

Proposed Changes to Existing Measure for HEDIS^{®1} MY 2022: Identification of Alcohol and Other Drug Services (IAD) Mental Health Utilization (MPT)

NCQA seeks comments on proposed revisions to the HEDIS measures *Identification of Alcohol and Other Drug Services* and *Mental Health Utilization*.

These utilization measures are similar in structure and intent. The IAD measure describes the number and percentage of members who receive a chemical dependency service with a substance use diagnosis during the year; the MPT measure describes the number and percentage of members who receive a mental health service with a mental health diagnosis during the year.

NCQA proposes revisions to clarify the measures' intent: The revised IAD measure captures the percentage of members with diagnosis of a substance-related disorder during the year; the revised MPT measure captures the percentage of members with a diagnosis of a mental health disorder during the year. NCQA also recommends streamlining reporting elements, as described in the table below, to improve interpretability and utility of performance scores.

Measure	Proposed Revisions
Both Measures	<ul style="list-style-type: none"> • Change measure structure from “utilization” to “diagnosed-prevalence” of substance-related and mental health disorders: <ul style="list-style-type: none"> – Denominator: Change measure calculation method from using member-years to members with one-year continuous enrollment in the denominator – Numerator: Remove procedure code requirements and service setting stratifications from the numerator* • Maintain measures in the “Utilization” domain, but modify reporting guidelines to follow the Guidelines for Effectiveness of Care Measures
IAD Only	<ul style="list-style-type: none"> • Revise measure name to “Diagnosed Substance-Related Disorders” • Revise the age groups for reporting: <ul style="list-style-type: none"> – Remove 0-12 years – Collapse stratifications to 13-17, 18-64 and 65+*
MPT Only	<ul style="list-style-type: none"> • Revise measure name to “Diagnosed Mental Health Disorders” • Change mental health diagnosis requirement from the “principal” position to “any” position • Remove mental health practitioner requirements from the numerator* • Revise the age groups for reporting: <ul style="list-style-type: none"> – Remove 0-5 years – Collapse the child and adolescent stratifications to 6-17*

* Proposed revisions marked with an asterisk were not tested, but recommended during reevaluation to streamline reporting requirements and align with the measures' clarified intent.

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NCQA conducted testing in the Medicare and commercial populations to confirm feasibility.

[Both Measures] Testing Results: Denominator Revision. NCQA believes that changing the denominator from member years to members is important to improve the validity and interpretability of performance scores. (**Note:** *The performance metric is percentage.*) In testing, NCQA found this revision decreased average denominator size for both measures. In IAD, average denominator size decreased by about 16% for Medicare (from 58,871 member years to 49,518 members) and 38% for commercial plans (from 260,097 member years to 160,834 members). In MPT, average denominator size decreased by about 8% for Medicare (from 69,140 member years to 63,507 members) and 25% for commercial plans (from 452,257 member years to 338,856 members). Despite the reduction, plans still had large average denominator sizes.

With the revised denominator, average performance scores in the IAD measure decreased for both product lines. Depending on drug diagnosis cohort, performance for Medicare plans decreased between 38% and 53% (from 2.6% to 1.6% for Alcohol; from 7.1% to 3.4% for Opioid; from 2.8% to 1.3% for Other Drug) and performance for commercial plans decreased between 13% and 21% (from 1.2% to 1.1% for Alcohol; from 0.7% to 0.6% for Opioid; from 0.8% to 0.7% for Other Drug).

In the MPT measure, the change in denominator also impacted performance scores. Average performance in Medicare plans increased by 25% (from 17.1% to 21.3%) and performance was relatively maintained among commercial plans (around 18%).

[MPT Only] Testing Results: Numerator Revision. For the MPT measure, NCQA recommends changing criteria for a mental health diagnosis to be present in “any” claims position, to both align with the IAD measure and more accurately capture the population diagnosed with a mental health disorder. When tested using the original measure calculation of member years in the denominator, results indicated that average performance nearly doubled, from about 7.6% to 17.1% of members diagnosed with a mental health disorder.

NCQA received support from expert panels on the proposed specification changes. NCQA seeks feedback on the proposed changes and on the following questions:

1. Testing results of the IAD measure indicated that substance use disorders are underdiagnosed when compared to prevalence reported by survey-based epidemiological data. Should the measure be maintained for HEDIS reporting?
2. Testing results of the MPT measure did not indicate underdiagnosis of mental health disorders. Should the measure be maintained for HEDIS reporting?

