# Quality Measurement in the Medicaid Innovation Accelerator Project

FINAL REPORT

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NATIONAL QUALITY FORUM

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# EXECUTIVE SUMMARY

Federal efforts to improve healthcare quality and value have long focused on Medicare. But, the U.S. Department of Health and Human Services (HHS) has recently been shifting more and more attention to improving quality and value of care provided in Medicaid programs. Medicaid is the nation's public health insurance program for low-income children, adults, seniors, and people with disabilities. Medicaid serves as the largest provider of health insurance, covering 1 in 5 Americans, many of whom are children.[1] State Medicaid programs and the Children's Health Insurance Program (CHIP) covered 72.8 million Americans in 2016.[2,3] Medicaid spending in FY 2016 totaled $553 billion up from $509 billion spent in the prior year.[4,5] As Medicaid continues to grow, measurement that enables care quality to be evaluated across states, and which addresses critical issues for Medicaid recipients, will be essential to lowering costs and improving quality.

State Medicaid programs face numerous challenges in finding and using standardized measures to evaluate quality within states and in comparing care delivered across providers, states, and payers. The decentralized nature of state quality programs has led to a proliferation of measures across states. This has also created a lack of alignment and increased reporting burden for providers. Benchmarking also can be difficult, as similar measures used in states may have different specifications.

The National Quality Forum (NQF), under contract with the Centers for Medicare & Medicaid Services (CMS), convened a multistakeholder Coordinating Committee and four Technical Expert Panels to identify and recommend measures that address key quality issues in each of the Medicaid Innovation Accelerator Program's four areas of focus. The Innovation Accelerator Program (IAP) is a collaboration between the Center for Medicaid and Children's Health Insurance Program Services (CMCS) and the Center for Medicare and Medicaid Innovation (CMMI).[6]

Launched in 2014, the Innovation Accelerator Program supports states' efforts to tie Medicaid payments to improved value with targeted technical support and tools, supporting states in their ongoing delivery system reform efforts through technical assistance across four main program areas. These include:

- Reducing substance use disorders;
- Improving care for Medicaid beneficiaries with complex care needs and high costs;
- Promoting community integration through long-term services and supports; and
- Supporting physical and mental health integration.

NQF's measure recommendations in the four IAP program areas include:

| Program Area | Measure Recommendations |
|---|---|
| Reducing Substance Use Disorders | 24 measures and five measure concepts promote measurement addressing high-priority issues, including screening and brief intervention, medication-assisted treatment, and continuity of care. |
| Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs | 18 measures and one measure concept promote measurement of high-priority issues, such as care utilization, follow-up care, and medication reconciliation. |
| Promoting Community Integration through Long-Term Services and Supports | 10 measures and four measure concepts promote measurement addressing high-priority issues, including quality of services, access to care, and medication reconciliation. |
| Supporting Physical and Mental Health Integration | 30 measures and one measure concept promote measurement of high-priority issues, such as coordination of treatment among providers, screening for physical and mental health conditions, and care follow-up. |

*Each program area is linked to the corresponding recommended measure list.

The four IAP program areas listed above represent high-cost and high-need priority areas for the Medicaid and CHIP population. These program areas overlap. Focusing on these interrelated areas supports a comprehensive and cohesive approach to improving healthcare for vulnerable populations. This report provides background for each program area, highlighting the issues affecting the recipients of care. Throughout the discussion and review by the Technical Expert Panels and Coordinating Committee, themes emerged regarding the focus of measures, availability of measures that specifically address the needs of the Medicaid population, and recommendations for future measure development.

The Coordinating Committee prioritized actionable measures, parsimony, and stakeholder perspectives throughout their deliberations. The proposed measures recommended in this report are available for use in all state Medicaid agencies and stakeholders to support their measurement strategies regardless of participation in the Innovation Accelerator Program. These measures and measure concepts are also readily available for states to leverage as they work to deliver and evaluate high-quality, efficient care provided to Medicaid beneficiaries. The Coordinating Committee reached consensus on the available measures that address high-priority areas for each program area and recommended measures and measure concepts to support state Medicaid agencies' delivery system reform efforts and to strengthen alignment across providers, payers, and states.

# INTRODUCTION AND PURPOSE

Federal efforts to improve healthcare quality and value have long focused on Medicare. However, HHS has recently been shifting more and more attention to improving quality and value of care provided in Medicaid programs. Medicaid is the nation's public health insurance program for low-income children, adults, seniors, and people with disabilities. Medicaid serves as the largest provider of health insurance covering 1 in 5 Americans, many of whom are children.[7] State Medicaid programs and the CHIP covered 72.8 million Americans in 2016.[8,9] In FY 2016, Medicaid spending totaled $553 billion, an increase from the $509 billion spent the prior year.[10,11] As Medicaid continues to grow, measures that address the critical issues for Medicaid recipients will be essential to lowering costs and improving quality of care.

Measurement of quality enables providers, health plans, payers (including state Medicaid programs), and consumers to gauge the value of care delivered. State Medicaid programs have faced numerous challenges in finding and using standardized measures to evaluate quality within states and in comparing care delivered across states. Programs (i.e., waivers, demonstrations, and health plans) are often state- and population-specific and vary in quality improvement and measurement activities. The decentralized nature of state quality programs has led to a proliferation of measures across states. This has also created a lack of alignment and increased reporting burden for providers. Benchmarking also can be difficult, as similar measures used in states may have different specifications.

To support states in their ongoing delivery system reform, CMCS and CMMI launched the Medicaid Innovation Accelerator Program (IAP). This program offers targeted technical assistance in four program areas: reducing substance use disorders (SUD); improving care for Medicaid beneficiaries with complex care needs and high costs (BCN); promoting community integration through long-term services and supports (CI-LTSS); and supporting physical and mental health integration (PMH). In addition, to support states' delivery system reform efforts in the program areas, IAP also works with states in other areas, including quality measurement. IAP supports states' efforts to select, report, and use standardized quality measures.

Under contract with the Centers for Medicare & Medicaid Services (CMS), the National Quality Forum (NQF) convened a multistakeholder Coordinating Committee (CC) and four Technical Expert Panels (TEPs)—one for each IAP program area—to identify and recommend measures that address key quality issues in each of the four program areas. The measures will serve as a resource for state Medicaid agencies developing measurement strategies for their delivery system reform efforts. Measures recommended in this report serve as a repository for states to supplement their existing measurement strategies. Adoption, implementation, and use of these measures is voluntary.

A wide range of stakeholders provided topic-specific expertise and knowledge of measurement to guide the selection of measures and measure concepts. Their work in identifying these measures across each program took into account the CMS quality domains, incorporated those ready to use, and emphasized alignment across states and programs. Guided by the NQF measure selection decision logic criteria, the TEPs and the CC recommended measures and measure concepts for the four IAP program areas. This report details measure recommendations for each program area.

# METHODOLOGY

This project aims to support states' efforts in using standardized measures that support alignment across programs, purchasers, and states. In order to achieve this goal, NQF developed a process to find, evaluate, and recommend measures that are ready for immediate use in each program area. Key elements of this process included the development of four measure summary spreadsheets that incorporated information for ranking and sorting of measures; the participation and knowledge of the TEPs in each of the four program areas; and the oversight and direction of the CC. Over the course of 12 months, NQF hosted multiple conference calls with the advisory group, which comprised the two CC co-chairs and the chair of each of the four TEPs, to solicit input on each stage of the measure search and selection process. There were seven web meetings throughout the project and two in-person meetings to select measures for inclusion in each measure set. In order to achieve standardized processes for staff and committees, NQF developed tools and processes as well as voting procedures to assure consistency in each step in the process. The goal of developing both tools and processes was to facilitate the selection of appropriate measures and measure concepts through discussion, evaluation, and voting. The details of each step of the processes are in Appendices (B, C, and D).

The Compendium Composite of Measures contains all measures that NQF staff collected during the environmental scan. Staff searched 51 measure sources during the environmental scan for measures including the NQF's repository of measures. All measure sources are listed in Appendix B. The table below summarizes the number of measures and measure concepts at each stage of the process.

**TABLE 1. MEASURES AND MEASURE CONCEPTS COLLECTED, RECOMMENDED BY TEPS, AND RECOMMENDED TO CMS BY PROGRAM AREA**

| | Measures and Measure Concepts Collected | Measures Recommended to the CC by the TEPs | Measure Concepts Recommended to the CC by the TEPs | Measures Recommended to CMS by the CC | Measure concepts Recommended to CMS by the CC |
|---|---|---|---|---|---|
| **BCN** | 69 | 14 | 6 | 18 | 1 |
| **SUD** | 114 | 19 | 6 | 24 | 5 |
| **PMH** | 63 | 23 | 2 | 30 | 1 |
| **CI-LTSS** | 66 | 6 | 7 | 10 | 4 |

# MEASURE-SPECIFIC RECOMMENDATIONS

The CC examined all measures based on each measure's potential to be of value to state Medicaid agencies in their delivery system reform efforts and to promote alignment across payers and settings. All measures recommended for each program area are included in a table in **Appendix E**. The measures that the CC considered but ultimately decided to exclude from the final list of measures and measure concepts are listed in **Appendix F**. A table of measure recommendations aligned with other programs (i.e., federal, state, etc.) is listed in **Appendix G**. NQF received numerous public comments on its draft recommendations as part of its transparent and open process. A public commenter noted that in addition to those highlighted in **Appendix E**, cross-cutting measures could be useful for more than one program area.

## Reducing Substance Use Disorders

Substance abuse, specifically alcohol and substance use issues, are two of the top 10 reasons for hospital readmissions among Medicaid beneficiaries.[12] An estimated 12 percent of adult and 6 percent of adolescent Medicaid beneficiaries have a substance abuse issue.[13] Given the prevalence of SUDs and the associated clinical and societal costs for individuals, their families, and the healthcare system at large, the focus on efforts to reduce SUDs is not only necessary, but is also an important step in improving overall population health for Medicaid beneficiaries.

For example, tobacco use, including cigarette smoking, is one of the largest drivers of cost and adverse health outcomes in the Medicaid population.[14] Smoking causes many serious diseases including cancer, heart disease, stroke, chronic obstructive pulmonary disease (COPD), and complications during pregnancy.[15] Consequently, smoking is responsible for more deaths each year than human immunodeficiency virus (HIV), illegal drug use, alcohol use, car accidents, and gun-related incidents combined.[16] Smoking accounts for an estimated 11 percent of Medicaid costs across all states, ranging from 6 percent in New Jersey to 18 percent in Arizona and Washington.[17]

Individuals with opioid use disorders also represent a large and growing portion of the SUD population. Opioid use disorder continues to grow nationally, affecting the Medicaid population at a higher rate with 8.7 per 1,000 beneficiaries diagnosed with an opioid use disorder.[18] Compared to patients on Medicare, private insurance, or the dual eligible beneficiaries, Medicaid-only beneficiaries have the highest combined rate of both illicit and prescription drug use.[19] Opioid misuse is associated with higher rates of emergency department (ED) use as well as increased risk of infectious disease transmission, specifically hepatitis C virus (HCV) and HIV.[20] Additionally, in 2015, opioid misuse was responsible for more than 33,000 deaths in the United States.[21] Given the toll of SUDs, NQF continues to address these issues through the Behavioral Health project and portfolio of measures.

Throughout the NQF Medicaid IAP measure selection process, the SUD TEP and the CC identified several themes. One reoccurring discussion involved the need for a cascade of SUD measures that start with screening and end with assessment and intervention and/or treatment. However, the CC noted that measures that include both screening and intervention in the numerator could cause difficulty in determining potential areas for improvement. The TEP also discussed the need to broaden the existing tobacco measures to include drugs and other nicotine products as well as tobacco.

The CC also noted concern about measures that focus on medication assisted treatment (MAT), stating that in carve-out states, where behavioral health services are separately managed and/or financed, the plan of care may not include

information indicating that a person is receiving MAT. The CC was also concerned about potentially incentivizing MAT prescribing without associated therapy.

An additional concern was lack of access to providers able to provide MAT. In some networks, only behavioral health professionals, including psychiatric providers, can provide MAT, preventing other providers (such as internists) from using this treatment option. Additionally, the CC expressed a need for a structural measure to address the availability of MAT as a community resource.

The CC discussed the lack of measures that address prevention of chronic use and prevention of addiction as well as SUDs among pregnant women. Some members mentioned that state laws criminalizing substance use during pregnancy pose a particular challenge in treatment, as women will not seek care during pregnancy for fear of arrest.

CC members also noted the lack of outcome measures. The recommended SUD measures include only two. Discussions focused on the need for specific outcome measures related to the long-term effect of SUD treatment, i.e. measuring patients who remain abstinent or out of the healthcare system following a patient stay for drug treatment. Such measures would address the issue of private rehabilitation centers that "run through" a person's private insurance resulting in loss of coverage and ultimate relapse. Finally, the CC highlighted the lack of measures that address HIV screening for individuals in the SUD population, as needle sharing can put this population at increased risk for contracting the virus.

The CC recommended that CMS consider 24 measures and five concepts for the SUD program area (List 1). The use of the recommended measures promotes measurement of a variety of high-priority issues, including screening and brief intervention, MAT, and continuity of care. List 1 identifies and describes the recommended measures. Explanation and rationale regarding the CC's support for these measures follow.

