Inpatient Psychiatric Facility Quality Reporting Program: Claims-Based Measure Specifications

This document is a resource for the Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program for the Centers for Medicare & Medicaid Services (CMS).

June 2024

Notices and Disclaimers

Current Procedural Terminology (CPT®)

International Classification of Diseases (ICD), Tenth Edition

Uniform Billing (UB) Revenue Codes

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Section 1: Follow-Up After Psychiatric Hospitalization (FAPH) Measure Specifications —Version 2.0

Description of Measure

FAPH is an intermediate outcome measure that assesses the percentage of inpatient psychiatric facility (IPF) hospitalizations for treatment of specified mental health or substance use disorders (SUDs) that were followed by an outpatient mental health care or SUD encounter. Two rates are reported:

- The percentage of discharges for which the patient received follow-up within 7 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, starting in July. For FY 2025 reporting, the FAPH measure will use a performance period of July 1, 2022, through June 30, 2023. The measurement period is July 1, 2022, through July 30, 2023, 30 days after the close of the performance period, to identify follow-up visits in the numerator.

As this is a claims-based measure, there is no action required by facilities to collect and submit data for the measure. CMS will calculate the measure rates using Part A and Part B claims data that Medicare receives for payment purposes. CMS will calculate this measure by linking Medicare fee-for-service (FFS) claims submitted by inpatient psychiatric facilities (IPFs) and subsequent outpatient providers for Medicare FFS IPF discharges. This approach requires no additional data collection or reporting by IPFs. Completion of this measure does not affect an IPF's payment determination.

For a full list of codes used in measure calculation, see the FAPH codebook posted on QualityNet at Qualitynet.cms.gov > Inpatient Psychiatric Facilities > Resources > Program Resources/View > Measure Resources. A summary of measure updates is in Appendix A.

Numerator Statement

This measure estimates the number of discharges from an IPF that are followed by an outpatient mental health care or SUD treatment encounter within 7 and 30 days after discharge. Outpatient encounters are defined as outpatient visits, intensive outpatient encounters, or partial hospitalizations provided by a mental health provider for which mental health or SUD diagnoses are mentioned anywhere on the follow-up visit claim. All codes used to identify providers are found in Medicare outpatient/carrier files.

Outpatient visits, intensive outpatient encounters, and partial hospitalizations are defined by the CPT, Healthcare Common Procedure Coding System (HCPCS), and UB Revenue codes listed in Table A1. A claim that meets any of the requirements in the table constitutes an outpatient visit. For a full list of codes, refer to the "Numerator Codes" tab of the FAPH codebook.

Table A1. Codes to identify outpatient visits, intensive outpatient encounters, and partial hospitalizations

CPT (Part A or B claims)		Telehealth modifier
90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90867, 90868, 90869, 98960, 98961, 98962, 98966, 98967, 98968, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99366, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99408, 99409, 99411, 99412, 99441, 99442, 99443, 99487, 99490, 99492, 99493, 99495, 99496, 99510	with or without	GT

HCPCS with or without telehealth modifiers (Part A or B claims)		Telehealth modifier
G0155, G0177, G0396, G0397, G0409, G0410, G0411, G0443, G0463, G0466, G0467, G0469, G0470, G0511, G0512, H0001, H0002, H0004, H0005, H0007, H0016, H0022, H0031, H0034, H0035, H0036, H0037, H0039, H0040, H0046, H0047, H0050, H2000, H2001, H2010, H2011, H2012, H2013, H2014, H2015, H2016, H2017, H2018, H2019, H2020, H2036, S0201, S0220, S0221, S9475, S9480, S9484, S9485, T1006, T1007, T1012, T1015, T1040, T1041	with or without	GT

CPT with or without telehealth modifiers (Part B claims)		Place of service		Telehealth Modifier
90791, 90792, 90845, 90847, 90849, 90853, 90863, 90870, 90875, 90876, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99381, 99382, 99383, 99384, 99385, 99386, 99387	with	02, 03, 05, 07, 09, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 24, 33, 49, 50, 52, 53, 71, 72	with or without	GT
90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90875, 90876	with	02, 03, 05, 07, 09, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 33, 49, 50, 52, 53, 57, 71, 72	with or without	GT
99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255	with	02, 52, 53		

CPT with or without telehealth modifiers (Part A claims)		Type of service/facility type classification (TYPSVC/FACTYP)		Telehealth Modifier
90791, 90792, 90845, 90847, 90849, 90853, 90863, 90870, 90875, 90876, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99251, 99252, 99253, 99254, 99255, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99381, 99382, 99383, 99384, 99385, 99386, 99387	with	TYPSVC = 2 or 3 if FACTYP = 1–4, 6, or 9 OR FACTYP = 7 or 8	with or without	GT

UB Revenue (Part A claims)
0510, 0513, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0526, 0527, 0528, 0529, 0900, 0901, 0902, 0903, 0904, 0905, 0906, 0907, 0911, 0912, 0913, 0914, 0915, 0916, 0917, 0919, 0944, 0945, 0982, 0983

Claims with codes for emergency room visits do not count toward the numerator and are excluded. Emergency room visits are defined by the UB Revenue, CPT, and Place of Service (POS) shown in Table A2.