Supporting documents include current measure specification, proposed measure specification and evidence workups.

NCQA acknowledges the contributions of the Geriatric, Behavioral Health and Technical Measurement Advisory Panels.

[Current] Mental Health Utilization (MPT)

SUMMARY OF CHANGES TO HEDIS MY 2020 & MY 2021

- Deleted the Mental Health Practitioner Value Set.
- Replaced references to “mental health practitioner” with “mental health provider.”
- Added telephone visits (Telephone Visits Value Set), e-visits and virtual check-ins (Online Assessments Value Set) to the *Telehealth* section.
- Deleted redundant value sets from the *Telehealth* section.
- Revised the instructions in the *Notes* for identifying mental health providers.

Description

This measure summarizes the number and percentage of members receiving the following mental health services during the measurement year:

- Inpatient.
- Intensive outpatient or partial hospitalization.
- Outpatient.
- ED.
- Telehealth.
- Any service.

Calculations

Note: *Members in hospice are excluded from this measure. Refer to General Guideline 17: Members in Hospice.*

Product lines	Report the following tables for each applicable product line: <ul style="list-style-type: none"> • Table MPT-1a Total Medicaid. • Table MPT-1b Medicaid/Medicare Dual-Eligibles. • Table MPT-1c Medicaid—Disabled. • Table MPT-1d Medicaid—Other Low Income. • Table MPT-2 Commercial. • Table MPT-3 Medicare.
Benefit	Mental health.
Member months	For each product line and table, report all member months during the measurement year for members with the benefit.
Categorizing mental health services	Use the instructions below to identify members who had any of the following services during the measurement year: <ul style="list-style-type: none"> • Inpatient. • Intensive outpatient or partial hospitalization. • Outpatient.

- ED.
- Telehealth.

Count services provided by physician and nonphysician providers.

For members who had more than one service on different dates of service in different service categories (Inpatient, Intensive Outpatient or Partial Hospitalization, Outpatient, ED, Telehealth), count only the first encounter in each service category and report the member in the respective age category as of the date of service or discharge. For example, if a member had an outpatient visit and an ED visit on January 5 and a telehealth service on March 5, report the member in the Outpatient, ED and Telehealth service categories.

Any Services. The Any Services category is not a sum of the Inpatient, Intensive Outpatient or Partial Hospitalization, Outpatient, ED and Telehealth categories. Report members who had an encounter in any listed setting during the measurement year only once in the Any Services category. Categorize members in the Any Services category based on their age as of the first eligible encounter in any service category.

The intent of excluding ED/observation visits that result in an inpatient stay is to not double count events. For example, an ED visit with a principal mental health diagnosis that resulted in an inpatient stay for a principal diagnosis of mental health is reported only once in the Inpatient Stay category. An ED visit with a principal mental health diagnosis that resulted in an inpatient stay with a principal diagnosis for something other than mental health (e.g., heart attack) is reported only once in the ED category.

Inpatient Report acute and nonacute inpatient discharges from either a hospital or a treatment facility with a mental health principal diagnosis (Mental Health Diagnosis Value Set) on the discharge claim. To identify acute and nonacute inpatient discharges:

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

Intensive outpatient and partial hospitalization Report intensive outpatient and partial hospitalization claims/encounters in conjunction with a principal mental health diagnosis. Any of the following code combinations meet criteria:

- Partial Hospitalization or Intensive Outpatient Value Set **with** a principal mental health diagnosis (Mental Health Diagnosis Value Set).
- (MPT IOP/PH Group 1 Value Set; Electroconvulsive Therapy Value Set; Transcranial Magnetic Stimulation Value Set) **with** Partial Hospitalization POS Value Set **with** a principal mental health diagnosis (Mental Health Diagnosis Value Set).
- (MPT IOP/PH Group 1 Value Set; Electroconvulsive Therapy Value Set; Transcranial Magnetic Stimulation Value Set) **with** Community Mental Health Center POS Value Set **with** a principal mental health diagnosis (Mental Health Diagnosis Value Set), where the organization can confirm that the visit was in an intensive outpatient or partial hospitalization setting (this POS code can be used in settings other than intensive outpatient and partial hospitalization).