### List 1. Measures/Concepts Recommended to the SUD Program Area

- **0004 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) (National Committee for Quality Assurance [NCQA])**
- **1654 TOB - 2 Tobacco Use Treatment Provided or Offered and the Subset Measure TOB-2a Tobacco Use Treatment (The Joint Commission)**
- **1656 TOB - 3 Tobacco Use Treatment Provided or Offered at Discharge and the subset measure TOB-3a Tobacco Use Treatment at Discharge (The Joint Commission)**
- **1661 SUB-1 Alcohol Use Screening (The Joint Commission)**
- **1663 SUB-2 Alcohol Use Brief Intervention Provided or Offered and SUB-2a Alcohol Use Brief Intervention (The Joint Commission)**
- **1664 SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge (The Joint Commission)**
- **2152 Preventive Care and Screening: Unhealthy Alcohol Use (American Medical Association-convened Physician Consortium for Performance Improvement [AMA-PCPI])**
- **2597 Substance Use Screening and Intervention Composite (Composite Measure) (American Society of Addiction Medicine [ASAM])**
- **2599 Alcohol Screening and Follow-Up for People with Serious Mental Illness (NCQA)**
- **2600 Tobacco Use Screening and Follow-Up for People with Serious Mental Illness or Alcohol or Other Drug Dependence (NCQA)**
- **2605 Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence (NCQA)**

- **2940 Use of Opioids at High Dosage in Persons Without Cancer (Pharmacy Quality Alliance [PQA)])**
- **2950 Use of Opioids from Multiple Providers in Persons Without Cancer (PQA)**
- **2951 Use of Opioids at High Dosages from Multiple Providers in Persons without Cancer (PQA)**
- **3225 (formerly #0028) Preventative Care and Screening: Tobacco Use: Screening and Cessation Intervention (AMA-PCPI)**
- **Adult Access to Preventive/Ambulatory Care 20-44, 45-64, 65+ (NCQA)**
- **Documentation of Signed Opioid Treatment Agreement (American Academy of Neurology)**
- **Evaluation or Interview for Risk of Opioid Misuse (American Academy of Neurology)**
- **Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA) (NCQA)**
- **Mental Health/Substance Abuse: Mean of Patients' Overall Change on the BASIS 24-Survey (Eisen, Susan V., PhD.)**
- **Percent of Patients Prescribed a Medication for Alcohol Use Disorder (ASAM)**
- **Percent Of Patients Prescribed a Medication for Opioid Use Disorders (OUD) (ASAM)**
- **The Percentage of Adolescents 12 to 20 Years of Age with a Primary Care Visit During the Measurement Year for Whom Tobacco Use Status Was Documented and Received Help with Quitting If Identified as a Tobacco User (NCQA)**
- **Annual Hepatitis C Virus (HCV) Screening for Patients Who Are Active Injection Drug Users (AMA-PCPI):** *Measure Concept*
- **Presence of Screening for Psychiatric Disorder (ASAM):** *Measure Concept*
- **Primary Care Visit Follow-Up (ASAM):** *Measure Concept*
- **Substance Use Disorders: Percentage of Patients Aged 18 Years and Older with a Diagnosis of Current Alcohol Dependence Who Were Counseled Regarding Psychosocial AND Pharmacologic Treatment Options for Alcohol Dependence Within the 12 Month Reporting Period (American Psychiatric Association [APA], NCQA, AMA-PCPI):** *Measure Concept*
- **Substance Use Disorders: Percentage of Patients Aged 18 Years and Older with a Diagnosis of Current Substance Abuse or Dependence Who Were Screened for Depression Within the 12-Month Reporting Period (APA, NCQA, AMA-PCPI):** *Measure Concept*
- **Substance Use Disorder Treatment Penetration (AOD) (Washington State Department of Social and Health Services):** *Measure Concept*

### 0004 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) (National Committee for Quality Assurance [NCQA])

NQF #0004 *Initiation and Engagement of Alcohol and Other Drug Dependence (IET)* examines the percentage of adolescent and adult patients with a new episode of alcohol or other drug dependence, who received initiation of alcohol and other drug (AOD) treatment through various care settings. The TEP noted that the measure is widely used, and the initiation of care that the measure addresses is an important need within the Medicaid population, CMS, and the SUD field. Additionally, the TEP noted that NQF #0004 offers a "quick" capture and treatment of alcohol and other drug dependence, as patients can have access to treatment within 14 days of diagnosis. The CC recommended the measure for inclusion in the Medicaid IAP SUD program. This measure is also included in the Medicaid Adult Core Set.

### 1654 TOB-2 Tobacco Use Treatment Provided or Offered and the Subset Measure TOB-2a Tobacco Use Treatment (The Joint Commission)

NQF #1654 *TOB-2 Tobacco Use Treatment Provided or Offered* and the subset measure*, TOB-2a Tobacco Use Treatment* includes two rates: (1) the rate of all hospitalized patients 18 and older to whom tobacco use treatment was provided or offered and refused and (2) the subset rate of those patients who received tobacco use treatment during their hospital stay. The CC recommended this measure, as it addresses the critical issue of tobacco use—a leading cause of preventable death in the United States. The Committee agreed that the care setting (hospital) and data source (EHRs) for the measure are key. The hospital setting could advantageously capture patients who may otherwise not receive care and who are potentially experiencing the negative consequences of their tobacco use. State agencies could easily capture data, since tobacco cessation counseling is billable, and it is captured in meaningful use in EHRs. This measure would therefore not pose a barrier to implementation and data collection. The CC recommended the measure for inclusion in the Medicaid IAP SUD program.

### 1656 TOB-3 Tobacco Use Treatment Provided or Offered at Discharge and the Subset Measure TOB-3a Tobacco Use Treatment at Discharge (The Joint Commission)

NQF #1656 *TOB-3 Tobacco Use Treatment Provided or Offered at Discharge* and the subset measure*, TOB-3a Tobacco Use Treatment at Discharge* focuses on two rates. The first rate captures hospitalized patients 18 years of age and older to whom tobacco use treatment was provided, or offered and refused, at the time of hospital discharge. The second rate captures the number of patients referred to evidence-based outpatient counseling who received a prescription for FDA-approved cessation medication at discharge. A subset of the first includes only those patients who received tobacco use treatment at discharge. Treatment at discharge includes a referral to outpatient counseling and a prescription for one of the FDA-approved tobacco cessation medications. The TEP noted that this measure substantially overlaps with the previous measure, NQF #1654. It is a part of a series of tobacco measures stewarded by The Joint Commission. NQF #1656 differs by focusing on services delivered at discharge. The CC agreed with the TEP's recommendation and supported inclusion in the Medicaid IAP SUD program.

### 1661 Sub-1 Alcohol Use Screening (The Joint Commission)

NQF #1661 *Sub-1 Alcohol Use Screening* assesses hospitalized patients 18 years of age and older who are screened within the first three days of admission using a validated screening questionnaire for unhealthy alcohol use. This measure is part of a set of four linked measures addressing substance use, two of which were also recommended: *Sub-2 Alcohol Use Brief Intervention Provided or Offered*; *Sub-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge*. While alcohol is less of a cost driver than tobacco, alcohol intervention generates proportionately greater cost reductions within the first year, due to reduced readmissions and a reduction in the complications for a patient with an alcohol use disorder.

### 1663 Sub-2 Alcohol Use Brief Intervention Provided or Offered and Sub-2a Alcohol Use Brief Intervention (The Joint Commission)

NQF #1663 *Sub-2 Alcohol Use Brief Intervention Provided or Offered and Sub-2a Alcohol Use Brief Intervention* focuses on all hospitalized patients 18 years of age and older to whom a brief intervention was provided, or offered and refused, and a second rate, a subset of the first, which includes only those patients who received a brief intervention. This measure is part of a set of four linked measures addressing substance use, two of which the CC also recommended: *Sub-1 Alcohol Use Screening*; *Sub-3 Alcohol and Other*

*Drug Use Disorder Treatment Provided or Offered at Discharge*. The TEP agreed that the measure addressed an important quality objective but noted that part 2a of the measure, which focuses on the provision of a brief intervention, is the most useful component. The TEP noted that the numerator, which includes patients who received or refused brief intervention, is confusing and seeks to measure two separate items at once.

### 1664 Sub-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge (The Joint Commission)

NQF #1664 *Sub-3 Alcohol and other Drug Use Disorder Treatment Provided or Offered at Discharge* focuses on all hospitalized patients 18 and older, for whom alcohol or drug use disorder treatment was provided, or offered and refused, at the time of hospital discharge. The second rate, a subset of the first, includes patients who received alcohol or drug use disorder treatment at discharge. This measure is part of a set of linked measures addressing substance use, two of which the CC also recommended: *Sub-1 Alcohol Use Screening*, *Sub-2 Alcohol Use Brief Intervention Provided or Offered*. This EHR measure assesses the offering of a prescription or referral. The TEP suggested that the measure would improve with claims data used to capture prescriptions filled rather than an EHR measure that captures prescriptions offered. However, only measure stewards can officially change measure specifications, which would then need to go through NQF's measure maintenance process. This measure exemplifies the need for more outcome measures for SUD measurement. Ultimately, the CC supported the measure because it would encourage physicians to consider medication assistance for substance use disorders and prevent the underuse of these treatments.

### 2152 Preventive Care and Screening: Unhealthy Alcohol Use (American Medical Association-convened Physician Consortium for Performance Improvement [AMA-PCPI])

NQF #2152 *Preventive Care and Screening: Unhealthy Alcohol Use* addresses the percentage of patients aged 18 years and older screened at least once within the last 24 months for unhealthy alcohol use using a systematic screening method, and who, received brief counseling if identified as an unhealthy alcohol user. One member of the TEP noted that the 24-month timeframe used in the measure could be problematic because some Medicaid recipients often do not have sustained enrollment for 24 months. The enrollment concerns extend to both enrollment in Medicaid and consistent enrollment in a single MCO, as both would affect the ability to measure the same patients over 24 months. However, other TEP members noted that the variability across state Medicaid programs could indicate that not all states face the same timeframe challenges. According to the TEP, the 24-month timeframe creates a two-year lag in the availability of the performance data, which prohibits rapid quality improvement. Ultimately, the TEP discussed the ability for the measure to continue to capture data on a patient across multiple providers within the two-year timeframe and decided that the measure addressed a critical quality issue. In addition, some members noted concern over screening the entire population, while other members noted the importance of screening all individuals, as previous research has shown a high number of hospitalizations related to substance use, specifically alcohol. Ultimately, the CC recommended the measure for inclusion in the Medicaid IAP SUD program.

### 2597 Substance Use Screening and Intervention Composite (American Society of Addiction Medicine [ASAM])

NQF #2597 *Substance Use Screening and Intervention Composite* focuses on the percentage of patients aged 18 years and older who were screened at least once within the last 24 months for tobacco use, unhealthy alcohol use, nonmedical prescription drug use, and illicit drug use and who received an intervention for all positive screening results. This measure received approval for trial use in 2015. Some members of the Expert Panel preferred this measure due to its comprehensive approach to screening and brief intervention (SBIRT). However, other members noted that the inclusion of both screening and intervention in one measure confounds these two different issues. In addition, the definition of illegal substances is likely to pose a challenge given variation across states, as marijuana is legal in some states but not others. Since some patients do not consider marijuana to be an illegal substance, they may underreport its use as well. Additionally, the CC noted concerns regarding the construct of the measure, such as multiple rates collected in the numerator. Despite these concerns, the CC supported the measure for inclusion in the Medicaid IAP SUD program.

### 2599 Alcohol Screening and Follow-Up for People with Serious Mental Illness (NCQA)

NQF #2599 *Alcohol Screening and Follow-Up for People with Serious Mental Illness* focuses on the percentage of patients 18 years and older with a serious mental illness, who were screened for unhealthy alcohol use and received brief counseling or other follow-up care if identified as an unhealthy alcohol user. The TEP emphasized that this measure focuses on a gap in care for high-risk populations who often do not seek or receive care that includes substance use screening because of their mental illness. The TEP noted that this measure was similar to the previously recommended measure, NQF #2152 *Preventative Care and Screening: Unhealthy Alcohol Use* and voiced concern over recommending too many measures with similar numerators and different denominators. The TEP warned that this could lead to redundant and misaligned measures, resulting in an inefficient use of resources. The TEP also noted that by having a measure that has a denominator that focuses on people with serious mental illness, states can decide to target this high-risk population and can compare disparities across states, which may not be available if states were to stratify a broader measure where variation among the states would limit comparison. The CC agreed with the TEP's recommendation and supported inclusion in the Medicaid IAP SUD program. This measure is also included in the recommended Medicaid IAP PMH program.

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

This measure focuses on the percentage of patients 18 years and older with a serious mental illness or alcohol or other drug dependence who received a screening for tobacco use and follow-up for those identified as a current tobacco user. The CC recommended this measure because it addresses a high-risk population similar to the previously reviewed NQF #2599 *Alcohol Screening and Follow-Up for People with Serious Mental Illness*. Using a measure with a specific denominator addressing the high-risk population allows for comparison across states with greater accuracy compared to measure stratification and subsequent comparison. This measure is also included in the recommended Medicaid IAP PMH program.

### 2605 Follow-Up After Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence (NCQA)

The CC supported NQF #2605 *Follow-Up After Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence.* This measure assesses the percentage of discharges for patients 18 and older who visited the emergency department

with a primary mental health or alcohol or other drug dependence diagnosis and who had a subsequent follow-up visit to any provider. The TEP unanimously agreed that the measure's focus on follow-up care addresses an important quality objective for states. This measure is important to health plans because it ensures follow-up care after an emergency department visit. The CC recommended this measure for inclusion in the SUD, BCN, and PMH programs supporting alignment across the program areas. This measure is included in the Medicaid Adult Core Set.

### 2940 Use of Opioids at High Dosages in Persons without Cancer (Pharmacy Quality Alliance [PQA])

NQF #2940 *Use of Opioids at High Dosages from Multiple Providers in Persons without Cancer* focuses on the proportion of individuals who do not have cancer and who received a daily opioid dosage of greater that 120mg for 90 consecutive days or longer. The TEP observed that the measure addressed a critical issue for the states. However, TEP members voiced concerns regarding the validity of the measure, especially given the different timeframes in the numerator and denominator. The CC agreed with the TEP's recommendation and supported its inclusion in the Medicaid IAP SUD program. This measure is also included in the Medicaid Adult Core Set.

### 2950 Use of Opioid from Multiple Providers in Persons Without Cancer (PQA)

NQF #2950 *Use of Opioid from Multiple Providers in Persons Without Cancer* measures the proportion of individuals who do not have cancer and who receive prescriptions for opioids from four or more prescribers and from four or more pharmacies. The CC supported this population measure because it addresses an important issue and provides an option for states to benchmark opioid prescriptions and track opioid prescription rates among multiple providers. However, the CC noted that the target rate for this measure is not 0 percent and that there is no clinical basis for what the target rate should be. The CC and the TEP warned of the unintended consequences associated with striving for such a result, which include underprescribing opioids in appropriate cases. Ultimately, the CC recommended the measure for inclusion in the Medicaid IAP SUD program.

### 2951 Use of Opioids at High Dosages from Multiple Providers in Persons Without Cancer (PQA)

NQF #2951 *Use of Opioids at High Dosages from Multiple Providers in Persons Without Cancer* focuses on the proportion of individuals, who do not have cancer, and who received prescriptions for daily opioid dosage of greater than 120mg for 90 consecutive days and who received opioid prescriptions from four or more prescribers and four or more pharmacies. The CC supported the measure because of the value it adds to addressing overprescribing, noting that the measure would be a helpful tool for states to identify plans with high number of over prescribers. This measure could be especially helpful in states with less advanced SUD efforts. The CC deliberations noted that the measure does not align with the CDC guidelines of a 90 mg daily dose of opioids. Additionally, members of the CC commented that the measure's approach to addressing SUD is irrelevant, since Medicaid programs already impose prescriber limits. However, the CC agreed that the measure addresses an important quality issue and recommended the measure for inclusion in the Medicaid IAP SUD program.

### 3225 (formerly #0028) Preventative Care and Screening: Tobacco Use: Screening and Cessation (AMA-PCPI)

NQF #3225 *Preventative Care and Screening: Tobacco Use: Screening and Cessation* assesses the percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months and who received cessation-counseling intervention if identified as

a tobacco user. The TEP noted the well-specified denominator and the critical quality issue that the measure addresses. The TEP suggested broadening the measure to include patients under the age of 18 as well as the use of other nicotine products including e-cigarettes. The CC agreed with the TEP's recommendation and supported inclusion in the Medicaid IAP SUD program.

### Adult Access to Preventive/Ambulatory Care 20-44, 45-64, 65+ (NCQA)

Adult Access to Preventative/Ambulatory Care 20-44, 45-64, 65+ assesses the percentage of people 20 years and older who had an ambulatory or preventive care visit during the measurement year or the two years prior to the measurement year. The CC supported this measure's inclusion in the SUD listing of measures, citing the importance of preventive care in addressing SUD. The CC also recommended this measure for inclusion in all four Medicaid IAP program areas, supporting alignment across program areas.