Table A2. Codes to identify emergency room visits

UB Revenue	0450, 0451, 0452, 0456, 0459, 0981
CPT	99281, 99282, 99283, 99284, 99285
Place of Service	23

Denominator Statement

The denominator includes discharges paid under the IPF prospective payment system (PPS) during the measurement period for Medicare FFS patients with a principal diagnosis of mental health or substance use disorders. Specifically, the measure includes IPF discharges (Table A3) for which the patient was:

- Discharged with a principal diagnosis of mental health, including dementia, or substance use disorders that would necessitate follow-up care with a mental health professional.
  - Defined using the ICD-10-CM diagnosis codes in the "Diagnosis Codes" tab of the FAPH codebook.
- 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 with a mental health professional may not always be recommended for younger children.
  - Defined using date of birth from the beneficiary data table from the Beneficiary Information on the Cloud (BIC).
- Admitted for fewer than 180 days.

Table A3. Codes to identify eligible IPF discharges

Criteria for eligible IPF discharges
Claim Type 60

CMS Certification Number (CCN) meets at least one of the following criteria:

- Last 4 digits of the CMS Certification Number (CCN) is 4000–4499 (Psychiatric Hospital excluded from inpatient prospective payment system)
- 3rd digit of CCN is 'S' (distinct Psychiatric Unit in an acute care hospital)
- 3rd digit of CCN is 'M' (Psychiatric Unit in a Critical Access Hospital [CAH])

Denominator Exclusions

Medicare files are used to identify all exclusions. The denominator excludes IPF discharges for patients who:

- Were 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.
  - Defined using the UB Revenue codes in the "Admission Transfer Codes" tab of the FAPH codebook.
- Were discharged against medical advice (AMA) because the IPF may have limited opportunity to complete treatment and prepare for discharge.
  - Defined using Discharge Status Code '07.'
- Died during the 30-day follow-up period because patients who expire may not have had the opportunity for an outpatient follow-up visit.
  - Defined using beneficiary date of death in the beneficiary data table from the Beneficiary Information on the Cloud (BIC).
- Used hospice services or elected 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.
  - Defined using the hospice codes listed in the "Hospice Codes" tab of the FAPH codebook.

Section 2: 30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF Readmission) Measure Specifications—Version 7.0

Description of Measure

IPF Readmission, also referred to as READM-30-IPF in publicly reported data, is a facility-level outcome measure that estimates an unplanned, 30-day, risk-standardized readmission rate for adult Medicare FFS patient discharges from an IPF with a principal discharge diagnosis of a psychiatric disorder or dementia/Alzheimer's disease. The performance period used to identify cases in the measure population is 24 months, starting in July. For FY 2025 reporting, the IPF Readmission measure will use a performance period of July 1, 2021, through June 30, 2023. The measurement period includes data from the start of the performance period through 30 days after its close to identify readmissions. Data from 12 months before the start of the performance period through the performance period are used to identify risk factors.

For a full list of codes used in measure calculation, see the IPF Readmission codebook posted on QualityNet at Qualitynet.cms.gov > Inpatient Psychiatric Facilities > Resources > Program Resources/View > Measure Resources. A summary of measure updates is in Appendix B.

Numerator Statement

The risk-adjusted outcome measure does not have a traditional numerator and denominator. The numerator statement describes the outcome being measured. A readmission is defined as any admission, for any reason, to an IPF or a short-stay acute care hospital (including Critical Access Hospitals) that occurs within 30 days after the discharge date from an eligible index admission to an IPF, except those considered planned. The measure uses the CMS 30-day Hospital-Wide Readmission Measure Planned Readmission Algorithm to identify planned readmissions (for more information, see Appendix D). The algorithm follows two principles to identify planned readmissions:

1. Select procedures and diagnoses, such as transplant surgery, maintenance chemotherapy/radiotherapy, and rehabilitation care are always considered planned. For a full list of planned procedures and diagnoses, refer to the "PR1" and "PR2" tabs of the IPF Readmission codebook.
2. Some procedures, such as colorectal resection or aortic resection, are considered planned or unplanned depending on the accompanying principal discharge diagnosis. For a full list of such procedures, refer to the "PR3" tab of the IPF Readmission codebook. Specifically, a procedure is considered planned if it does not coincide with a principal discharge diagnosis of an acute illness or complication. For a full list of such principal discharge diagnoses, refer to the "PR4" tab of the IPF Readmission codebook.

Denominator Statement

The risk-adjusted outcome measure does not have a traditional numerator and denominator. The denominator statement describes the measure population. The measure population consists of eligible index admissions to IPFs. A readmission within 30 days will also be eligible as an index admission, if it meets all other eligibility criteria. Patients may have more than one index admission within the measurement period.

