location	varchar (50)	All
Diagnoses	patient_unique_ID	Unique ID assigned to the Patient (may or may not be MRN or EMR number)	varchar (50)	All
Diagnoses	diagnosis_code	Diagnosis code that describes the problem, condition or diagnosis	varchar (50)	All
Diagnoses	diagnosis_code_system	The coding system used for the diagnosis code (i.e., SNOMED, ICD-9, ICD-10 code, DSM-5)	varchar (50)	All
Diagnoses	diagnosis_code_desc	Diagnosis code description that describes the problem, condition or diagnosis	varchar (500)	All
Diagnoses	date_of_diagnosis	Date of diagnosis	date	All
Diagnoses	diagnosis_phase	Describes phase of diagnosis including; acute, chronic, recurring, remission, past mental disorder	varchar (50)	All
Diagnoses	diagnosis_type	Type of diagnosis including; primary, 2ndary, chief complaint, comorbid, complication, etc.	varchar (50)	All
Diagnoses	enc_diagnoses	Indicates diagnosis applicable to encounter or ascribed to encounter	varchar (20)	All
Patient Reported	patient_unique_ID	Unique ID assigned	varchar (50)	All

		to the Patient (may or may not be MRN or EMR number)		
Patient Reported	completer	Person completing the questionnaire	varchar (100)	All
Patient Reported	completer_relationship	Relationship of the person completing the questionnaire with the patient	varchar (100)	All
Patient Reported	completer_relationship_other	Relationship of the person completing the questionnaire with the patient if other than valid values for 'completer_relationship.' Free text field	varchar (100)	All
Patient Reported	pt_chiefcomps	The main problems or symptoms that caused patient to come to the clinic or office	varchar (100)	All
Patient Reported	pt_assent	Patient indicates they understand the possible uses of their data (values = 1 for ascent; 0 for no assent)	varchar (100)	All
Patient Reported	scale_completion_date	Date the patient completed the patient reported assessment scale	dateTime	All
Patient Reported	scale_completion_time	Time the patient completed the patient reported assessment scale	dateTime	All
Patient Reported	scale_name	Patient reported assessment scale name	varchar (100)	All
Patient Reported	scale_name_scr	Patient reported assessment scale total score	numeric	All
Patient Reported	scale_name_tscr	Patient reported assessment scale transformed score (t-score)	numeric	All
Patient Reported	Scale_name_chagne	Patient reported assessment scale change in score		All
Patient Reported	safety plan_ completion_date	Date the patient completed the suicide safety plan		Suicide

Patient Reported	Safety plan_completion_time	Time the patient completed the suicide safety plan		Suicide
Patient Reported	safety plan_ update_date	Date the patient updated the suicide safety plan		Suicide
Patient Reported	Safety plan_update_time	Time the patient updated the suicide safety plan		Suicide
Interventions	patient_unique_ID	Unique ID assigned to the Patient (may or may not be MRN or EMR number)	varchar (50)	FEP
Interventions	intervention_code	Standard code for a Interventions, including CPT Codes or SNOMED CT codes	varchar (50)	FEP
Interventions	intervention _code_desc	Standard Interventions code description in text	varchar (500)	FEP
Interventions	intervention _code_std	The standard Interventions code used: CPT code; SNOMED CT	varchar (100)	FEP
Interventions	intervention _category	Category of Interventions code	tinyint	FEP
Interventions	intervention _date	Date of Intervention	date	FEP
Interventions	intervention _status_code	Code for Intervention status	varchar (50)	FEP
Interventions	intervention _status_desc	Intervention status description in text	varchar (50)	FEP
Medications	patient_unique_ID	Unique ID assigned to the Patient (may or may not be MRN or EMR number)	varchar (50)	FEP
Medications	medication_code	The medication codes are the standard codes used to identify the medicines, e.g. RxNorm, NDC codes.	varchar (50)	FEP
Medications	medication_brand_ name	Prescribed drugs specific marketed brand name	varchar (500)	FEP
Medications	medication_generic _name	Prescribed drugs chemical name	varchar (500)	FEP
Medications	med_start_date	Date the patient was advised to take the medicines. Normally the same	date	FEP