### Documentation of Signed Opioid Treatment Agreement (American Academy of Neurology)

The measure *Documentation of Signed Opioid Treatment Agreement* assesses all patients 18 and older prescribed opiates for longer than six weeks duration who signed an opioid treatment agreement at least once during opioid therapy documented in the medical record. The TEP noted that signing opioid treatment agreements is a standard best practice among providers, but is rarely reviewed and enforced as a standard of care. The TEP also noted that many electronic health records (EHRs) already include a standard opioid agreement that can be easily printed and signed. Capturing this measure through chart review can be expensive, but individual organizations can decide if the measure is feasible for them. The CC recommended the measure for inclusion in the Medicaid IAP SUD program.

### Evaluation or Interview for Risk of Opioid Misuse (American Academy of Neurology)

The CC supported the measure *Evaluation or Interview for Risk of Opioid Misuse*. This measure assesses all patients 18 and older prescribed opiates for longer than six weeks duration. This measure evaluates patients at risk of opioid misuse in one of the following two ways: using a brief validated instrument (e.g., Opioid Risk Tool, SOAAP-R) or a patient interview. Each evaluation method is documented at least once during opioid therapy in the medical record. The CC unanimously agreed this measure aligns with CDC's recommendation to use a validated tool for evaluating risk of opioid misuse. However, the CC expressed concern that the measure applies only to those in treatment for longer than six weeks rather than at day one. Ultimately, the CC recommended the measure for inclusion in the Medicaid IAP SUD program.

### Follow-Up after Emergency Department Visit for Alcohol and Other Drug Dependence (FUA) (NCQA)

*Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)* measures the percentage of ED visits for members 13 years of age and older with a primary diagnosis of AOD dependence, who had an outpatient visit, an intensive outpatient encounter, or a partial hospitalization for AOD. The CC noted that the measure addresses a key issue as many SUD individuals present initially in the emergency department and often do not receive follow-up care. The CC recommended the measure for inclusion in the Medicaid IAP SUD program as well as the BCN program, supporting alignment across program areas.

### Mental Health/Substance Abuse: Mean of Patients' Overall Change on the BASIS 24-Survey (Eisen, Susan V., PhD)

*Mental Health/Substance Abuse: Mean of Patients' Overall Change on the BASIS 24-Survey* assesses an individual's change in score on the BASIS-24® survey substance abuse subscale. Providers administer the survey at the beginning of a treatment episode with repeat assessments obtained at desired intervals to assess change during or following treatment. Members of the CC noted that the measure addresses a critical gap in SUD outcome measures. The CC voted to include this measure in the Medicaid IAP SUD program.

### Percent of Patients Prescribed a Medication for Alcohol Use Disorder (ASAM)

*Percent of Patients Prescribed a Medication for Alcohol Use Disorder* focuses on the number of patients receiving a medication for alcohol use disorder (AUD). The TEP noted the significant opportunity for improvement in this area as patients may not receive medications and pointed out that patients and families are generally unaware of their options. Some members of the TEP voiced concerns on the effectiveness of these medications for people with mild alcohol use disorders, but felt that the measure addressed an important gap in care. The CC discussed the measure's poorly defined numerator, which encompasses off-label use of medications. The CC noted that coverage decisions differ state to state—some states would not cover off-label use—and that the practice could potentially violate the False Claims Act 31 U.S.C. §§ 3729 - 3733. Some members did not share these concerns about off-label use, noting that evidence exists regarding the successful use of such drugs. Ultimately, the CC decided to recommend this measure for inclusion in the Medicaid IAP SUD program.

### Percent of Patients Prescribed a Medication for Opioid Use Disorders (OUD) (ASAM)

*Percent of Patients Prescribed a Medication for Opioid Use Disorders (OUD)* focuses on the number of patients receiving a medication for opioid use disorder. The TEP noted that this measure is of the highest importance to state Medicaid agencies and is of critical importance to providing high-quality care in the 21st century. During the CC's discussion of the measure, members noted that the states often lack the funds to address MAT. The CC also discussed limitations related to measure reporting, noting that this measure may be reportable at the state level but not the plan level. The CC also raised concerns that the measure did not require concomitant therapy with the prescription. The CC commented that MAT subscribers need case managers, care coordinators, and/or therapy services to reduce the risk of promoting prescribing practices without considering beneficial concomitant therapy. Finally, the TEP discussed the recurring theme of challenges presented in carve-out states where various aspects of MAT and/or the concomitant therapy may not be covered. Ultimately, the CC concluded that the measure addressed a critical quality issue and supported inclusion of the measure in the Medicaid IAP SUD program.

### The Percentage of Adolescents 12 to 20 Years of Age with a Primary Care Visit During the Measurement Year for Whom Tobacco Use Status Was Documented and Received Help with Quitting If Identified as a Tobacco User (NCQA)

This measure assesses the percentage of adolescents 12 to 20 years of age with a primary care visit for whom tobacco use status was documented and who received help with quitting if identified as a tobacco user. The CC supported this measure because it includes the adolescent population who are a significant driver of tobacco-related care cost and who often are not included from SUD measures because of their age. However, the CC noted that a comprehensive

measure would include other nicotine products and/or marijuana as well. The CC recommended the measure for inclusion in the Medicaid IAP SUD program.

### Annual Hepatitis C Virus (HCV) Screening for Patients Who Are Active Injection Drug Users (AMA-PCPI): Measure Concept

The measure concept *Annual Hepatitis C Virus (HCV) Screening for Patients who Are Active Injection Drug Users* focuses on the percentage of patients who are active injection drug users and received an HCV screening. The TEP discussed the lack of clarity with the measure concept's denominator and voiced concerns that the population may be under-represented in the measure. The TEP was also concerned that the measure did not include a systematic screening for HCV. The CC expressed concern that the measure did not address HIV as well. The CC also questioned reasons for not including similar HIV measures in the set. Some members of the TEP noted that HIV screening in this population is standard of care and does not present a quality gap. However, the CC noted the urgent need for similar measures that address HIV in this population as well as the preference for combined HIV and HCV screening measures. Ultimately, the CC agreed that this measure concept addressed an important quality issue and supported the measure concept's inclusion in the Medicaid IAP SUD program.

### Primary Care Visit Follow-Up (ASAM): Measure Concept

The measure concept *Primary Care Visit Follow-Up* addresses the proportion of individuals who have a primary care visit following an SUD treatment encounter. The TEP noted that the measure provides discharge planning and continuity of care after detox. Together, these components create a strategy to hold the care team accountable and to get individuals back into the primary care setting. The TEP noted that the referral to primary care is currently a focus area for improvement and could reduce the use of emergency services by connecting patients with primary care providers. This measure applies to all ages and is not limited to those 18 and older. The TEP voiced concerns on the six-month timeframe and felt that the follow-up time should be one to two months. The CC supported the measure concept for inclusion in the Medicaid IAP SUD program.

### Presence of Screening for Psychiatric Disorder (ASAM): Measure Concept

The measure concept *Presence of Screening for Psychiatric* Disorder assesses the number of patients with an SUD diagnosis receiving addiction treatment assessed for a psychiatric diagnosis. The CC recommended this measure concept because it addressed screening for co-morbid psychiatric conditions, which can often increase difficulties with childhood treatment, adherence to treatment, and other medical problems.

### Substance Use Disorder Treatment Penetration (AOD) (Washington State Department of Social and Health Services): Measure Concept

The measure concept *Substance Use Disorder Treatment Penetration (AOD)* assesses the percentage of individuals with a substance use disorder who received SUD treatment. The TEP discussed the measure's denominator, noting that it needs clarification and further refinement. However, the TEP agreed that the measure focuses on a very important issue in substance use, i.e., addressing the lack of treatment for substance use disorders. The TEP stated that this measure could help to advance and expedite SUD treatment. The CC agreed with the TEP's recommendation and supported inclusion in the Medicaid IAP SUD program.

### Substance Use Disorders: Percentage of Patients Aged 18 Years and Older with a Diagnosis of Current Alcohol Dependence Who Were Counseled Regarding Psychosocial AND Pharmacologic Treatment Options for Alcohol Dependence Within the 12 Month Reporting Period (American Psychiatric Association, NCQA, PCPI): Measure Concept

This measure concept assesses the percentage of patients 18 and older who have a current alcohol dependence diagnosis and who received counseling regarding psychosocial and pharmacologic treatment options for their alcohol dependence. The CC recognized the importance of the concept and recommended it for inclusion even though the concept lacked clear specifications, such as a clear denominator definition. In addition, the measure timeframe as defined in the concept is 12 months, which the CC agreed should be an immediate timeframe (i.e., a week or a month). The TEP also noted that the concept could also measure whether a patient remembers receiving the counseling and not whether there was counseling.

### Substance Use Disorders: Percentage of Patients Aged 18 Years and Older with a Diagnosis of Current Substance Abuse or Dependence Who Were Screened for Depression Within the 12 Month Reporting Period (American Psychiatric Association, CQA, PCPI): Measure Concept

This concept measures the percentage of patients 18 and older who have a current diagnosis of substance abuse or dependence and who received a depression screening in the past 12 months. The CC supported this concept noting that the recognition of dual diagnosis as an important practice that should be standard of care. However, they also acknowledged that chart reviews required by the measure might not offer the most efficient use of resources. The CC agreed with the TEP's recommendation and supported inclusion in the Medicaid IAP SUD program.

## Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs

Medicaid beneficiaries with complex care needs use high levels of costly but preventable services.[22] This subpopulation within Medicaid is an extremely heterogeneous group with varying medical, behavioral, and psychosocial needs. While patients with complex care needs may be a relatively small portion of the Medicaid population, they account for a significant amount of Medicaid expenditures. In Medicaid, 5 percent of beneficiaries account for 54 percent of total Medicaid expenditures, and 1 percent of beneficiaries account for 25 percent of total Medicaid expenditures.[23] Within this 1 percent of Medicaid beneficiaries, 83 percent have at least three chronic conditions and more than 60 percent have five or more chronic conditions.[24]

Medicaid beneficiaries with complex care needs have approximately four times as many hospital stays per year as compared with other patients.[25] Congestive heart failure, COPD, and diabetes-related complications account for three of the top reasons for hospitalizations among high-need individuals.[26]

To address these high-need individuals, programs across the country currently implement innovative models and systems of care, such as Accountable Care Organizations (ACOs) and Medicaid health homes, with the goals of improving the health and containing the healthcare costs of Medicaid beneficiaries with complex needs.[27] Nevertheless, addressing the health needs of this population presents difficulties. For instance, variations in design, focus, and setting among care management interventions make comparisons challenging. As a result, the literature has not identified best practices for wide implementation.[28]

Furthermore, available measures that address complex care issues are often not comprehensive or focus on condition-specific needs. Additionally, the costs associated with complex care patients

underscore the need to improve their care delivery, coordination, and connection to various support services. Many institutions, including NQF, addressed this issue conceptually. NQF developed a multiple chronic conditions measurement framework in 2012.[29]

The CC recommended 18 measures and one measure concept for the Medicaid IAP BCN program area (List 2). Safety (e.g., readmissions) and care coordination measures predominate in the BCN portfolio. The CC discussed several gap areas in measurement critical to the BCN population, including the lack of measures focusing on access and patient engagement. Although there is one access measure, there is a need for additional measures that focus on primary and preventive care for high-need populations. Providing high-need beneficiaries with greater access to primary healthcare services could mitigate potentially preventable interactions with the healthcare system. There is also a lack of patient engagement measures. These measures address the whole person and focus on nonclinical indicators. CC members identified these types of measures as particularly important to the BCN population as they may increase patient satisfaction and improve care outcomes. Finally, the CC noted a lack of measures targeting pediatric, high-cost, complex patients. One CC member noted that high-need pediatric patients often disengage from the health system and resurface in emergency settings with exacerbated physical or mental health conditions. Measures targeting pediatric, high-need patients could provide insight on how children transition to adult care and highlight opportunities to address patients' disengagement from the health system.

The CC considered both parsimony and alignment when recommending measures. The recommended measures promote measurement of a variety of high-priority issues, including care utilization, follow-up care, and medication reconciliation. Further explanation and rationale regarding the CC's support for these measures follow.

### List 2. Measures/Concepts Recommended to the BCN Program Area

- **0097 Medication Reconciliation Post-Discharge (NCQA)**
- **0105 Antidepressant Medication Management (AMM) (NCQA)**
- **0576 Follow-Up After Hospitalization for Mental Illness (FUH) (NCQA)**
- **0709 Proportion of Patients with a Chronic Condition That Have a Potentially Avoidable Complication During a Calendar Year (Altarum Institute)**
- **1598 Total Resource Use Population-Based PMPM Index (HealthPartners)**
- **1604 Total Cost of Care Population-Based PMPM Index (HealthPartners)**
- **1768 Plan All-Cause Readmissions (PCR) (NCQA)**
- **2371 Annual Monitoring for Patients on Persistent Medications (MPM) (NCQA)**
- **2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient (Brigham and Women's Hospital)**
- **2483 Gains in Patient Activation (PAM) Scores at 12 Months (Insignia Health)**
- **2605 Follow-Up After Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence (NCQA)**
- **Adult Access to Preventive/Ambulatory Care 20-44, 45-64, 65+ (NCQA)**
- **Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA) (NCQA)**
- **Medication Reconciliation Post-Discharge: Percentage of Discharges from January 1 to December 1 of the Measurement Year for Members 18 Years of Age and Older for Whom**

**Medications Were Reconciled the Date of Discharge Through 30 Days After Discharge (31 total days) (NCQA)**

- **Potentially Preventable Emergency Room Visits (3M)**
- **Potentially Preventable Readmissions (3M)**
- **Prevention Quality Indicators #90 (PQI #90) (AHRQ)**
- **Psychiatric Inpatient Readmissions – Medicaid (PCR-P) (Washington State Department of Social and Health Services)**
- **Potentially Preventable Emergency Room Visits (for Persons with BH diagnosis) (3M):** *Measure Concept*

### 0097 Medication Reconciliation Post-Discharge (NCQA)

NQF #0097 *Measure of Medication Reconciliation Post-Discharge* assesses the percentage of adult discharges for which a clinician reconciled the discharge medication list with the current medication list in the outpatient medical record. TEP members identified the practice of medication reconciliation as a critical concept for the BCN population. The CC provided no additional comments or objections and supported the measure's inclusion in the Medicaid IAP BCN program area. The CC also recommended this measure for inclusion in the Medicaid IAP CI-LTSS and PMH program areas.

### 0105 Antidepressant Medication Management (AMM) (NCQA)

NQF #0105 *Antidepressant Medication Management (AMM)* assesses the percentage of adult patients with a diagnosis of major depression, newly treated with antidepressant medication and, who remained on an antidepressant medication treatment. TEP members expressed concern about a single diagnosis in the measure specifications as well as the phrasing, "newly treated with an antidepressant medication," due to difficulties capturing those "newly treated" in the BCN population. Ultimately, TEP members noted that the measure is included in the HEDIS measure set and is widely reported by states, therefore measure reporting feasibility is not an issue. NQF #0105 is included in the 2017 Medicaid Adult Core Set. The CC recommended this measure for inclusion in the Medicaid IAP BCN program area as well as the PMH program area. Public comment noted that NCQA added telehealth modifiers to the numerator in HEDIS 2018, which may be useful information to states with mental or behavioral health access issues.