- MPT IOP/PH Group 2 Value Set **with** Partial Hospitalization POS Value Set **with** a principal mental health diagnosis (Mental Health Diagnosis Value Set) billed by a mental health provider.
- MPT IOP/PH Group 2 Value Set **with** Community Mental Health Center POS Value Set **with** a principal mental health diagnosis (Mental Health Diagnosis Value Set), where the organization can confirm that the visit was in an intensive outpatient or partial hospitalization setting (this POS code can be used in settings other than intensive outpatient and partial hospitalization) **and** billed by a mental health provider.

Note: Report only in-person services in the Intensive Outpatient and Partial Hospitalization category. Exclude all services billed with a telehealth modifier (Telehealth Modifier Value Set) or billed with a telehealth POS code (Telehealth POS Value Set) from the Intensive Outpatient and Partial Hospitalization category.

Outpatient Report outpatient. Any of the following meet criteria:

- MPT Stand Alone Outpatient Group 1 Value Set **with** a principal mental health diagnosis (Mental Health Diagnosis Value Set).
- MPT Stand Alone Outpatient Group 2 Value Set **with** a principal mental health diagnosis (Mental Health Diagnosis Value Set) billed by a mental health provider.
- Observation Value Set **with** a principal mental health diagnosis (Mental Health Diagnosis Value Set) billed by a mental health provider.
- (Visit Setting Unspecified Value Set; Electroconvulsive Therapy Value Set; Transcranial Magnetic Stimulation Value Set) **with** Outpatient POS Value Set **with** a principal mental health diagnosis (Mental Health Diagnosis Value Set).
- (Visit Setting Unspecified Value Set; Electroconvulsive Therapy Value Set; Transcranial Magnetic Stimulation Value Set) **with** Community Mental Health Center POS Value Set **with** a principal mental health diagnosis (Mental Health Diagnosis Value Set), where the organization can confirm that the visit was in an outpatient setting (this POS code can be used in settings other than outpatient).
- (Electroconvulsive Therapy Value Set; Transcranial Magnetic Stimulation Value Set) **with** (Ambulatory Surgical Center POS Value Set) **with** a principal mental health diagnosis (Mental Health Diagnosis Value Set).

Do not include observation visits that result in an inpatient stay (Inpatient Stay Value Set).

Note: Report only in-person services in the Outpatient category. Exclude all services billed with a telehealth modifier (Telehealth Modifier Value Set) or billed with a telehealth POS code (Telehealth POS Value Set) from the Outpatient category.

ED Report ED. Any of the following meets criteria:

- ED Value Set **with** a principal mental health diagnosis (Mental Health Diagnosis Value Set) billed by a mental health provider.
- Visit Setting Unspecified Value Set **with** ED POS Value Set **with** a principal mental health diagnosis (Mental Health Diagnosis Value Set).

- Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set with a principal mental health diagnosis (Mental Health Diagnosis Value Set), where the organization can confirm that the visit was in an ED setting (this POS code can be used in settings other than the ED).

Do not include ED visits that result in an inpatient stay (Inpatient Stay Value Set).

Note: Report only in-person services in the ED category. Exclude all services billed with a telehealth modifier (Telehealth Modifier Value Set) or billed with a telehealth POS code (Telehealth POS Value Set) from the ED category.

Telehealth Report telehealth. Any of the following meet criteria.

- Visit Setting Unspecified Value Set **with** (Telehealth Modifier Value Set; Telehealth POS Value Set) **with** a principal mental health diagnosis (Mental Health Diagnosis Value Set).
- Telephone Visits Value Set **with** a principal mental health diagnosis (Mental Health Diagnosis Value Set).
- Online Assessments Value Set **with** a principal mental health diagnosis (Mental Health Diagnosis Value Set).