Index admissions are defined as admissions to IPFs for patients with the following characteristics:

- Age 18 or older at admission.
- Discharged alive.
- Enrolled in Medicare FFS Parts A and B during the 12 months before, during the month of, and at least one month after the index admission.
- Discharged with a psychiatric principal diagnosis included in the "PsychCCS" tab of the IPF Readmission codebook. The list of diagnoses uses the Agency for Healthcare Research and Quality (AHRQ) Clinical Classification Software (CCS) ICD groupings. Information on sorting ICD codes into clinically coherent groups is available on the AHRQ CCS web page at https://www.hcup-us.ahrq.gov/toolssoftware/ccsr/ccsr_archive.jsp#ccsr.
- Admitted for fewer than 180 days.

The measure population excludes admissions for patients with the following characteristics:

- Discharged against medical advice (AMA) because the IPF may have limited opportunity to complete treatment and prepare for discharge.
- Unreliable demographic and vital status data, defined as:
    - Age greater than 115 years.
    - Missing sex.
    - Discharge status of "dead" but with subsequent admissions.
    - Death date prior to admission date.
    - Death date within the admission and discharge dates but the discharge status was not "dead."
- Readmissions on the day of discharge or day following discharge because those readmissions are likely transfers to another inpatient facility. The IPF that discharges the patient to home or to a non-acute care setting is accountable for subsequent readmissions.

Readmissions two days following discharge because readmissions to the same IPF within two days of discharge are combined within the same claim as the index admission and do not appear as readmissions due to the interrupted stay billing policy. Therefore, complete data on readmissions within two days of discharge are not available.

Statistical Risk Model

Hierarchical logistic regression is used to estimate a risk-standardized readmission rate.

Factors Used for Risk Adjustment

Four factors are included in the risk-adjustment model for the risk-standardized readmission rate:

1. Demographics (Table B1)
   - Sex and age
2. Principal discharge diagnosis of the IPF index admission. Discharge diagnoses are summarized into 13 distinct principal discharge risk factors using a modified version of the AHRQ CCS groupings. For a full list of codes, please refer to the "Principal_DxICD10_CCS" tab of the IPF Readmission codebook.
3. Comorbidity risk variables
   - Comorbidities are summarized into distinct psychiatric and non-psychiatric risk factors using a modified version of CMS's Hierarchical Condition Categories (HCC). For a full list of codes, refer to the "ModifiedCCIcd10" tab of the IPF Readmission codebook. The comorbidity risk factors are derived from three sources:
     - Secondary diagnoses of the index admission when not considered a potential complication of care.
     - Principal or secondary diagnoses of inpatient encounters during the 12 months prior to the index admission.
     - Primary or secondary diagnoses of outpatient encounters that had evaluation and management (E&M) procedure codes indicating services were provided by physicians or qualified health professionals. To eliminate diagnoses that may have been assigned during diagnostic workup without later confirmation, a minimum of two outpatient claims with a diagnosis in the same HCC are required during the 12 months prior to the index admission for inclusion as a risk variable for a given patient.
4. Other risk factor variables among psychiatric patients (Table B2)
   - Other risk factors were summarized into three distinct risk factor descriptions using Medicare FFS claims. For a full list of codes to identify suicide attempt/self-harm and aggression, refer to the "SuicideICD10" and "AggressionICD10" tabs of the IPF Readmission codebook.

Table B1. Demographic factors

Risk Factor Name/Description
Sex: male or female
Age: 18–34, 35–44, 45–54, 55–64, 65–74, 75–84, or 85+

Table B2. Other factors

Risk Factor Name	Description
Suicide attempt/self-harm	• At least 1 claim with a diagnosis in the 12 months prior to the index admission • Secondary diagnosis during the index admission
Aggression	• Diagnosis during inpatient admission in the 12 months prior to the index admission • At least 2 outpatient claims in the 12 months prior to the index admission • Secondary diagnosis during the index admission
Discharge disposition	• Discharged against medical advice (AMA) in the prior 12 months • Not discharged AMA in the prior 12 months • No admissions to determine AMA discharge

Section 3: Medication Continuation Following Inpatient Psychiatric Discharge (MedCont) Measure Specifications—Version 5.0

Description of Measure

MedCont is an intermediate outcome measure that assesses whether psychiatric patients admitted to an IPF for major depressive disorder (MDD), schizophrenia, or bipolar disorder filled a prescription for evidence-based medication within two days prior to discharge and 30 days post-discharge. The performance period for the measure is two years, starting in July. For FY 2025 reporting, the MedCont measure will use a performance period of July 1, 2021, through June 30, 2023. The measurement period is two days prior to the start of the performance period through 30 days after the close of the performance period, to identify medications dispensed two days prior to 30 days post-discharge.

As this is a claims-based measure, there is no action required by facilities to collect and submit data for the measure. CMS will calculate the measure rates using Part A and Part B claims data that Medicare receives for payment purposes. CMS will calculate this measure by linking Medicare FFS claims submitted by IPFs and subsequent outpatient providers for Medicare FFS IPF discharges. This approach requires no additional data collection or reporting by IPFs. Completion of this measure does not affect an IPF's payment determination.