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

NQF #0576 *Follow-Up After Hospitalization for Mental Illness (FUH)* measures the percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of designated mental illness diagnoses and who had a follow-up visit with a mental health practitioner. This measure has two rates reported at varying post-discharge timeframes. One issue with this measure is that it does not account for patients who move from an inpatient to a residential setting. The CC supported this measure, as it could be potentially valuable for states with inadequate behavioral health networks because it could highlight deficiencies or critical issues. Exclusion of the measure from the Medicaid IAP BCN program area would create a critical gap. The CC recommended this measure for inclusion in the Medicaid IAP BCN program area. NQF #0576 is included in the 2017 Medicaid Adult and Child Core Sets. The CC also recommended this measure for inclusion in the Medicaid IAP PMH program area. Public comment noted that NCQA added telehealth modifiers to the numerator in HEDIS 2018, which may be useful information to states with mental or behavioral health access issues.

### 0709 Proportion of Patients with a Chronic Condition That Have a Potentially Avoidable Complication During a Calendar Year (Altarum Institute)

The CC supported NQF #0709 *Proportion of Patients with a Chronic Condition That Have a Potentially Avoidable Complication During a Calendar Year*. This measure evaluates the percent of adults identified as having at least one of six defined chronic conditions, followed for a minimum of one year, and having one or more potentially avoidable complications (PACs) in the prior 12 months. NQF #0709 is a measure that specifically addresses the Medicaid BCN population and is ready for implementation. The CC recommended this measure for inclusion in the Medicaid IAP BCN program area.

### 1598 Total Resource Use Population-Based PMPM Index (HealthPartners)
### 1604 Total Cost of Care Population-Based PMPM Index (HealthPartners)

NQF #1598 *Total Resource Use Population-Based PMPM Index* is a risk-adjusted measure of the frequency and intensity of services used to manage a provider group's patients. Alternately, NQF #1604 *Total Cost of Care Population-Based PMPM Index* reflects a mix of complicated factors such as patient illness burden, service utilization, and negotiated prices. TEP members suggested that if reported separately, neither NQF #1598 nor NQF #1604 would provide a complete picture of quality on their individual merits. In order to maximize the potential reporting benefits, the TEP proposed the reporting of both together. The CC agreed that it would be beneficial if both measures were in use and reported at the same time in the Medicaid IAP BCN program area. The CC recommended this measure for inclusion in the Medicaid IAP BCN program area.

### 1768 Plan All-Cause Readmissions (PCR) (NCQA)

NQF #1768 *Plan All-Cause Readmissions (PCR)* assesses the number of adult patients' acute inpatient stays during the measurement year followed by any unplanned acute readmission within 30 days and the predicted probability of an acute readmission. One CC member voiced a concern that this measure may not capture multiple hospitalizations at different hospitals if it measures readmissions at the hospital level instead of the plan level. NQF #1768 is included in the 2017 Medicaid Adult Core Set. The CC supported this measure's inclusion in the Medicaid IAP BCN program area.

### 2371 Annual Monitoring for Patients on Persistent Medications (MPM) (NCQA)

NQF #2371 *Annual Monitoring for Patients on Persistent Medications (MPM)* assesses the percentage of adult patients who received at least 180 treatment days of ambulatory medication therapy for a therapeutic agent during the measurement year and at least one therapeutic monitoring event for the specified agent during the measurement year. The CC recommended this measure because the measure captures important aspects of care for Medicaid beneficiaries with complex care needs and high costs. NQF #2371 is included in the 2017 Medicaid Adult Core Set. The CC recommended this measure for inclusion in the Medicaid IAP BCN program area.

### 2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient (Brigham and Women's Hospital)

NQF #2456 *Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient* assesses the actual quality of the medication reconciliation process by identifying errors at admission and discharge due to problems with the medication reconciliation process. The CC recommended this measure because it establishes the 'gold standard' of medication reconciliation due to the measure's ability to identify who is

responsible and delineating which action should be taken. Additionally, the measure could incentivize emergency departments to use continuity-of-care documents (CCD). The CC acknowledged potential challenges in extracting data.

### 2483 Gains in Patient Activation (PAM) Scores at 12 Months (Insignia Health)

NQF #2483 *Gains in Patient Activation (PAM) Scores at 12 Months* is a 10- or 13-item questionnaire that assesses individuals' knowledge, skill, and confidence for managing their health and healthcare. The measure assesses individuals on a 0-100 scale. Additionally, CC members identified patient engagement as a critical quality gap, particularly for the BCN population. The CC recommended NQF #2483 for inclusion in the Medicaid IAP BCN program area for the following reasons: the measure is patient-focused; it is an outcome measure, which increases the diversity of measures in a portfolio that has many process measures; and the measure is important to stakeholders. However, CC members emphasized the importance of appropriately training clinicians to administer the questionnaire. One CC member noted that the implementation experience at the state level and in plan-led or provider-led programs had mixed feedback for vulnerable populations. The CC also recognized the cost associated with these measures, thus creating a barrier and decreasing its reporting feasibility. However, the CC recommended this measure for inclusion in the Medicaid IAP BCN program area. The CC also recommended the measure for the Medicaid IAP CI-LTSS program area.

Public comment generated significant discussion regarding the recommendation to include the PAM measure in both the BCN and CI-LTSS program areas. Comments reflected the CC's discussion of the measure. CC members noted both favorable and unfavorable experience implementing PAM. Those in favor noted benefits to using the measure, including increased patient activation leading to improved health outcomes. Those who discussed less favorable experiences noted challenges implementing PAM. Members also discussed the cost of using the PAM as a possible deterrent to use while others suggested that it is not a mandate and some have factored the value of this measure into the cost. Several members discussed the issue of literacy as a problem noting that it may be a barrier in obtaining valid results. Others suggested that there is not enough research and historical use at this time to confirm that literacy is a problem. Ultimately, after discussing public comments, the CC moved forward with the recommendation to include the measure in both BCN and CI-LTSS. The CC noted the PAM is one measure of a list of measures. The measure is important, as it is a patient-centered, outcome measure.

### 2605 Follow-Up after Emergency Department Visit for Mental Illness or Alcohol and Other Drug Dependence (NCQA)

NQF #2605 assesses the percentage of discharges for adults, with an emergency department visit, with a primary diagnosis of mental illness or alcohol or other drug dependence during the measurement year who had a follow-up visit with a provider with a corresponding primary diagnosis of mental illness or alcohol or other drug dependence within 7 to 30 days of discharge. NQF #2605 is similar to *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)* and NQF #0576 *Follow-Up After Hospitalization for Mental Illness (FUH)*. The CC recommended NQF #2605 as the stronger measure because it encompasses both mental health and substance use. This measure uses claims data, thereby increasing implementation feasibility. The CC recommended this measure for inclusion in the Medicaid IAP BCN program area. NQF #2605 is included in the 2017 Medicaid Adult Core Set. The CC also recommended this measure for the Medicaid IAP SUD and PMH program areas.

### Adult Access to Preventative/Ambulatory Care 20-44, 45-64, 65+ (NCQA)

The CC supported the inclusion of *Adult Access to Preventative/Ambulatory Care 20-44, 45-64, 65+*, noting the importance of this measure as a proxy for whether people can get access to necessary care. This measure assesses the percentage of members 20 years and older who had an ambulatory or preventive care visit. The CC recommended this measure for inclusion in the Medicaid IAP BCN program area to address the scarcity of access measures in the portfolio. The CC acknowledged that the measure's broad denominator definition could hinder its ability to catalyze significant performance improvement year to year. The CC recommended this measure for inclusion in the Medicaid IAP BCN program area as well as the CI-LTSS, SUD, and PMH program areas. The measure's inclusion in multiple program areas contributes to alignment.

### Follow-Up after Emergency Department Visit for Alcohol and Other Drug Dependence (FUA) (NCQA)

*Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)* assesses the percentage of emergency department (ED) visits for members 13 years of age and older with a primary diagnosis of alcohol or other drug (AOD) dependence, who had an outpatient visit, an intensive outpatient encounter, or a partial hospitalization for AOD. Substance abuse is a critical issue among the Medicaid BCN population. The identification of SUD frequently occurs in the emergency department; however, subsequent treatment is inconsistent. The CC recommended this measure for the Medicaid IAP BCN and SUD program areas.

### Medication reconciliation post-discharge: percentage of discharges from January 1 to December 1 of the measurement year for members 18 years of age and older for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days) (NCQA)

This measure assesses the percentage of discharges from January 1 to December 1 of the measurement year for members 18 years of age and older for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days). The CC recommended this measure for inclusion in the Medicaid IAP BCN program area because it would give providers consistency in reporting while also aligning with Medicare. This measure addresses the BCN population and is important to key stakeholders.

### Potentially Preventable Emergency Room Visits (3M) Potentially Preventable Readmissions (3M) Potentially Preventable Emergency Room Visits (for persons with BH diagnosis) (3M): Measure Concept

TEP members were familiar with the suite of 3M measures because they are widely used across states, but due to proprietary restrictions, TEP members were unable to evaluate the detailed specifications. Publically available 3M materials indicate that potentially preventable emergency room visits and readmissions are designated as such when clinical action or inaction occurs leading to an avoidable emergency visit or readmission.[30,31] The TEP also noted that many Medicaid pay-for-value programs use the measures. The CC recommended all three measures for inclusion in the Medicaid IAP BCN program area.

### Prevention Quality Indicators #90 (PQI #90) (AHRQ)

*Prevention Quality Indicators (PQI)* is an overall composite per 100,000 population, targeting individuals ages 18 years and older. The measure includes admissions for one of 12 conditions. This measure is currently used in California's 1115 Medicaid waiver program as a pay-for-performance measure across all public hospital systems, both for complex care management intervention as well as intervention more broadly. The CC recommended PQI #90 because it is an actionable measure that address avoidable admissions.

### Psychiatric Inpatient Readmissions – Medicaid (PCR-P) (Washington State Department of Social and Health Services)

*Psychiatric Inpatient Readmissions – Medicaid (PCR-P)* assesses the proportion of acute inpatient psychiatric stays for adults during the measurement year followed by an acute psychiatric readmission within 30 days. The CC recommended this measure because it addresses an opportunity for improvement. Readmissions for this measure's target cohort are particularly high and potentially mitigated with enhanced care coordination.

## Promoting Community Integration Through Long-Term Services and Supports

Community Integration through Long-Term Services and Supports empowers millions of Americans to live meaningful lives in the community of their choice. CI-LTSS services include daily self-care activities (e.g., walking, bathing, and dressing), medication management, food preparation, transportation, employment, and other activities that support community living provided by paid and unpaid individuals and caregivers. Individuals who use CI-LTSS require these services due to disability, mental illness, and/or multiple chronic conditions. Medicaid is the primary payer for institutional LTSS and CI-LTSS.[32] Approximately 4.8 million Medicaid beneficiaries received CI-LTSS in 2011.[33] Specifically, people with CI-LTSS needs account for about one-third of all Medicaid expenditures.[34] Total federal and state CI-LTSS spending was $158 billion in FY2015; including $87 billion for home and community-based services (HCBS).[35] In the future, these expenditures may grow in concert with demand, with growth specifically occurring within HCBS. [36]

Throughout the project, CC members acknowledged and supported recent measure development in the field and strongly encouraged further development of measures. The 10 measures and four concepts recommended in this project address four of the six CMS quality domains—one measure in access, five measures in care coordination, two in clinical care, and five in patient and caregiver experience. Significant gaps remain in many areas, including care plans and lack of care plan delivery, choice and control, delivery of services, and workforce shortage.

A few themes emerged as the CC discussed the lack of available measures for consideration and use. The CC discussed the diversity within the CI-LTSS population. This population represents a variety of conditions and healthcare needs. Among those who use CI-LTSS are elderly and nonelderly individuals who have intellectual and developmental disabilities, behavioral health diagnoses, physical disabilities, spinal cord or traumatic brain injury (TBI), and/or disabling chronic conditions. In addition to these conditions, other social factors, such as a beneficiary's age, living arrangement, disability status, gender, socioeconomic status, etc., can affect the type of long-term care needed as well as the appropriate duration of care.[37] Each of these populations would benefit from measures that account for their individual characteristics and significant differences. Furthermore, medical measures are often adapted for people in the CI-LTSS community. While these measures address the medical component of health, they do not address issues such as quality of life, community

integration, and rebalancing. Given the state of measurement for CI-LTSS, the CC recognized the challenge of developing measures that meet the needs of such a diverse population without established standards of practice and/or language.

The CC recommended 10 measures and four concepts for the Medicaid IAP CI-LTSS program area (List 3). The CC considered both parsimony and alignment when recommending measures. The recommended measures would result in a strong list by promoting measurement of a variety of high-priority issues, including quality of services, access to care, and medication reconciliation. Further explanation and rationale regarding the CC's support for these measures follow.

### List 3. Measures/Concepts Recommended to the CI-LTSS Program Area

- **0097 Medication Reconciliation Post-Discharge (NCQA)**
- **0101 Falls: Screening for Fall Risk (NCQA)**
- **0326 Advance Care Plan (NCQA)**
- **0419 Documentation of Current Medications in the Medical Record (CMS)**
- **0647 Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) (PCPI)**
- **2483 Gains in Patient Activation (PAM) Scores at 12 Months (Insignia Health)**
- **2967 CAHPS® Home and Community Based Services (HCBS) Measures (CMS)**
- **Adult Access to Preventive/Ambulatory Care 20-44, 45-64, 65+ (NCQA)**
- **Home- and Community-Based Long Term Services and Supports Use Measure Definition (HCBS) (Washington State Department of Social and Health Services)**
- **Percentage of Short-Stay Residents Who Were Successfully Discharged to the Community (CMS)**
- **Individualized Plan of Care Completed:** *Measure Concept*
- **National Core Indicators (Human Services Research Institute [HSRI] and The National Association of State Directors of Developmental Disabilities Services [NASDDDS]):** *Measure Concept*
- **National Core Indicators – Aging and Disability (Human Services Research Institute [HSRI] and The National Association of State Directors of Developmental Disabilities Services [NASDDDS]):** *Measure Concept*
- **Number and Percent of Waiver Participants Who Had Assessments Completed by the MCO That Included Physical, Behavioral, and Functional Components to Determine the Member's Needs:** *Measure Concept*

#### 0097 Measure of Medication Reconciliation (NCQA)

This is one of two medication reconciliation measures supported for inclusion in the CI-LTSS measure set. The measure assesses the percentage of discharges for patients 18 years of age and older for whom the discharge medication list was reconciled with the current medication list in the outpatient medical record by a prescribing practitioner, clinical pharmacist, or registered nurse. The denominator measures discharges from an inpatient facility. The CC noted the challenge CI-LTSS providers have when trying to access clinical records. Ultimately, the CC voted to support this measure despite the challenges in the use of the measure. The CC recommended this measure for the BCN and PMH program areas.