Note

- *Supplemental data may not be used for this measure.*
- *Refer to Appendix 3 for the definition of “mental health provider.” Organizations must develop their own methods to identify mental health providers. Methods are subject to review by the HEDIS auditor.*

Table MPT-1/2/3: Mental Health Utilization

Member Months			
Age	Male	Female	Total
0-12			
13-17			
18-64			
65+			
Unknown			
Total			

Age	Sex	Any Service		Inpatient		Intensive Outpatient/Partial Hospitalization		Outpatient		ED		Telehealth	
		Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
0-12	Male												
	Female												
	Total												
13-17	Male												
	Female												
	Total												
18-64	Male												
	Female												
	Total												
65+	Male												
	Female												
	Total												
Unknown	Male												
	Female												
	Total												
Total	Male												
	Female												
	Total												

[Proposed] Diagnosed Mental Health Disorders (MPT)

SUMMARY OF CHANGES TO HEDIS MY 2022

- Revised the measure’s name from *Mental Health Utilization* to *Diagnosed Mental Health Disorders*.
- Revised the measure’s structure from Utilization to Diagnosed Prevalence.
- Revised measure guidance to follow guidelines for Effectiveness of Care measures.
- Updated the calculation method of the percentage rate (using member-months) to a member-based calculation.
- Removed procedure codes and requirements for a mental health practitioner from the numerator criteria.
- Removed the service setting stratifications.
- Removed the requirement for the mental health diagnosis in the “principal” position.
- Revised lower age limit from 0 to 6 years old.
- Combined the two youngest age stratifications into one age group: 6–17 years.
- Removed stratified reporting based on eligibility categories for Medicaid.
- Revised the *Rules of Allowable Adjustments* section.

Description

The percentage of members 6 years of age and older who were diagnosed with a mental health disorder during the measurement year.

Eligible Population

Product lines	Commercial, Medicaid, Medicare (report each product line separately).
Age	<p>6 and older as of December 31 of the measurement year.</p> <p>Report three age stratifications and a total rate. The total is the sum of the age stratifications.</p> <ul style="list-style-type: none"> • 6–17 years. • 18–64 years. • 65 years and older. • Total. <p>The total is the sum of the age stratifications.</p>
Continuous enrollment	The measurement year.
Allowable gap	Members who have had no more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	None.

Benefit Mental health.
Event/diagnosis None.

Administrative Specification

Denominator The eligible population.
Numerator Members who had a mental health disorder diagnosis (Mental Health Diagnosis Value Set) during the measurement year.

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table MPT-1/2/3: Data Elements for Mental Health Utilization

	Administrative
Measurement year	✓
Eligible population	<i>For each age stratification and total</i>
Numerator events by administrative data	<i>For each age stratification and total</i>
Reported rate	<i>For each age stratification and total</i>

Mental Health Utilization (MPT)

Measure Workup

Topic Overview

The *Mental Health Utilization (MPT)* measure describes the percentage of members diagnosed with a mental health disorder in the year. The measure provides information on the diagnosed prevalence of mental health disorders in the plan's population—adding insight on the potential underdiagnosis of mental health disorders and the approximate population size assessed by behavioral health quality measures.

Prevalence and Importance

Prevalence

The American Psychiatric Association defines mental illnesses as “health conditions involving changes in emotion, thinking or behavior (or a combination of these) [and are] associated with distress and/or problems functioning in social, work or family activities” (APA, 2018). Mental illnesses include many different conditions and vary in severity, and can be described by two broad categories: Any Mental Illness (AMI) (all recognized mental illnesses) and Serious Mental Illness (SMI) (severe subset of AMI). In 2017, 18.9% of U.S. adults lived with AMI (47.6 million adults), and 4.5% of U.S. adults lived with an SMI (11.2 million adults) (SAMHSA, 2019).

Health importance

According to the 2018 National Survey on Drug Use and Health (NSDUH), approximately 37.1 million adults (15% of adults) received any mental health service during the last year (SAMHSA, 2019). The survey indicated that among the 47.6 million adults in 2018 with AMI, only 43.3% (20.6 million) received mental health services in the past year (SAMHSA, 2019). Among adolescents, about 3.9 million adolescents 12–17 years (16% of adolescents) received mental health services in a specialty mental health setting (inpatient or outpatient care) in the past year (SAMHSA, 2019).

Utilization of services by children with mental health disorders was examined by the Centers for Disease Control and Prevention's National Health and Nutrition Examination Survey. This survey shows that in 2010, only half (50.6%) of children with mental disorders received treatment for their disorder, with variability in treatment rates depending on the mental disorder and anxiety disorder the least likely to be treated (32.2%) (NIMH, 2011).