For a full list of codes used in measure calculation, see the MedCont codebook posted on QualityNet at Qualitynet.cms.gov > Inpatient Psychiatric Facilities > Resources > Program Resources/View > Measure Resources. A summary of measure updates is in Appendix C.

Numerator Statement

The numerator for this measure includes:

1. Discharges with a principal diagnosis of MDD in the denominator population for which patients were dispensed evidence-based outpatient medication within two days prior to discharge through 30 days post-discharge
2. Discharges with a principal diagnosis of schizophrenia in the denominator population for which patients were dispensed evidence-based outpatient medication within two days prior to discharge through 30 days post-discharge
3. Discharges with a principal diagnosis of bipolar disorder in the denominator population for which patients were dispensed evidence-based outpatient medication within two days prior to discharge through 30 days post-discharge

The following tables show the evidence-based medications for treating MDD (Table C1), schizophrenia (Table C2), and bipolar disorder (Table C3), by class. The route of administration includes all oral formulations and the long-acting (depot) injectables of the medications listed in this section, except where noted. Active ingredients for the oral medications listed are limited to oral, buccal, sublingual, and translingual formulations. Obsolete drug products are excluded from National Drug Codes (NDCs) with an inactive date more than three years before the beginning of the measurement period.

Table C1. Medications for treatment of MDD

Type	Medication
Monoamine Oxidase Inhibitors	– isocarboxazid – phenelzine – selegiline (transdermal patch) – tranylcypromine
Selective Serotonin Reuptake Inhibitors (SSRI)	– citalopram – escitalopram – fluoxetine – fluvoxamine – paroxetine – sertraline
Serotonin Modulators	– nefazodone – trazodone – vilazodone – vortioxetine
Serotonin Norepinephrine Reuptake Inhibitors (SNRI)	– desvenlafaxine – duloxetine – levomilnacipran – venlafaxine
Tricyclic and Tetracyclic Antidepressants	– amitriptyline – amoxapine – clomipramine – desipramine – doxepin – imipramine – maprotiline – nortriptyline – protriptyline – trimipramine
Other Antidepressants	– bupropion – mirtazapine
Psychotherapeutic Combinations	– amitriptyline-chlordiazepoxide – amitriptyline-perphenazine – fluoxetine-olanzapine

Table C2. Medications for treatment of schizophrenia

Type	Medication
First-generation Antipsychotics	– chlorpromazine – fluphenazine – haloperidol – haloperidol lactate – loxapine succinate – molindone – perphenazine – pimozide – prochlorperazine – thioridazine – thiothixene – trifluoperazine
Second-generation (Atypical) Antipsychotics	– aripiprazole – asenapine – brexpiprazole – cariprazine – clozapine – iloperidone – lurasidone – olanzapine – paliperidone – quetiapine – risperidone – ziprasidone – lumateperone
Psychotherapeutic Combinations	– amitriptyline-perphenazine – fluoxetine-olanzapine
Long-acting (Depot) Injectable Antipsychotics	– fluphenazine decanoate – haloperidol decanoate – aripiprazole – aripiprazole lauroxil – olanzapine pamoate – paliperidone palmitate (1-month, 3-month, and 6-month extended-release injections) – risperidone – risperidone microspheres

Table C3. Medications for treatment of bipolar disorder

Type	Medication
Anticonvulsants	– carbamazepine – divalproex sodium – lamotrigine – valproic acid
First-generation Antipsychotics	– chlorpromazine – haloperidol – haloperidol lactate – loxapine succinate
Second-generation (Atypical) Antipsychotics	– aripiprazole – asenapine – cariprazine – clozapine – lurasidone – olanzapine – quetiapine – risperidone – ziprasidone – lumateperone
Lithium Salts	– lithium – lithium carbonate – lithium citrate
Psychotherapeutic Combinations	– fluoxetine-olanzapine
Long-acting (Depot) Injectable Antipsychotics	– haloperidol decanoate – aripiprazole – aripiprazole lauroxil – olanzapine pamoate – risperidone – risperidone microspheres

Denominator Statement

The target population for this measure is Medicare FFS beneficiaries with Part D coverage ages 18 years and older discharged from an IPF with a principal diagnosis of MDD, schizophrenia, or bipolar disorder.

The denominator for this measure includes patients discharged from an IPF who:

- Had a principal diagnosis of MDD, schizophrenia, or bipolar disorder. For a full list of codes, please refer to the "Diagnosis Codes" tab of the MedCont codebook.
- Were 18 years of age or older at admission.
- Were enrolled in Medicare FFS Part A and Part B during the index admission and Parts A, B, and D two days prior to discharge through at least 30 days post-discharge.
- Were alive at discharge and alive during the follow-up period.
- Had a discharge status code indicating they were discharged to home or home health care without a planned readmission.
- Were admitted for fewer than 180 days.