#### 0101 Falls: Screening for Fall Risk (NCQA)

The CC noted that the change in function and balance at age 65 and over could be significant

regardless of psychosocial barriers. Falls can make a difference between admission to a nursing home versus staying in the community. NQF #0101 is a process measure that assesses fall prevention in older adults. This measure has three rates: (1) screening for future fall risk; (2) falls risk assessment; and (3) plan of care for falls. The CC recommended this measure for the Medicaid IAP CI-LTSS program.

### 0326 Advance Care Plan (NCQA)

This measure assesses the percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record, or documentation in the medical record that an advance care plan was discussed, but the patient did not wish or was not able to name a surrogate decision maker, or provide an advance care plan. The CC noted that this measure is consistent with person-centered care. The CC agreed that this measure helps high-risk elderly (65+) individuals maintain personal choice, so they can remain in their home/community. Therefore, the CC recommended this measure for the Medicaid IAP CI-LTSS program.

### 0419 Documentation of Current Medications in the Medical Record (CMS)

This is one of two medication reconciliation measures supported for inclusion in the CI-LTSS measure set. This measure assesses the percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. The denominator of this measure includes eligible outpatient individuals already in the community. The CC agreed that this measure includes a broader approach to medication reconciliation and reflects the state of practice in home health. This measure is also included in the Family of Measures for Dual Eligible Beneficiaries. The CC recommended this measure for inclusion in the CI-LTSS as well as the PMH program area.

### 0647 Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) (PCPI)

This measure assesses the transmission of transition record to a patient's primary care physician or other healthcare professional within 24 hours of discharge from an inpatient facility. This measure intends to improve the continuity of care and reduce hospital readmissions by ensuring that the patient's discharge information is available at the first post-discharge physician visit. The CC noted that it is critically important that all providers, family members, and community supports have information (e.g., inpatient care, post-discharge/patient self-management, etc.) to start appropriate care upon discharge.

The Consensus Standards Approval Committee (CSAC) in July 2017 voted to remove endorsement from NQF #0647 due to a lack of current performance data and because the testing during measure development only used data from one site's EHR. Ultimately, the CC voted to recommend this measure for the Medicaid IAP CI-LTSS program for the reasons noted above.

### 2483 Gains in Patient Activation (PAM) Scores at 12 Months (Insignia Health)

The CC supported the inclusion of NQF #2483. The Patient Activation Measure® (PAM®) is a 10- or 13-item questionnaire that assesses individuals' knowledge, skill, and confidence for managing their health and healthcare. The measure assesses individuals on a 0-100 scale. The change score would indicate a change in the patient´s knowledge, skills, and confidence for self-management. This measure addresses the effectiveness of providers in engaging and activating individuals to take an active role in their health and healthcare. One of the goals of CI-LTSS is educating and activating individuals, giving them the tools they need to take control. The CC also recommended this measure for the BCN program area. Inclusion of the measure in multiple program areas supports alignment.

Public comment generated significant discussion regarding the recommendation to include the PAM measure in both the BCN and CI-LTSS program areas. Comments reflected the CC's discussion of the measure. CC members noted both favorable and unfavorable experience implementing PAM. Those in favor noted benefits to using the measure, including increased patient activation leading to improved health outcomes. Those who discussed less favorable experiences noted challenges implementing PAM. Members also discussed the cost of using the PAM as a possible deterrent to use while others suggested that that it is not a mandate and some have factored the value of this measure into the cost. Several members discussed the issue of literacy as a problem noting that it may be a barrier in obtaining valid results. Others suggested that there is not enough research and historical use at this time to confirm that literacy is a problem. Ultimately, after discussing public comments the CC moved forward with the recommendation to include the measure in both BCN and CI-LTSS. The CC noted the PAM is one measure of a list of measures. The measure is important, as it is a patient-centered, outcome measure.

### 2967 CAHPS® Home and Community Based Services (HCBS) Measures (CMS)

The CAHPS® Home and Community Based Services (HCBS) Measures elicit feedback from adult Medicaid beneficiaries receiving home and HCBS about the quality of the long-term services and supports they receive in the community and delivered to them under the auspices of a state Medicaid HCBS program. The CC supported the inclusion of this measure for several reasons. First, this measure is part of a suite of CAHPS surveys. States have accepted and have experience implementing CAHPS surveys. Second, it is one of the first tools with performance measures to assess HCBS quality from the perspective of the individuals receiving support. Third, it focuses on supports needed to live independently, instead of many current measures adapted from clinical and medical care. In addition, NQF's MAP Medicaid Adult Taskforce supported this measure for inclusion in the 2018 Adult Core Set. If CMS adds this measure to the CI-LTSS program area and the Adult Core Set, there would be alignment between the various programs and corresponding measure set.

### Adult Access to Preventative/Ambulatory Care 20-44, 45-64, 65+ (NCQA)

The CC supported the inclusion of this measure, and noted the importance of this measure as a proxy for whether people can get to necessary care. This measure assesses the percentage of members 20 years and older who had an ambulatory or preventive care visit. From the CI-LTSS perspective, this measure could be a proxy for whether people have transportation and capacity to reach care or available services. The CC recommended this measure for the Medicaid IAP BCN, SUD, and PMH programs. Inclusion of the measure in multiple program areas supports the concept of measurement alignment.

### Home- and Community Based Long Term Services and Supports Use Measure Definition (HCBS) (Washington State Department of Social and Health Services)

This measure assesses the proportion of months receiving long-term services and supports (LTSS) associated with receipt of services in home and community-based settings during the measurement year. The CI-LTSS TEP agreed that this is a good measure for assessing states' rebalancing efforts, but it is not a quality measure. Rebalancing in the CI-LTSS field is very important because it addresses states' efforts to move people from institutional settings to community settings. Due to the nascence of CI-LTSS measurement, it is important for a state to capture and understand the performance of its CI-LTSS program. Therefore, the CC supports the inclusion of this measure.

### Percentage of Short-Stay Residents Who Were Successfully Discharged to the Community (CMS)

This measure assesses the percentage of all new admissions to a nursing home from a hospital for short-stay residents discharged to the community within 100 calendar days of entry and for 30 subsequent days, did not die, were not admitted to a hospital for an unplanned inpatient stay, and were not readmitted to a nursing home. The CC supported this measure for inclusion as a rebalancing measure. Although, the denominator includes only Medicare fee-for-service and not Medicaid, the CC noted that Medicaid waiver programs can broaden the definition of the denominator. The managed care plans are responsible for all individuals in the plan, including Medicare Advantage, fee-for-service, or Medicaid.

### Individualized Plan of Care Completed: Measure Concept

The CI-LTSS TEP acknowledged the *Individualized Plan of Care Completed* (IPC) as a good measure concept with the potential for implementation, after there is further development with detailed specifications. This measure concept assesses those with high-risk score who have an individual plan of care (IPC). The CC noted that the specifications of the concept lack clarity. Therefore, it was difficult to determine if the IPC is synonymous with a person-centered plan. The CC recommended clarifying measure specifications and defining IPC. The TEP and the CC agreed that the CI-LTSS populations benefit from care plans that are person-centered and person-driven and/or caregiver-driven based on the preferences, goals, and values of the individual. This measure applies to all populations in Medicaid. Ultimately, the CC supported the measure concept for inclusion in the Medicaid IAP CI-LTSS program.

### National Core Indicators (NCI) (HSRI and NASDDDS): Measure Concept

The NCI survey provides states with information about the experiences of adults with intellectual and developmental disabilities receiving publicly funded services and supports. Currently, the survey is in use in 46 states plus the District of Columbia. The Administration for Community Living has provided grant funding to the stewards of the NCI and NCI-AD measures. The funding supports the stewards' pursuit of NQF endorsement for at least 20 Patient Reported Outcome-Performance Measures (PRO-PMs) from the NCI Adult Consumer Survey (ACS) and NCI-AD ACS over the next three years. The CC supported inclusion of this measure concept because it focuses on elements important to quality of life. The NCI addresses individuals with intellectual and developmental disabilities.

### National Core Indicators – Aging and Disability (NCI-AD) (HSRI and NASDDDS): Measure Concept

The NCI-AD survey measures approximately 50 "indicators" of outcomes of CI-LTSS for older adults and adults with physical and other disabilities, excluding adults with intellectual disability/developmental disability (ID/DD). The CC agreed that the survey focuses on elements related to quality of life, which is critically important to the disability and aging populations. Currently, 14 states use this survey. The Administration for Community Living has provided grant funding to the stewards of the NCI and NCI-AD measures. The funding supports the stewards' pursuit of NQF endorsement for at least 20 PRO-PMs from the NCI ACS and NCI-AD ACS over the next three years. The CC recommended this measure concept for inclusion in the Medicaid IAP CI-LTSS program.

### Number and Percent of Waiver Participants Who Had Assessments Completed by the MCO That Included Physical, Behavioral, and Functional Components to Determine the Member's Needs: Measure Concept

This measure concept requires physical, mental, and psychosocial considerations in the assessment done by a managed care organization. The TEP members agreed that this assessment should inform the development of the care plan once the person's needs are considered. The measure concept is in use in multiple states including Kansas. The CC supported this measure concept for inclusion as it screens for physical, behavioral, and functional status—all critical components for the CI-LTSS population.

## Supporting Physical and Mental Health Integration

In 2015, 20 percent of Medicaid enrollees lived with a diagnosed mental health condition or substance use disorder. According to a 2015 Government Accountability Office publication, these beneficiaries accounted for a disproportionate share of Medicaid expenditures.[38] Over half of the Medicaid-only enrollees in the top 5 percent of expenditures had a mental health condition, and one-fifth had a substance use disorder. Individuals with mood disorders or schizophrenia and other psychotic disorders represented the top two most common diagnoses for re-hospitalizations among Medicaid beneficiaries.[39]

Currently, numerous barriers impede the integration of physical and mental health services throughout the healthcare system. For instance, states often limit the number of reimbursable visits to one type of care per day, i.e., either a mental health or physical health visit, which makes it difficult for providers to provide comprehensive care within a specific visit.[40]

Furthermore, workforce shortages create an immense problem; an estimated 91 million people live in geographic areas lacking sufficient mental health professionals.[41] In addition to workforce shortages, many electronic health records (EHR) systems are limited in their ability to document relevant behavioral health and physical health information as well as their ability to support communication and coordination of care among integrated teams.[42]

Consequently, individuals with serious mental illness (SMI) die approximately 25 years earlier compared to those without SMI.[43] With the co-occurrence of both physical and mental health conditions and the negative effect on overall health and well-being, integration of care across physical and mental health conditions is imperative for improving the overall health of Medicaid beneficiaries, and for reducing the cost of their care.

There are many efforts to improve the integration of physical and mental health services. For example, NQF's Behavioral Health Standing Committee identified measures that encompass multiple settings to better assist in achieving integrated behavioral health and physical health—a major gap. These measures would improve the Committee's portfolio and move the healthcare community towards a more integrated practice.[44]

During its deliberations, the CC discussed the challenges of measuring the integration of physical and mental health. It deliberated on the difficulties of capturing data in states whose Medicaid Managed Care plans "carve out" behavioral health service financing compared with those states that include behavioral health services in their Medicaid Managed Care plans. Further, the CC noted that in many states behavioral health benefits are specific to the Medicaid program. Consequently, quality measures included in the list should be specific to the Medicaid population and in certain instances, the state benefit package. An additional impediment in measuring care integration is the inability to stratify measures by subpopulations. The CC recommended that future measure and measure concept recommendations allow for segmentation by subpopulation, as this would allow providers to assess areas of care that are well integrated along with those areas needing improvement.

Additionally, the CC noted an insufficient number of outcome measures and too many process measures in this area. Further, it commented on the lack of measures that addressed critical aspects of care in this population, including adherence to medication treatment and patient engagement and activation. In addition, the PMH recommendations lacked measures that address the social determinants of health (SDOH). The CC commented on the shift from individualized acute care towards population health and prevention. To capture individuals with co-occurring mental and physical health conditions, quality measures must include SDOH. Measures that assess the impact of SDOH can promote health equity among individuals with co-occurring mental and physical conditions.

Looking forward, the CC provided several recommendations for future iterations of the PMH measure and measure concept recommendations. For example, the CC discussed the emergence of screening and treatment of individuals who experienced trauma as a measurement gap area. The CC noted that a few of the current measures screened for trauma and violence, but it highlighted the need for more advanced measures that screen for adverse childhood experiences (ACEs) in care settings and measures that capture trauma-informed services.

The CC recommended that CMS consider 30 measures and one concept for the PMH program area (List 4). The recommended measures would result in a strong list by promoting measurement of a variety of high-priority issues, including coordination of treatment among providers, screening for physical and mental health conditions, and care follow-up. Further explanation and rationale regarding the CC's support for these measures follow.

### List 4. Measures/Concepts Recommended to the PMH Program Area

- **0097 Medication Reconciliation Post-Discharge (NCQA)**
- **0105 Antidepressant Medication Management (AMM) (NCQA)**
- **0419 Documentation of Current Medications in the Medical Record (CMS)**
- **0576 Follow-Up After Hospitalization for Mental Illness (FUH) (NCQA)**
- **0710 Depression Remission at Twelve Months (Minnesota Community Measurement)**
- **1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia (CMS)**
- **1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder (CMS)**
- **1922 HBIPS-1 Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths Completed (The Joint Commission)**
- **1927 Cardiovascular Health Screening for People With Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications (NCQA)**
- **1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) (NCQA)**
- **1933 Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC) (NCQA)**
- **1934 Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD) (NCQA)**
- **1937 Follow-Up After Hospitalization for Schizophrenia (7- and 30-day) (NCQA)**
- **2599 Alcohol Screening and Follow-Up for People with Serious Mental Illness (NCQA)**
- **2600 Tobacco Use Screening and Follow-Up for People with Serious Mental Illness or Alcohol or Other Drug Dependence (NCQA)**
- **2602 Controlling High Blood Pressure for People with Serious Mental Illness (NCQA)**

- **2603 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Testing (NCQA)**
- **2604 Diabetes Care for People with Serious Mental Illness: Medical Attention for Nephropathy (NCQA)**
- **2605 Follow-Up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence (NCQA)**
- **2607 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (NCQA)**
- **2609 Diabetes Care for People with Serious Mental Illness: Eye Exam (NCQA)**
- **3148 (formerly #0418) Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan (CMS)**
- **Adult Access to Preventive/Ambulatory Care 20-44, 45-64, 65+ (NCQA)**
- **Behavioral Health Risk Assessment (for Pregnant Women) (BHRA) (AMA-PCPI)**
- **Combined BH-PH Inpatient 30-Day Readmission Rate for Individuals With SMI Eligible Population, Denominator and Numerator Specifications (IPRO)**
- **Depression Remission or Response for Adolescents and Adults (NCQA)**
- **Follow-Up After Emergency Department Visit for Mental Illness (NCQA)**
- **Mental Health Service Penetration (Washington State DSHS)**
- **Mental Health Utilization: Number and Percentage of Members Receiving the Following Mental Health Services During the Measurement Year: Any Service, Inpatient, Intensive Outpatient or Partial Hospitalization, and Outpatient or ED (NCQA)**
- **Post-Partum Follow-Up and Care Coordination (AHRQ)**
- **PACT Utilization for Individuals with Schizophrenia (APA):** *Measure Concept*

### Medication Reconciliation Post-Discharge (NCQA)

NQF #0097 assesses the percentage of discharges for patients 18 years of age and older for whom practitioners reconciled the discharge medication list with the current medication list. The CC recommended this measure because it promotes care coordination among various providers, which is an important aspect of care integration for individuals with co-occurring conditions. The CC recommended NQF #0097 in the BCN and CI-LTSS program area as well. The inclusion of the measure in multiple sets supports alignment across the IAP program areas.