Relation to Outcomes

Benefits and relationship to outcomes

The Centers for Disease Control and Prevention state that members with mental health conditions are more highly at risk for chronic medical conditions (CDC, 2011). Mental health disorders (most often depression) are strongly associated with risk, occurrence, progression and outcome of serious chronic diseases and health conditions (Chapman et al. 2005). Evidence indicates that positive mental health is linked with improved health outcomes. It is estimated that 80% of people with a specific mental illness can become well again with proper treatment (MHAG, 2011).

By providing data on the diagnosed-prevalence of mental health disorders, health plans may gain insight on the potential underdiagnosis of these conditions in their population. The measure's performance scores may also provide an estimate of the population size assessed and affected by complementary behavioral health quality measures.

Disparities

Summary of Data on Disparities by Population Group

Racial/Ethnic group

Disparities exist in both access to and quality of mental health treatment for racial/ethnic minorities (Maura and Weisman de Mamani, 2017).

Depression is less prevalent in African Americans (24.6%) and Hispanics (19.6%) than in Whites (34.7%), but is more likely to be persistent in African Americans and Hispanics (Budhwani et al., 2015). Studies indicate that African Americans are less likely than Whites to have outpatient follow-up visits 90 days following their diagnosis and are less likely to receive regular outpatient care and follow-up visits (Maura and Weisman de Mamani, 2017). Racial/ethnic minorities with SMI are more likely to utilize psychiatric emergency services (vs. community support services) and to be hospitalized when seeking care, and have lower rates of initial treatment utilization (Maura and Weisman de Mamani, 2017).

Among adults, the percentage of individuals who received minimally adequate treatment for mood, anxiety or impulse control disorders is lower among African Americans and Hispanics than Whites (and is lower among those with less than a high school education). Although the quality of health care is slowly improving for the nation as a whole, it is getting worse for Hispanics, especially those who speak little or no English (AHRQ, 2009).

Among children, findings from a study of the Medicaid-eligible children in Florida suggest at least two different disparity patterns when Hispanic and African Americans are compared to Whites in terms of mental health status and service utilization. The first pattern, associated with Hispanic children, consists of receiving fewer mental health diagnoses for the most prevalent disorders, fewer inpatient services for those who have a mental health diagnosis and more days until rehospitalization.

The second pattern, experienced by African American children, is more complex. African American children also have lower prevalence of attention deficit and depression disorders, but have greater prevalence of conduct disorder than their White counterparts. When services are considered, African American children receive more outpatient services from all providers and from mental health providers only. However, when inpatient services are compared, African American children receive fewer hospitalizations and have fewer days for a first hospital stay (Greenbaum, 2007).

A variety of factors may contribute to racial/ethnic differences in mental health service utilization, including higher rates of stigma, negative attitudes toward treatment, cultural beliefs about illness and treatment and racial/ethnic mismatch between patients and clinicians (Horvitz-Lennon et al., 2009; Fontanella et al., 2014). Additional studies, however, suggest a more complicated pattern of treatment utilization among racial/ethnic minorities, considering factors such as local initiatives or provisions of specialized programs to serve racial/ethnic minority communities (e.g., use of racial/ethnic minority providers), impacting treatment utilization among these groups (Maura and Weisman de Mamani, 2017).

Age/Gender

Older women are more likely to experience common mental disorders (e.g. depression and anxiety) than older men, and the gender gap is even greater at younger ages. Conversely, the mortality-related effects of poor mental health (e.g., suicide) are more severe for older men than older women (Kiley et al., 2019; Whiteman et al., 2016). These differences could be due to a number of factors, including cultural and social norms, life stressors, differentiation of gender roles, disadvantage and (dis)empowerment across the life course and the coping styles of older men (Kiley et al., 2019; Whiteman et al., 2016).

Redesigning the system to include integration of aging services and mental health services (i.e., colocation), or cross-system coordination could reduce the stigma of receiving mental health treatment, and improve provider communication and treatment access for individuals in need (Whiteman et al., 2016).

Financial Impact

Mental health and substance abuse disorders are ranked the fourth highest-cost health condition in the United States, with \$187.8 billion spent in 2013. There was a 3.7% annual rate of increase in spending on mental health and substance abuse disorders between 1996 and 2013. On depressive disorders alone, \$71 billion was spent on treatment, categorizing this condition as the costliest among mental health and substance abuse disorders and the sixth most costly health condition overall (Dieleman et al., 2016).

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