Denominator Exclusions

The denominator for this measure excludes discharged patients who:

- Received electroconvulsive therapy (ECT) during the inpatient stay or follow-up period.
- Received transcranial magnetic stimulation (TMS) during the inpatient stay or follow-up period.
- Were pregnant at discharge.
- Had a secondary diagnosis of delirium at discharge.
- Had a principal diagnosis of schizophrenia with a secondary diagnosis of dementia at discharge.

For a full list of codes, please see the "Exclusions" tab of the MedCont codebook.

CMS Disparity Methods Public Reporting

Identifying disparities in care is an important step toward closing gaps in care. CMS has developed methodologies to examine quality differences between patients with and without social risk and demographic variables—specifically, patients who are eligible for both Medicare and Medicaid (dually eligible) and those who are eligible only for Medicare (non-dually eligible). [1] Disparities in health status and hospital outcomes are well established for patients who are dually eligible.[2]

The two methods used to calculate differences in the FAPH, IPF Readmission, and MedCont measures between patients who are dually eligible and those who are non-dually eligible are as follows:

- **Within-Hospital Disparity Method** compares the quality of care for patients who are and are not dually eligible within the same IPF. This method shows whether facilities are closer to achieving health equity across different subgroups of their own patients.[3]
- **Across-Hospitals Disparity Method** compares the quality of care for patients who are dually eligible at one IPF to the quality of care for patients who are dually eligible at other IPFs. This method shows whether some IPFs provide better care (through better outcomes) for patients who are dually eligible than other IPFs do.

Additional information on disparity methods reporting is available in Appendix E.

[1] **Social risk and demographic variables** are social risk factors (such as disability status, low-income status, or geographic indices) that influence health outcomes and demographic factors (such as sex, race, and ethnicity) associated with structural inequity.
[2] Office of the Assistant Secretary for Planning and Evaluation (ASPE). "Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs." 2016; Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs | ASPE (hhs.gov).
[3] **Health equity** is the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sex, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes.

Appendix A. Updates to Follow-Up After Psychiatric Hospitalization (FAPH) Measure Specifications

Version 2.0—Fiscal Year 2025 Public Reporting

Due to the high number of codes, please see the measure's codebook, which has a column to indicate whether a code was added or removed.

1. Added methodology for disparity reporting by dual eligibility status.
2. Added 72 new ICD-10 codes to, and removed eight ICD-10 codes from, the "Diagnosis Codes" tab of the FAPH codebook.
3. Removed one CPT code from the "Numerator Codes" tab of the FAPH codebook.

Appendix B. Updates to 30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an IPF (IPF Readmission) Measure Specifications

Version 7.0—Fiscal Year 2025 Public Reporting

Due to the high number of codes, please see the measure's codebook, which has a column to indicate whether a code was added or removed.

1. Added 82 new ICD-10 codes to the "Principal_DxICD10_CCS" tab of the IPF Readmission codebook.
2. Added 630 new ICD-10 codes to, and removed 341 ICD-10 codes from, the "ModifiedCCIcd10" tab of the codebook.
3. Added one new ICD-10 code to, and removed one ICD-10 code from, the "SuicideICD10" tab of the codebook.
4. Removed one CPT code from the "PCPOfficeCodes" tab of the codebook.
5. Added 1,224 ICD-10-CM codes to, and removed 459 ICD-10 codes from, the "ICD10CCS_ISRreadmitdx" tab of the codebook.
6. Added 16 new ICD-10 codes to, and removed 11 ICD-10 codes from, the "PR3" tab of the codebook.
7. Added 69 new ICD-10 codes to, and removed 46 ICD-10 codes from, the "PR4" tab of the codebook.

Appendix C. Updates to Medication Continuation Following Inpatient Psychiatric Discharge (MedCont) Measure Specifications

Version 4.0—Fiscal Year 2025 Public Reporting

Due to the high number of codes, please see the measure's codebook, which has a column to indicate whether a code was added or removed.

1. Added methodology for disparity reporting by dual eligibility status.
2. Added 69 ICD-10 CM codes to, and removed six ICD-10 CM codes from, the "Exclusions" tab of the MedCont codebook.
3. Added 10,491 NDC codes to, and removed 1,598 NDC codes from, the "Numerator – NDCs" tab of the MedCont codebook.

Appendix D. Planned Readmission Algorithm

Planned Readmission Algorithm (Version 4.0, 2024)[4]

IPF Readmission excludes readmissions identified as planned through the Planned Readmission Algorithm. The algorithm is a set of criteria for classifying readmissions as planned using Medicare claims and Veterans Affairs (VA) administrative data. The algorithm identifies admissions that are typically planned and may occur within 30 days of discharge from the IPF.

The planned readmission algorithm has three fundamental principles:

1. A few specific, limited types of care are always considered planned (transplant surgery, maintenance chemotherapy/immunotherapy, rehabilitation).
2. Otherwise, a planned readmission is defined as a non-acute readmission for a scheduled procedure.
3. Admissions for acute illness or for complications of care are never planned.