		as visit date.		
Medications	med_stop_date	date when patient is advised to stop taking the medicines	date	FEP
Medications	dose_quantity	The quantity of dose prescribed to patient.	varchar (100)	FEP
Medications	dose_quantity_unit_code_desc	The quantity of dose unit code description prescribed to patient.	varchar (100)	FEP
Medications	max_dose_quantity	Maximum quantity of medicine to be consumed during the course or restricted dosage of medicine	varchar (100)	FEP
Medications	med_status_code	Medication Status whether the medication is active, completed etc.	Varchar (50)	FEP
Medications	med_status_code_desc	Medication Status description whether the medication is active, completed etc	Varchar (100)	FEP
Medications	med_refill_number	Medication refill number	varchar (50)	FEP
Referral	referral_from	The referring physician or other health care provider	Varchar (100)	FEP
Referral	referral_from_type	The referring physician or other health care provider type -	Varchar (100)	FEP
Referral	referral_to	The physician or other health care provider the patient is referred to	Varchar (100)	FEP
Referral	transfer_to_type	The type of treatment or facility the patient is referred to	Varchar (100)	FEP
Transfer of care	transfer_from	The transferring physician or other health care provider	Varchar (100)	All
Transfer of care	transfer_from_type	The transferring physician or other health care provider	Varchar (100)	All

		type -		
Transfer of care	transfer_to	The physician or other health care provider the patient is transferred to	Varchar (100)	All
Transfer of care	referral_to_type	The type of treatment or facility the patient is transferred to	Varchar (100)	All
Notes	patient_unique_ID	Unique ID assigned to the Patient (may or may not be MRN or EMR number)	varchar (50)	All
Notes	note_section_name	The section to which the note belongs (e.g., care plan)	varchar (500)	All
Notes	note_text	This is free text note	varchar (500)	All
Notes	note_date	Documentation date	date	All

Appendix B: WHODAS 2.0

WHODAS 2.0

WORLD HEALTH ORGANIZATION
DISABILITY ASSESSMENT SCHEDULE 2.0

12-item version, self-administered

This questionnaire asks about difficulties due to health conditions. Health conditions include diseases or illnesses, other health problems that may be short or long lasting, injuries, mental or emotional problems, and problems with alcohol or drugs.

Think back over the past 30 days and answer these questions, thinking about how much difficulty you had doing the following activities. For each question, please circle only one response.

In the past 30 days, how much difficulty did you have in:						
S1	Standing for long periods such as 30 minutes?	None	Mild	Moderate	Severe	Extreme or cannot do
S2	Taking care of your household responsibilities?	None	Mild	Moderate	Severe	Extreme or cannot do
S3	Learning a new task, for example, learning how to get to a new place?	None	Mild	Moderate	Severe	Extreme or cannot do
S4	How much of a problem did you have joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can?	None	Mild	Moderate	Severe	Extreme or cannot do
S5	How much have you been emotionally affected by your health problems?	None	Mild	Moderate	Severe	Extreme or cannot do

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Appendix B: WHODAS 2.0 (continued)

WHODAS 2.0
WORLD HEALTH ORGANIZATION
DISABILITY ASSESSMENT SCHEDULE 2.0

12
Self

In the past 30 days, how much difficulty did you have in:						
S6	Concentrating on doing something for ten minutes?	None	Mild	Moderate	Severe	Extreme or cannot do
S7	Walking a long distance such as a kilometre [or equivalent]?	None	Mild	Moderate	Severe	Extreme or cannot do
S8	Washing your whole body?	None	Mild	Moderate	Severe	Extreme or cannot do
S9	Getting dressed?	None	Mild	Moderate	Severe	Extreme or cannot do
S10	Dealing with people you do not know?	None	Mild	Moderate	Severe	Extreme or cannot do
S11	Maintaining a friendship?	None	Mild	Moderate	Severe	Extreme or cannot do
S12	Your day-to-day work?	None	Mild	Moderate	Severe	Extreme or cannot do

H1	Overall, in the past 30 days, how many days were these difficulties present?	***Record number of days ____***
H2	In the past 30 days, for how many days were you totally unable to carry out your usual activities or work because of any health condition?	***Record number of days ____***
H3	In the past 30 days, not counting the days that you were totally unable, for how many days did you cut back or reduce your usual activities or work because of any health condition?	***Record number of days ____***

This completes the questionnaire. Thank you.

Page 2 of 2 (12-item, self-administered)