### 0105 Antidepressant Medication Management (AMM) (NCQA)

NQF #0105 assesses the percentage of patients 18 years of age and older with a diagnosis of major depression who were newly treated with antidepressant medication and who remained on the antidepressant medication treatment. The CC voted to recommend NQF #0105 to the PMH program area because the measure assesses continuous treatment both in the short and long term. Additionally, NQF #0105 is a HEDIS measure reported by numerous health plans, allowing for comparisons of performance across entities. The CC recommended that the developer update the measure specification to reflect recent coding changes (ICD-10 from ICD-9 for major depression). Adherence to medication is an important element of care for individuals who suffer from both mental and physical health issues. The CC recommended NQF #0105 for the BCN program area, and the measure is currently part of the Medicaid Adult Core Set as well. The addition of the measure in multiple program areas along with its inclusion in the Adult Core Set promotes alignment across both different IAP areas and other Medicaid programs. Public comment noted that NCQA added telehealth

modifiers to the numerator in HEDIS 2018, which may be useful information to states with mental or behavioral health access issues.

### 0419 Documentation of Current Medications in the Medical Record (CMS)

NQF #0419 assesses the percentage of visits for patients aged 18 years and older for whom an eligible professional documents a list of current medications on the date of the encounter. The CC recommended NQF #0419 since medication reconciliation of all medications—including those for physical and mental health conditions—provides an opportunity for improving the integration of care. The CC recommended NQF #0419 to the CI-LTSS program area as well. The inclusion of the measure in multiple sets supports alignment across the IAP program areas.

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

NQF #0576 assesses the percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner. The TEP voiced concern that since the measure only captures follow-up provided by behavioral health clinicians it would exclude many people who had follow-ups after hospitalization provided by other clinicians. This is especially true in areas of the country that experience behavioral healthcare provider shortages. Ultimately, the CC recommended it. The CC also recommended NQF #0576 as part of the BCN set, and it is already part of the Medicaid Adult and Child Core Sets. The addition of the measure in multiple program areas as well as its inclusion in the Core Sets promotes alignment across different IAP areas and other Medicaid programs. Public comment noted that NCQA added telehealth modifiers to the numerator in HEDIS 2018, which may be useful information to states with mental or behavioral health access issues.

### 0710 Depression Remission at Twelve Months (Minnesota Community Measurement)

NQF #0710 captures adult patients age 18 and older with major depression or dysthymia who have a PHQ-9 score greater than 9 and demonstrate remission at twelve months as defined by a PHQ-9 score below 5. The CC emphasized that the measure can encourage screening and treatment of depression within this population. The CC shared the TEP's concern that reporting the measure may be challenging for some entities, as the measure relies on capturing data from a survey from paper records, but it agreed that the measure was important enough to recommend.

### 1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia (CMS)

NQF #1879 assesses the percentage of individuals 18 years and older with schizophrenia or schizoaffective disorder who had a proportion of days covered (PDC) of at least 0.8 for antipsychotic medications during 12 consecutive months. The CC recommended NQF #1879 because many health plans report this HEDIS measure, creating an opportunity to compare performance across different entities/states. Additionally, adherence to antipsychotic medications is highly correlated with health stability among individuals who suffer from schizophrenia.

### 1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder (CMS)

NQF #1880 captures the percentage of individuals 18 years or older with bipolar I disorder who had a PDC of at least 0.8 for mood stabilizer medications during 12 consecutive months. The CC recommended the measure since adherence to mood stabilizers is highly correlated with health stability among individuals who suffer from bipolar I disorder.

### 1922 HBIPS-1 Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths Completed (The Joint Commission)

NQF #1922 measures the proportion of patients admitted to a hospital-based inpatient psychiatric setting who receive screening within the first three days of hospitalization for all of the following: risk of violence to self or others, substance use, psychological trauma history, and patient strengths. The CC highlighted the importance of measures that address trauma within the population. Despite the high rate of adherence, the CC recommended NQF #1922 because there is still an opportunity to drive practice improvements among those who do not report the measure.

### 1927 Cardiovascular Health Screening for People with Schizophrenia or Bipolar Disorder Who are Prescribed Antipsychotic Medications (NCQA)

NQF #1927 measures the percentage of individuals 25 to 64 years of age with schizophrenia or bipolar disorder prescribed any antipsychotic medication, and who received a cardiovascular health screening during the measurement year. The CC recommended NQF #1927, as it measures a widely accepted standard of care that addresses a key physical health risk for individuals who suffer from schizophrenia and bipolar disorder.

### 1932 Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) (NCQA)

NQF #1932 captures the percentage of patients 18-64 years of age with schizophrenia or bipolar disorder who received an antipsychotic medication and diabetes-screening test during the measurement year. The CC recommended the measure because it is relatively easy to capture and assesses care integration through screening. NQF #1932 is already part of the Adult Core Set, which will promote reporting alignment among programs.

### 1933 Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC) (NCQA)

NQF #1933 measures the percentage of patients 18-64 years of age with schizophrenia and cardiovascular disease, who had an LDL Cholesterol (LDL-C) test during the measurement year. The CC recommended NQF #1933 because it monitors cardiovascular health in individuals who are living with both cardiovascular disease and schizophrenia.

### 1934 Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD) (NCQA)

NQF #1934 captures the percentage of patients 18-64 years of age with schizophrenia and diabetes who had both an LDL-C test and an HbA1c test during the measurement year. The CC recommended NQF #1934 since the measure focuses on a high-risk population that has life threatening physical and mental health co-morbidities. Further, the two tests that the measure captures are accepted standards of care.

### 1937 Follow-Up After Hospitalization for Schizophrenia (7- and 30-day) (NCQA)

NQF #1937 measures the percentage of discharges for individuals between 18-64 years of age hospitalized for treatment of schizophrenia and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner after discharge. The measure reports two rates: first, the percentage of individuals who received follow-up within 30 days of discharge and second, and the percentage of individuals who received follow-up within seven days of discharge. The CC recommended the measure because it addresses an important element of physical and mental health integration—follow-up post-discharge. However, members expressed concern that the measure only includes mental health practitioners and does not include wraparound services such as assertive community treatment (ACT).

### 2599 Alcohol Screening and Follow-Up for People with Serious Mental Illness (NCQA)

NQF #2599 captures the percentage of patients 18 years of age and older with a serious mental illness, who received screening for unhealthy alcohol use and received follow-up care if identified as an unhealthy alcohol user. The TEP noted that many providers who screen for alcohol in a primary care settings do not bill to codes that reflect this interaction. Consequently, the measure may not capture enough data. Despite this concern, the CC recommended the measure because of the high rate of alcohol abuse and lack of treatment for individuals with mental health issues. The CC recommended NQF #2599 to the SUD program area as well. The recommendation of the measure to multiple IAP program areas promotes alignment.

### 2600 Tobacco Use Screening and Follow-Up for People with Serious Mental Illness or Alcohol or Other Drug Dependence (NCQA)

NQF #2600 measures the percentage of patients 18 years of age and older with SMI or alcohol or other drug dependence who received a screening for tobacco use and follow-up for those identified as a current tobacco user. The TEP recommended this measure because there is an underuse of screening and intervention for people with SMI who use tobacco. The TEP noted that NQF #2600 may encourage behavioral health clinicians to provide screening and intervention. Moreover, the measure has the ability to promote parity in tobacco cessation services for people with SMI. The TEP voiced concern that since behavioral health providers did not receive meaningful use funds they may not have the EHR capabilities to capture the information needed for the measure. The CC affirmed the TEP's recommendation. The CC also recommended NQF #2600 to the SUD program area. The recommendation of the measure to multiple IAP program areas promotes alignment.

### 2602 Controlling High Blood Pressure for People with Serious Mental Illness (NCQA)

NQF #2603 measures the percentage of patients 18-85 years of age with SMI who had a diagnosis of hypertension and who had adequately controlled blood pressure during the measurement year. The CC recommended this measure because when the physical health issues of individuals with mental health are not treated, they become costly for individuals. Specifically, some providers often do not adequately manage blood pressure for individuals with SMI.

### 2603 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Testing (NCQA)

NQF #2603 captures the percentage of patients 18-75 years of age with SMI and type 1 or type 2 diabetes who had hemoglobin A1c testing during the measurement year. The TEP expressed concern that the measure's definition of serious mental illness is too narrow; it only includes individuals with schizophrenia, bipolar I disorder, or major depression. However, it noted that entities can easily capture the measure through claims data and that it is important to stakeholders. The CC recommended the measure.

### 2604 Diabetes Care for People with Serious Mental Illness: Medical Attention for Nephropathy (NCQA)

NQF #2604 assesses the percentage of patients 18-75 years of age with a serious mental illness and type 1 or type 2 diabetes who received a nephropathy-screening test or had evidence of nephropathy during the measurement year. The TEP expressed concern that the measure's definition of serious mental illness is too narrow; it only includes individuals with schizophrenia, bipolar I disorder, or major depression. However, the TEP recommended NQF #2604 since it captures a widely accepted standard of care for a high-risk population. The CC affirmed the TEP's recommendation.

### 2605 Follow-Up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence (NCQA)

NQF #2605 captures the percentage of discharges for patients 18 years of age and older who had a visit to the emergency department with a primary diagnosis of mental health or alcohol or other drug dependence during the measurement year and who had a follow-up visit with any provider within seven and 30 days of discharge. The TEP noted that the denominator of the measure lacked clarity, and entities could not easily discern the rate of follow-up for individuals with mental health illness compared to those with substance use disorder. Further, it was unclear if the measure includes the new suicide billing code that captures individuals admitted for that reason. Lastly, it noted that the measure does not include certain wraparound clinical services that improve care quality for individuals with SMI and physical health conditions such as ACT, mobile crisis services, or Lifeline—a suicide crisis line. Ultimately, the TEP recommended the measure since it captures follow-up care for individuals with either a mental health or substance abuse diagnosis and is more inclusive than many of the measures it reviewed. The CC affirmed the TEP's recommendation. NQF #2605 is part of the Medicaid Adult Core Set, and the CC recommended the measure for the BCN and SUD sets. This promotes alignment and reduces reporting burden.

### 2607 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (NCQA)

NQF #2607 measures the percentage of patients 18-75 years of age with SMI and type 1 or type 2 diabetes whose most recent HbA1c level during the measurement year is >9.0 percent. Although the population measured by NQF #2607 is small, the CC recommended the measure since it captures a high-risk group that requires immediate medical intervention. The CC affirmed the TEP's recommendation. NQF #2607 is a part of the Medicaid Adult Core Set. The recommendation of this measure promotes alignment among different programs.

### 2609 Diabetes Care for People with Serious Mental Illness: Eye Exam (NCQA)

NQF #2609 captures the percentage of patients 18-75 years of age with SMI and type 1 and type 2 diabetes who had an eye exam during the measurement year. The TEP noted that ACOs and health plans currently report the measure. It agreed that the measure directly addresses care integration especially for behavioral health providers who were not a part of the EHR meaningful use incentives. The CC affirmed the TEP's recommendation.

### 3148 (formerly 0418) Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan (CMS)

NQF #3148 assesses the percentage of patients aged 12 years and older, screened for clinical depression and who receive a follow-up plan. Several TEP members expressed concern about reporting the measure, as it is very labor intensive and involves chart review. However, the CC recommended the measure because it focuses on the key issue of care coordination and is important to stakeholders. NQF #3148 is part of the Medicaid Adult Core Set. In addition, NQF's MAP Medicaid Child Taskforce supported this measure for inclusion in the 2018 Child Core Set. The recommendation of the measure for the PMH set promotes alignment across programs.

### Adult Access to Preventive/Ambulatory Care 20-44, 45-64, 65+ (NCQA)

This measure assesses the percentage of people 20 years and older who had an ambulatory or preventive care visit during the measurement year or the two years prior to the measurement year. The CC voted to include the measure in the PMH set because it measures access to ambulatory services, an important aspect of care management for individuals with co-occurring

physical and mental health conditions. The CC recommended the measure to the SUD, CI-LTSS, and BCN program areas. The recommendation of a measure to multiple IAP program areas promotes alignment.

### Behavioral Health Risk Assessment (for Pregnant Women) (BHRA) (American Medical Association - Physician Consortium for Performance Improvement)

BHRA determines the percentage of patients who gave birth during a 12-month period who had at least one prenatal care visit and received a behavioral health screening risk assessment on their first visit. The screenings include depression, alcohol use, tobacco use, drug use, and intimate partner violence. The CC noted that BHRA addresses a gap in the PMH measure and measure concept recommendations, since it is the only measure that assesses behavioral health screening for prenatal women. This is an eMeasure and is captured through electronic health records (EHRs). Further, as the measure is a part of the Medicaid Child Core Set, the recommendation to the PMH program area would promote alignment across programs and reduce reporting burden. The CC expressed concern that since some states criminalize screening positive for drinking or drug use during pregnancy, the measure may discourage women from receiving prenatal care.

### Combined BH-PH Inpatient 30-Day Readmission Rate for Individuals with SMI (IPRO)

This measure determines the 30-day inpatient readmission rate for adults with a history of SMI. The TEP agreed that although the measure is only in its first year of implementation it directly addresses key issues in the program area. Specifically, the measure captures how well care integration occurs for individuals with acute health needs, since the numerator includes hospital readmissions for either physical or mental causes among individuals who suffer from SMI. The CC supported the measure but noted that states with carve-outs for behavioral health services may have more difficulty capturing the data than states that include behavioral health service financing in the Medicaid Managed Care Organizations (MMCOs).

### Depression Remission or Response for Adolescents and Adults (NCQA)

The measure captures the percentage of people aged 12 or older with a diagnosis of major depressive disorder or dysthymia and an elevated Patient Health Questionnaire (PHQ-9) score, who had evidence of response or remission within five to seven months after the initial elevated score. Given that the measure is a first-year HEDIS measure, the TEP expressed concern that it may not be an efficient use of resources since it is not sure of the efficiency of the measure in capturing appropriate individuals. However, the CC recommended this outcome measure because it extends beyond screening for depression and highlights the individual's response to treatment. Additionally, the measure relies on patient-reported data, which is different from the clinical data source reflected in most of the measures in this set.