The algorithm was developed and is maintained by Yale New Haven Health Services Corporation as part of the hospital-wide readmission measure. In 2013, CMS applied the algorithm to its other readmission measures. The planned readmission algorithm uses a flowchart and four tables of specific AHRQ CCS procedure categories, AHRQ CCS diagnosis categories, and singular ICD-10 codes to classify readmissions as planned. Readmissions are considered planned if ANY of the following occurs during the readmission:

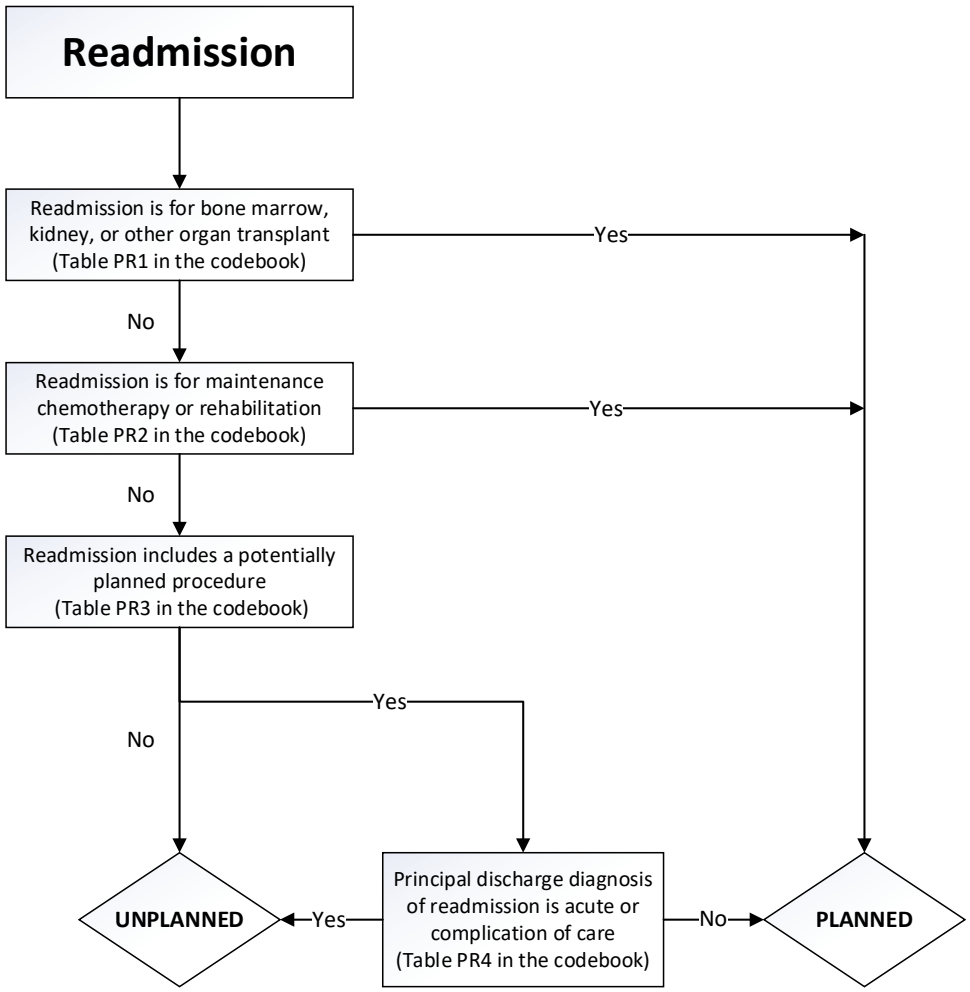
- A procedure is performed that is in one of the procedure categories that are always planned regardless of diagnosis.
- The principal diagnosis is in one of the diagnosis categories that are always planned.
- A procedure is performed that is one of the defined potentially planned procedures and the principal diagnosis is not in the list of defined acute discharge diagnoses.

Methodology for the Planned Readmission Algorithm is available in the 2024 All-Cause Hospital-Wide Measure Updates and Specifications Report: Hospital-Wide Readmission. The diagnoses and procedures referred to above can be found in Tables PR1 through PR4 in the FY 2025 IPF Readmission Measure Codebook.

Note that CCS mappings to ICD-10-CM and ICD-10-PCS codes are available *QualityNet* (https://qualitynet.cms.gov/inpatient/measures/readmission/resources).

[4] For more information, see QualityNet's Readmission Measures Methodology page: https://qualitynet.cms.gov/inpatient/measures/readmission/methodology.

Figure D1. Planned Readmission Algorithm version 4.0 2024 flowchart



Appendix E. CMS Disparity Methods Public Reporting

Promoting health equity is a priority in CMS's Meaningful Measures Initiative, an effort that includes a "health care system that promotes quality outcomes, safety, equity, and accessibility for all individuals, especially for people in historically underserved and under-resourced communities."[5]

The statistical calculations for the Within- and Across-Hospitals Disparity Methods used for the FAPH, MedCont, and IPF Readmission measures are outlined below.

Within-Hospital Disparity Method

Background

The *Within-Hospital Disparity Method* measures differences in the quality of care by comparing results for different patient social or demographic factors *within an individual IPF;* for example, between patients who are dually and non-dually eligible. More specifically, it answers the question**:**

> **"Could patients who are dually eligible for Medicare and Medicaid who receive services at Facility A have worse health outcomes than patients who are non-dually eligible and receive services at Facility A?"** IPFs can use the results from this method to determine whether they have a gap in the care provided to patients who are dually eligible for Medicare and Medicaid compared to care provided to patients who are non-dually eligible for these programs.

Methodology

The *Within-Hospital Disparity Method* evaluates the difference in measures' rates between patients who are dually eligible and those who are non-dually eligible. For the IPF Readmission measure, a risk-adjustment model is estimated for each patient subgroup (that is, dually eligible and non-dually eligible) to account for differences in clinical case mix. This method uses the same risk-adjustment model that is used in calculating results for the overall IPF Readmission measure to account for differences in demographic and clinical characteristics. The predicted and expected values from each model are used to calculate a standardized readmission rate (SRR) for each subgroup for each IPF. The within-hospital rate difference (RD) is then calculated between the SRR for each subgroup within the IPF. The SRR is used to calculate the Within-Hospital RD to ensure that the Within-Hospital RDs are not overly influenced by the national rates, which are used as multiplicative factors in the calculation of a risk-standardized readmission rate (RSRR) and can vary widely for each subgroup. Therefore, the within-hospital RD reflects the difference in predicted to expected ratios among the two subgroups at each IPF.

For the FAPH and MedCont measures, because they are not risk-adjusted measures, only the observed rates for the two subgroups are calculated separately for each IPF without a risk-adjustment model. The *Within-Hospital Disparity Method* for the FAPH and MedCont measures calculates the IPF-level measure rates for the population with the social risk factor (dually eligible patients) and the comparison population (non-dually eligible patients). The percentage rates are calculated for each subgroup separately by IPF. Then the within-hospital RD is calculated as the difference between the IPF's dually eligible and non-dually eligible rate.

[5] For more information, see What is the CMS National Quality Strategy? at https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/value-based-programs/cms-quality-strategy.

Interpretation and Categorization of Hospital Performance

To interpret the IPF-specific disparity effect, we report the result as an RD between dually eligible and non-dually eligible patients. The RDs for the FAPH and MedCont measures are interpreted as differences in percentages, and the RD for the IPF Readmission measure is interpreted as differences in SRR, since it is a risk-adjusted measure. For the FAPH and MedCont measures, a positive RD indicates a higher (i.e. better outcomes) rate for patients who are dually eligible versus patients who are non-dually eligible; likewise, a negative RD indicates a lower (i.e. worse outcomes) rate for patients who are dually eligible versus patients who are non-dually eligible. For the IPF Readmission measure, the opposite is true: a negative RD indicates better outcomes for dually eligible versus non-dually eligible patients, while a positive RD indicates worse outcomes. For all three measures, a RD equal to zero reflects that, on average, there are no disparities found between dually eligible and non-dually eligible patients within the same IPF.

For risk-standardized measures, specifically the IPF Readmission measure, the final results are placed into three performance categories based on the size and 95 percent confidence interval limits calculated using a bootstrap for the dually eligible and non-dually eligible SRRs. The performance categories are as follows:

1. "Better outcomes for patients who are dually eligible" if the upper confidence interval limit for the IPF's dually eligible SRR is less than the lower confidence interval limit for the non-dually eligible SRR. The interpretation indicates that patients who are dually eligible have statistically lower readmission rates compared to patients who are non-dually eligible.
2. "Similar outcomes for patients who are dually eligible and non-dually eligible" if the IPF's confidence intervals for the dually eligible SRR and the non-dually eligible SRR overlap. The interpretation indicates that patients who are dually eligible and non-dually eligible have statistically similar readmission rates.
3. "Worse outcomes for patients who are dually eligible" if the lower confidence interval limit for the IPF's dually eligible SRR is greater than the upper confidence interval limit for the non-dually eligible SRR. The interpretation indicates that patients who are dually eligible have statistically higher readmission rates compared to patients who are non-dually eligible.

Minimum Sample Size for Reporting Results for the Within-Hospital Disparity Methods

To ensure sufficient sample size for comparison, results for the *Within-Hospital Disparity Method* are reported only for IPFs with at least 12 admissions in each subgroup (that is, dually eligible and non-dually eligible) and with the total admissions between the two subgroups meeting the minimum reporting threshold for each measure. For the IPF Readmission measure, this would mean a total of at least 25 dually eligible and non-dually eligible cases. For the FAPH measure, the threshold is at least 40 dually eligible and non-dually eligible admissions, and at least 75 dually eligible and non-dually eligible admissions for the MedCont measure. IPFs with less than the minimum number of cases for each subgroup are assigned the "Number of cases too small" category, and no RD will be calculated for them. For confidential reporting, all IPFs with at least one dually eligible patient and one non-dually eligible patient will receive their RD, regardless of the sample size. However, only IPFs that meet the minimum threshold for reporting will be included in generating the performance categories.