### Follow-Up After Emergency Department Visit for Mental Illness (NCQA)

The measure assesses the percentage of ED visits for members aged six years and older with a primary diagnosis of mental illness, who had an outpatient visit, an intensive outpatient encounter or a partial hospitalization for mental illness. The TEP noted that the measure does not include certain wraparound clinical services for individuals with co-occurring SMI and physical health conditions such as ACT, mobile crisis services, or Lifeline—a suicide crisis line. However, the CC recommended the measure because it includes follow-up care provided by both behavioral health and nonbehavioral health clinicians, which specifically addresses the integration of mental and physical health.

### Mental Health Service Penetration (Washington State Department of Social and Health Services)

This measure assesses the percentage of people with a mental health service need who received the services in the measurement year. This measure is important to include in the set because it allows programs to measure the effectiveness of behavioral health services integration from a payer perspective. The denominator allows for population stratification so that programs can use the measure's mental health service penetration among different subpopulations. Further, the measure assesses care provided by both behavioral health and nonbehavioral health clinicians and will capture a large population of people who receive services. The CC recommended this measure for inclusion in the set.

### Mental Health Utilization: Number and Percentage of Members Receiving the Following Mental Health Services During the Measurement Year: Any Service, Inpatient, Intensive Outpatient or Partial Hospitalization, and Outpatient or ED (NCQA)

This measure captures the number and percentage of people receiving mental health services during the measurement year. TEP members expressed concern that since the measure focuses on individuals with mental health issues such as the primary diagnosis in the ED it will capture only a small sample of those with co-occurring mental and physical health conditions who use emergency services. However, the CC recommended the measure because it is a HEDIS measure, so NCQA accredited programs, including commercial Medicare and Medicaid programs, will report on it. This creates an opportunity to compare performance across programs to drive quality improvement. The CC noted that the measure is an indication of care utilization and a good starting point to identify areas where too few people receive services. Further, the measure can help detect disparities in access to services.

### Post-Partum Follow-Up and Care Coordination (AHRQ)

This measure assesses the percentage of patients, regardless of age, who gave birth during a 12-month period and who were seen for post-partum care within eight weeks of giving birth, and who received a breast-feeding evaluation and education, post-partum depression screening, post-partum glucose screening for gestational diabetes patients, and family and contraceptive planning. The CC noted that the measure includes both physical health screening in addition to depression screening in a population at risk for depression. This is especially important because only few measures within the PMH measures and measure concepts address maternal health. One concern the CC had is that, in some states, Medicaid coverage ends prior to the measurement timeframe. Ultimately, the CC recommended the measure.

### PACT Utilization for Individuals with Schizophrenia (American Psychiatric Association): Measure Concept

The measure assesses the number of adult patients in a plan who have two or more inpatient stays or four emergency room crisis visits with a diagnosis of schizophrenia in the prior 12-month period enrolled in a Program for Assertive Community Treatment (PACT). The TEP discussed some of the limitations of the measure concept. Specifically, the denominator only includes individuals who suffer from schizophrenia and not individuals who suffer from other types of SMI, and its sole focus is on the Program for Assertive Community Treatment (PACT) intervention. Focusing solely on PACT poses implementation difficulty in rural areas. However, the TEP noted that readmission rates for individuals with schizophrenia are incredibly high and that PACT is an evidence-based program with demonstrated impact. The CC affirmed the TEP's recommendation.

# CONCLUSION

NQF convened four Technical Expert Panels and a Coordinating Committee to review and recommend measures and measure concepts for inclusion in each of the CMS Medicaid IAP program areas. This project aims to identify measures that are ready for immediate use in each of the program areas and that support state efforts to select, report, and align standardized quality measures. Each program area represents a critical priority population seeking care under the Medicaid program, which serves as the single largest provider of health insurance coverage in the U.S.

The CC prioritized actionable measures, parsimony, and stakeholder perspectives throughout their deliberations. As a result, the CC recommended 24 measures and five measure concepts for the SUD program area, 18 measures and one measure concept for the BCN program area, 10 measures and four measure concepts for the CI-LTSS program area, and 30 measures and one measure concept for the PMH program area. These measures and measure concepts are available for states to leverage as they work to deliver and evaluate high quality, efficient care to Medicaid beneficiaries.

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# APPENDIX A:
## Technical Expert Panels and Coordinating Committee Rosters

## Technical Expert Panels

### REDUCING SUBSTANCE USE DISORDERS

**Sheryl Ryan, MD, FAAP (TEP Chair)**
Yale School of Medicine

**Christina Andrews, PhD**
University of South Carolina

**Richard Brown, MD, MPH**
University of Wisconsin School of Medicine and Public Health

**Dennis McCarty, PhD**
Oregon Health & Science University

**Tiffany Wedlake, MD, MPH**
Maryland Department of Health and Mental Hygiene

### IMPROVING CARE FOR MEDICAID BENEFICIARIES WITH COMPLEX CARE NEEDS AND HIGH COSTS

**Andrea Gelzer, MD, MS, FACP (TEP Chair)**
AmeriHealth Caritas Family of Companies

**James Bush, MD, FACP**
Wyoming Office of Health Care Financing

**Dan Culica, MD, PhD**
Texas Health and Human Services Commission

**David Moskowitz, MD, MAS**
Alameda Health System

**Howard Shaps, MD, MBA**
WellCare Health Plans, Inc.

### PROMOTING COMMUNITY INTEGRATION THROUGH LONG-TERM SERVICES AND SUPPORTS

**Barbara McCann, BSW, MA (TEP Chair)**
Interim HealthCare Inc.

**Diane McComb, MSEd**
Delmarva Foundation

**Judit Olah, PhD, MS**
UCHealth

**Robert Schreiber, MD**
Hebrew SeniorLife

**Janice Tufte**
Engaged Patient

### SUPPORTING PHYSICAL AND MENTAL HEALTH INTEGRATION

**Maureen Hennessey, PhD, CPCC (TEP Chair)**
Precision Advisors

**Angela Kimball**
National Alliance on Mental Illness (NAMI)

**Virna Little, PsyD, LCSW-r, MBA, CCM, SAP**
The Institute for Family Health

**David Mancuso, PhD**
Washington State Department of Social and Health Services

**James Schuster, MD, MBA**
UPMC Insurance Division

## Coordinating Committee

**William Golden, MD (Co-Chair)**
Arkansas Medicaid & University of Arkansas

**Jennifer Moore, PhD, RN (Co-Chair)**
Institute for Medicaid Innovation

**Karen Amstutz, MD, MBA, FAAP**
Magellan Health, Inc.

**Sandra Finestone, AA, BA, MA, PsyD**
Association of Cancer Patient Educators

**Andrea Gelzer, MD, MS, FACP**
AmeriHealth Caritas Family of Companies

**Allison Hamblin, MSPH**
Center for Health Care Strategies, Inc.

**Maureen Hennessey, PhD, CPCC**
Precision Advisors

**David Kelley, MD, MPA**
Pennsylvania Department of Human Services

**Deborah Kilstein, RN, MBA, JD**
Association for Community Affiliated Plans (ACAP)

**SreyRam Kuy, MD, MHS, FACS**
Louisiana Department of Health

**Barbara McCann, BSW, MA**
Interim HealthCare Inc.

**Sarita Mohanty, MD, MPH, MBA**
Kaiser Permanente

**MaryBeth Musumeci, JD**
Kaiser Family Foundation

**Michael Phelan, MD, JD, FACEP, RDMS, CQM**
Cleveland Clinic

**Cheryl Powell, MPP**
Truven Health Analytics

**Sheryl Ryan, MD, FAAP**
Yale School of Medicine

**Jeff Schiff, MD, MBA**
Minnesota Department of Human Services

**John Shaw, MEng**
Next Wave

**Alvia Siddiqi, MD, FAAFP**
Advocate Physician Partners

**Susan Wallace, MSW, LSW**
LeadingAge Ohio

**Judy Zerzan, MD, MPH**
Colorado Department of Health Care Policy and Financing

**Christine Hawkins, RN, MBA, MSML**
Centene Corporation (unable to attend the in-person meeting)

## NQF Project Staff

**Helen Burstin, MD, MPH, FACP**
Chief Scientific Officer

**Elisa Munthali, MPH**
Acting Senior Vice President, Quality Measurement

**Margaret Terry, PhD, RN**
Senior Director

**Shaconna Gorham, MS, PMP**
Senior Project Manager

**Tara Rose Murphy**
Project Manager

**Kate Buchanan, MPH**
Project Manager

**Miranda Kuwahara, MPH**
Project Analyst

# APPENDIX B:
## Measure Sources and Measure Search Process

The approach to forming the four IAP program area lists of measures and measure concepts began with a measure search process. This process incorporated many steps and the use of several tools offering standardized methods throughout each step. Initially, this process involved the development of a measure summary spreadsheet (MSS), creation of the search criteria, and identification of sources. The MSS ensured a consistent and uniform approach to the collection of measures. Each MSS had different key words and concepts that reflected each program's focus.

NQF conducted an environmental scan for measures and measure concepts. With input from CMS staff, members from the Advisory Group (AG), Technical Expert Panels (TEPs), and Coordinating Committee (CC), staff searched 51 sources, including nine NQF projects, 17 states, and 25 selected sources (listed below). Sources included NQF's repository of measures, CMS Measures Inventory, HEDIS, American Society of Addiction Medicine, etc. Key to this search was the identification of measures that address critical aspects of each program area as well as those currently in use in multiple states.

## Measure Sources

### NQF Projects

- Behavioral Health – Consensus Development Process (CDP)
- Care Coordination (CDP)
- Family of Measures for Dual Eligible Beneficiaries – Measure Applications Partnership (MAP)
- Health and Well-Being (CDP)
- Medicaid Adult and Child Core Sets (MAP)
- Person- and Family-Centered Care (CDP)
- Population Health (CDP)
- Quality in Home and Community-Based Services to Support Community Living: Addressing Gaps in Performance Measurement
- Readmissions 2015-2017 (CDP)

### States

| | | |
|---|---|---|
| Arkansas | Maryland | Oregon |
| California | Massachusetts | Pennsylvania |
| Colorado | Minnesota | Vermont |
| Georgia | Missouri | Washington |
| Kansas | New York | Wyoming |
| Kentucky | Ohio | |

### Selected Sources

- Agency for Healthcare Research and Quality (AHRQ) National Quality Measures Clearinghouse
- American Society of Addiction Medicine
- Center for Medicare and Medicaid Innovation (CMMI) Behavioral Health Integration Projects
- Center for Quality Assessment and Improvement in Mental Health (CQAIMH)
- CMS Consensus Core Set: Accountable Care Organization (ACO) and Patient-Centered Medical Home (PCMH) / Primary Care Measures
- CMS Quality Measures Inventory
- CMS Quality Measure Development Plan: Supporting the Transition to the Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMs)
- Dr. Robert Bree Collaborative – Behavioral Health Integration Report and Recommendations

- Healthcare Effectiveness Data and Information Set (HEDIS)
- IMPACT Act Measures
- Implementing Coverage and Payment Initiatives: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2016 and 2017
- Kaiser Family Foundation
- Kennedy Forum Report on a Core Set of Outcome Measures for Behavioral Health
- Marketplace Quality Measures
- National Institute on Alcohol Abuse and Alcoholism (NIAA)
- National Institute on Drug Abuse (NIDA)
- Outcome measures for Recovery After an Initial Schizophrenia Episode (RAISE)
- Pediatric Integrated Care Survey (PICS)
- Pharmacy Quality Alliance
- Population-Level Quality Measures for Behavioral Screening and Intervention
- Robert Wood Johnson Foundation (RWJF) – Buying Value
- State-by-State Analysis of Medicaid MCO Requirements for Providers Alternative Payment Reimbursement
- Substance Abuse and Mental Health Services Administration (SAMHSA) publication on National Behavioral Health Quality Framework
- The National Academies Press – Vital Signs
- Trends in Emergency Department Visits Involving Mental and Substance Use Disorders, 2006-2013

For each of the IAP program areas, NQF in collaboration with CMS, the Advisory Group and the CC identified search terms (listed below) including key words and concepts to aid in the search for measures. In some cases, measures and measure concepts addressed key words/concepts in more than one IAP program area so they were also included in more than one MSS.

## Reducing Substance Use Disorders Search Terms

- Early intervention
- Screening and brief intervention
- Attainment of timely and appropriate healthcare
- Standardized assessment to identify level of substance use
- Maintenance, recovery, and maintaining treatment outcomes
- Outpatient services
- Continuity of care after detox
- Prevention activities for opioid prescribing practices
- Screening for: level of substance use, intoxication/withdrawal, potential conditions and complications, readiness to change, relapse and recovery
- Care coordination after detox
- Medication-assisted treatment

## Medicaid Beneficiaries with Complex Care Needs and High Costs Search Terms

- No specific conditions-all cause measures
- Self-management
- Coordination of care, continuity of care
- Underuse of primary care all cause follow-up
- Outpatient, home health and other post-acute care preventive services
- Potentially avoidable hospital and ED utilization
- Hospitalization and ED use
- Transitions across care settings
- Mental illness and two or more chronic conditions
- Super-utilizers
- Relationship between care/case manager, physician, and beneficiary

- Self-management of chronic diseases
- All cause readmissions and follow-up
- Outpatient preventive services for multiple conditions

## Promoting Community Integration through Community-Based Long-Term Services and Supports Search Terms

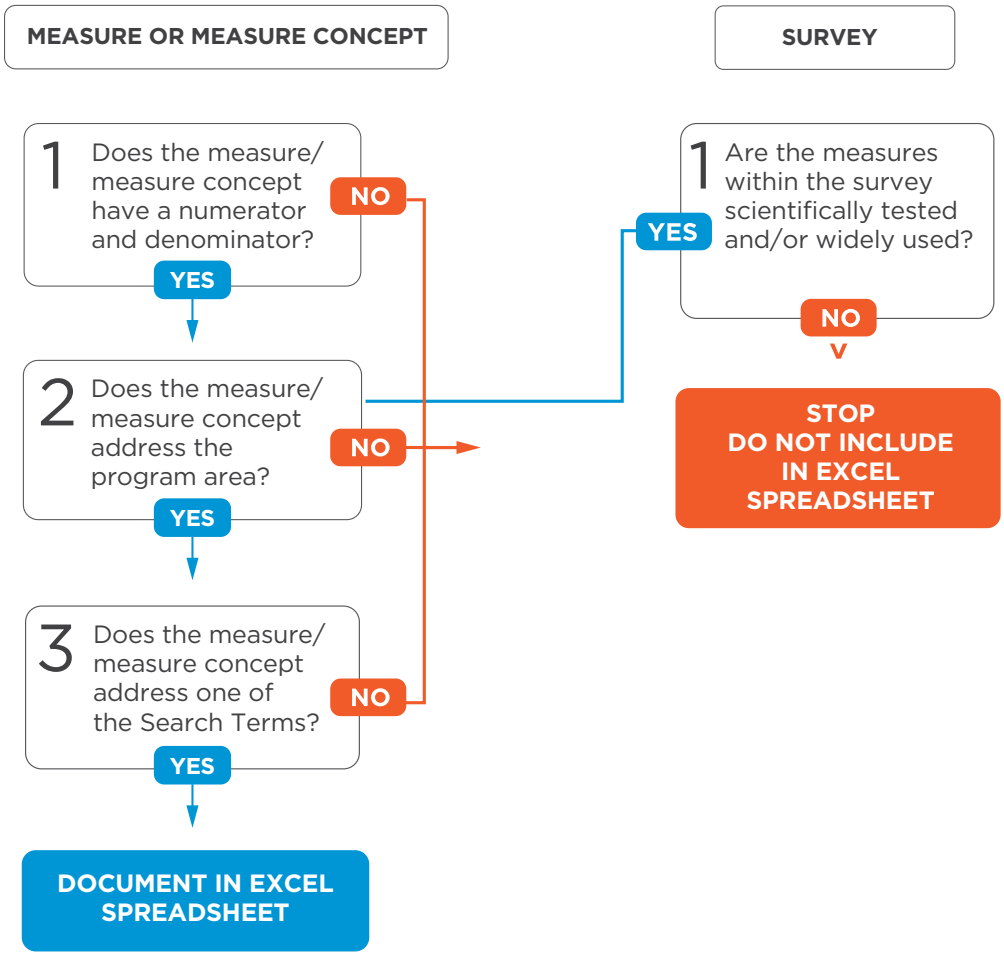
- Person-centered system and planning
- Sufficient, accessible, and appropriate services
- Care coordination and service coordination for LTSS
- Community Inclusion
- Beneficiary measure of care coordination
- HCBS EOC survey
- LTSS workforce
- Patient centeredness
- Self-direction of services
- Rebalancing or transitioning from institution to community
- Meaningful activity in the community
- Quality of life
- Medication reconciliation
- Patient and caregiver experience
- Access
- Person and family-centered care

## Supporting Physical and Mental Health Integration Search Terms

- Coordinated communication across physical and mental health providers
- Behavioral and primary care integration
- Integration of physical/mental health care for individuals with serious mental illness
- Clinical care
- Screening for physical and mental conditions
- Team-based care for physical and mental health
- Coordination of treatment among providers
- Person-centered care/planning
- Care coordination/follow-up
- Shared decision making

The decision logic for inclusion of measures in the four IAP program area measure sets appears in Figure B1 below.