Performance categorization will not be done if less than 10 percent of IPFs meet the case minimum described above. Reporting comparative performance categorization for measures with low reporting volumes risks masking disparities that exist in facilities that do not meet reporting minimums, which are frequently higher than IPFs that do meet reporting minimums. Despite the potential variations in

the measure rates by patient groups, the disparity analyses might not reveal meaningful differences in measures performance between subgroups at the facility level. This is because the small sample size within each subgroup could pose challenges in accurately addressing and interpreting the performance differences.

Across-Hospitals Disparity Method

Background

The *Across-Hospitals Disparity Method* compares performance *across IPFs* by calculating an IPF's outcome rate separately for patients who are dually eligible. More specifically, it answers the question:

> **"How does Facility A's provision of care for patients who are dually eligible for Medicare and Medicaid compare with the provision of care by other facilities to similar patients?"** IPFs can use the results from this method to compare their rate for patients who are dually eligible to other facilities, their state, and the nation.

In contrast with the *Within-Hospital Disparity Method*, which calculates the RD between patients who are dually eligible and non-dually eligible within a given IPF, the *Across-Hospitals Disparity Method* compares an individual IPF's readmission rate for patients who are dually eligible to that of other IPFs' readmissions rates. To measure across-hospital differences for patients who are dually eligible, we apply the overall measure methodology to the cohort of patients who are dually eligible at each IPF. Each IPF receives a measure score for patients who are dually eligible: an RSRR for IPF Readmission, and the percentage of patients receiving follow-up care for FAPH and medication continuation for MedCont.

Methodology

For the IPF Readmission measure, an RSRR is calculated only for patients who are dually eligible for each IPF. For calculating the *Across-Hospital Disparity Method* rate among dually eligible patients, the eligible index stays are filtered to patients with dual eligibility status, and the numerator and denominator are calculated the same as the overall IPF Readmission measure. The national observed readmission rate and risk-standardized model are then calculated only for those who are dually eligible patients, which are then used in the calculations for each IPF's SRR and RSRR. The mechanics of the *Across-Hospital Disparity Method* for IPF Readmission follows the same risk-adjustment approach as the overall measure but applied only to dually eligible patient stays at the IPF. Similar to the overall quality measure, the results of the risk-adjustment model are used to construct the ratio of the total number of predicted readmissions for patients who are dually eligible to the total number of expected readmissions for patients who are dually eligible for each IPF. This ratio of total predicted to total expected is multiplied by the overall national readmission rate for patients who are dually eligible to produce an RSRR for each IPF.

For the FAPH and MedCont measures, which are not risk-standardized, an observed rate is calculated for dually eligible patients. For calculating the *Across-Hospital Disparity Method* rate among dually eligible patients, the eligible index stays are filtered to patients with dual eligibility status, and the numerator and denominator are calculated for each IPF. The national observed readmission rate is then calculated only for those who are dually eligible patients.

Interpretation and Categorization of Hospital Performance

To aid with comparisons across IPFs, final results for the risk-standardized IPF Readmission measure are categorized into three groups based on the 95 percent confidence interval calculated using bootstrap for each IPF's dual RSRR, which is then compared with the national dually eligible readmission rate. The performance categories are as follows (Figure E3):

1. "Better than the national rate" if the upper confidence interval limit for the IPF's dual RSRR is less than the national average readmission rate for patients who are dually eligible.
2. "No different than the national rate" if the national average readmission rate for duals falls within the confidence interval limit of the IPF's dual RSRR.
3. "Worse than the national rate" if the lower confidence interval limit for the IPF's dual RSRR is greater than the national average readmission rate for patients who are dually eligible.

Minimum Sample Size for Reporting Results for the Across-Hospitals Disparity Methods

For the *Across-Hospital Disparity Method*, dually eligible patients are compared to the national average for each measure. To ensure sufficient sample size for comparison, results for the *Across-Hospitals Disparity Method* are reported only for IPFs with at least 25 admissions of dually eligible patients for IPF Readmission, at least 40 admissions of dually eligible patients for FAPH, and at least 75 admissions of dually eligible patients for MedCont. IPFs must have the same minimum of dually eligible patients as the minimum reporting threshold for the measure to ensure reliable results for the *Across-Hospital Disparity Method.* IPFs with fewer than the minimum admissions of dually eligible patients will be categorized as "Number of cases too small". For confidential reporting, all IPFs with at least one dually eligible patient will receive their dual-specific RSRR, regardless of the sample size. Only IPFs that meet the minimum threshold for reporting will be included in performance categorization.

Performance categorization will not be done if less than 10 percent of IPFs meet the case minimum described above. Reporting comparative performance categorization for measures with low reporting volumes risks masking disparities that exist in facilities that do not meet reporting minimums, which are frequently higher than IPFs that do meet reporting minimums.