FIGURE B1. MEASURE SEARCH INCLUSION CRITERIA




## Process for Developing Lists of Measures and Measure Concepts

a. **Environmental Scan**: NQF staff used various measure sources to search for relevant measures. An inclusive list of sources is in Appendix B.

b. **Capture Measures for Potential Inclusion in the Measure Sets**: NQF staff identified measures based on feedback from the TEPs, and the CC regarding the goals of each program area and the current measurement activities of states' delivery system reform efforts. NQF staff grouped and summarized measures on each spreadsheet by the most relevant CMS quality measurement domain (e.g., access, clinical care, care coordination, safety, patient and caregiver experience, and population health and prevention).

c. **Assign Rankings to Specific Measure Criteria:** NQF staff assigned a yes/no/unsure ranking to the evidence criterion for each measure as well as a high/medium/low/unsure ranking to the feasibility, usability, and scientific acceptability criteria. NQF then assigned a numeric value to the ranking for use in the calculation of the overall measure score.

- Feasibility is the extent to which the specifications, including measure logic, require data that are readily available or

could be captured without undue burden and can be implemented for performance measurement. The ranking has been included below:

- High (3): Administrative/claims
- Medium (2): Paper record/medical record/ EHR/ registry data
- Low (1): Patient-reported outcome performance measure
- Unsure (0)

- Usability is the extent to which potential audiences (e.g., state Medicaid agencies, health plans, consumers, purchasers, providers, and policy-makers) are using or could use performance results for both accountability and quality improvement to achieve the goal of high quality, efficient healthcare for individuals or populations.
  - High (3): Use in federal program or use in multiple states for accountability/quality improvement
  - Medium (2): Use by state/local/health plan for accountability/quality improvement or planned use in state Medicaid programs
  - Low (1): No indication of use in field or any programs
  - Unsure (0)
- Scientific Acceptability, which refers to a measure's reliability and validity, is the extent to which a measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented.
  - High (3): Currently NQF-endorsed OR evidence of reliability/validity testing in the Medicaid population
  - Medium (2): Any evidence of reliability/ validity testing OR testing in Medicaid project is underway
  - Low (1): No evidence of testing
  - Unsure (0)
- Evidence is the extent to which the specific measure focus is evidence-based and important to making significant gains in healthcare quality where there is variation in or overall less-than-optimal performance.
  - Yes (1): There is evidence of data or information resulting from studies and analyses of the data elements and/ or scores for a measure as specified, unpublished, published, or NQF-endorsed without exception to evidence
  - No (0): Evidence is not available
  - Unsure (0)

d. **Assign Overall Score to Each Measure:** NQF staff weighted the criteria listed above to assign an overall measure score to each measure:

**Overall Measure Score Composite**

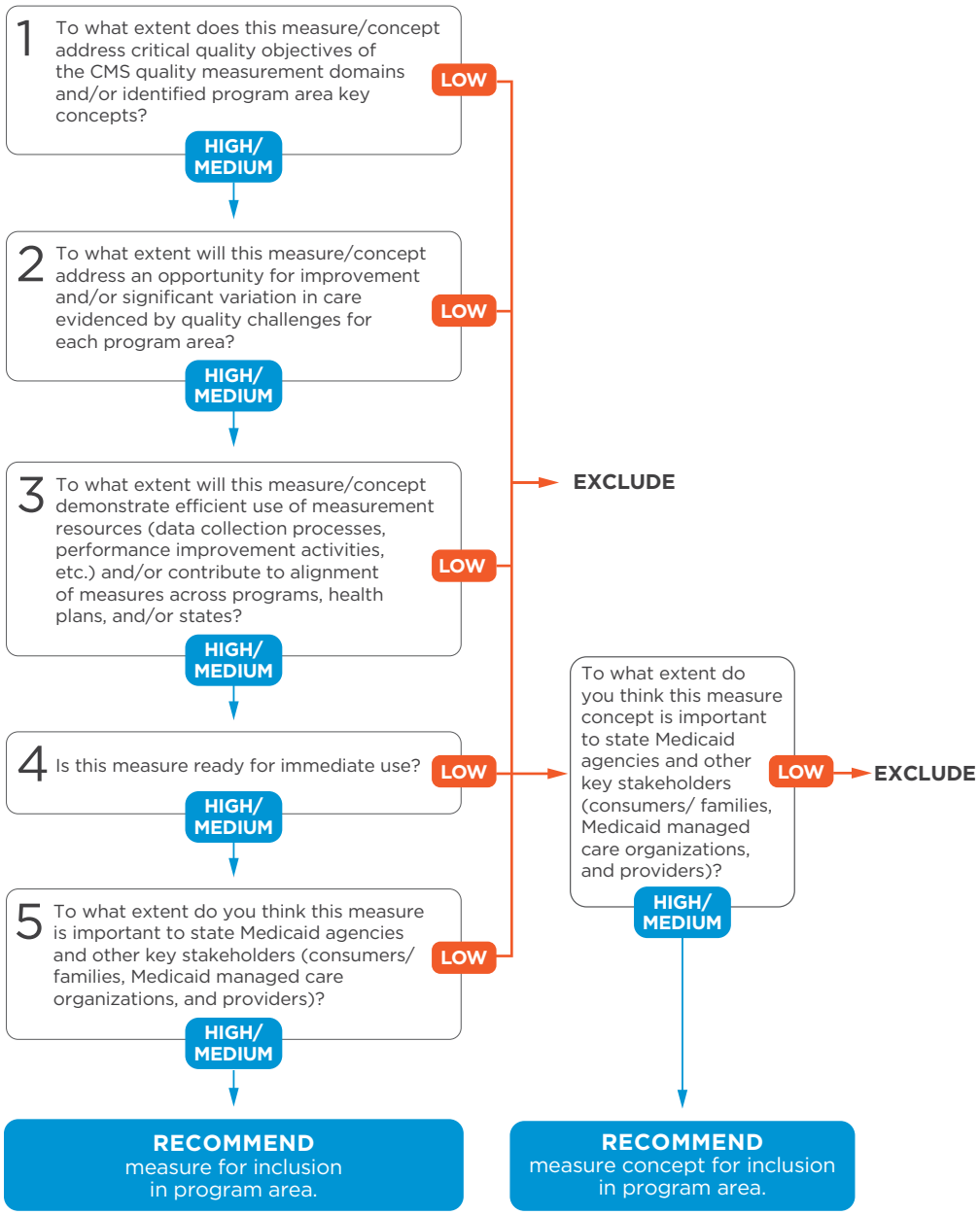
| Criteria | Weight |
|---|---|
| Feasibility | 30% |
| Usability | 30% |
| Scientific Acceptability | 25% |
| Evidence | 15% |

# APPENDIX C:
## Technical Expert Panel Measure Selection Process

### Goal

**To evaluate measures and the potential benefit of including them in the measure sets**. The TEP members used the measure selection process, including a defined decision logic, to determine whether the measures are the "best-available" to support states' ongoing delivery system reform efforts. The TEPs discussed these measures largely based on the specifications and the feasibility of implementing them for state-level payment and delivery reform.

**FIGURE C1. TECHNICAL EXPERT PANEL MEASURE SELECTION DECISION LOGIC CRITERIA**



# APPENDIX D:
## Coordinating Committee Measure Selection Process

### Goals

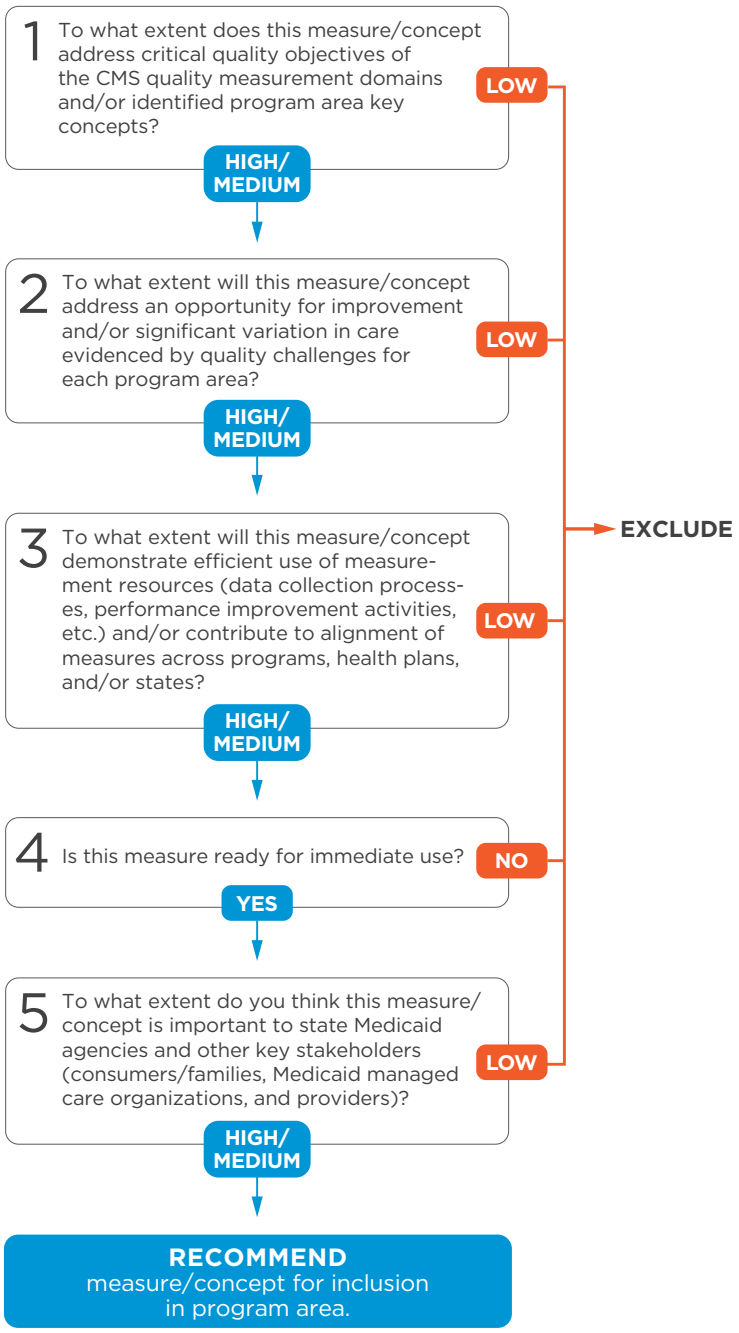
To submit the "best-available" Medicaid-relevant measures and measure concepts that can be used to support the Centers for Medicare & Medicaid Services' (CMS) Medicaid innovation Accelerator Program (IAP) and states' Medicaid delivery reform efforts. The CC evaluated additional measures and approved measures and concepts recommended by the TEPs. The CC selected measures and measure concepts—grouped them according to relevant IAP program areas—and recommended these measures and concepts to CMS.

### Objectives

1. To review measures evaluated by the TEPs to assure agreement with the recommendations.
2. To review newly submitted measures for recommendation using the decision logic
3. To submit four lists of measures that can be used to support states' healthcare delivery efforts to CMS

The CC used the measure selection decision logic criteria shown in Figure D1 below to reach consensus on the measures and measure concepts recommended for each of the four IAP program areas.

**FIGURE D1. COORDINATING COMMITTEE MEASURE SELECTION DECISION LOGIC CRITERIA**



# APPENDIX E:
## Measures Recommended Across Program Areas and Medicaid Adult and Child Core Sets

The CC recommended several measures for inclusion in more than one Medicaid IAP program area. All measures recommended for each program area—including measures recommended for multiple program areas—are in the table below. The table also highlights measures included in the 2017 Adult and Child Medicaid Core Sets or those recommended for inclusion in the 2018 Adult and Child Core Sets.

| Measure Title | SUD | BCN | CI-LTSS | PMH | Medicaid Adult and/or Child Core Set |
|---|---|---|---|---|---|
| 0004 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) | X | | | | Medicaid Adult Core Set |
| 0097 Medication Reconciliation Post-Discharge | | X | X | X | |
| 0101 Falls: Screening for Fall Risk | | | X | | |
| 0105 Antidepressant Medication Management (AMM) | | X | | X | Medicaid Adult Core Set |
| 0326 Advance Care Plan | | | X | | |
| 0419 Documentation of Current Medications in the Medical Record | | | X | X | |
| 0576 Follow-Up After Hospitalization for Mental Illness (FUH) | | X | | X | Medicaid Adult and Child Core Sets |
| 0647 Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) | | | X | | |
| 0709 Proportion of Patients with a Chronic Condition That Have a Potentially Avoidable Complication During a Calendar Year | | X | | | |
| 0710 Depression Remission at Twelve Months | | | | X | |
| 1598 Total Resource Use Population-Based PMPM Index | | X | | | |
| 1604 Total Cost of Care Population-Based PMPM Index | | X | | | |
| 1654 TOB - 2 Tobacco Use Treatment Provided or Offered and the subset measure TOB-2a Tobacco Use Treatment | X | | | | |
| 1656 TOB - 3 Tobacco Use Treatment Provided or Offered at Discharge and the subset measure TOB-3a Tobacco Use Treatment at Discharge | X | | | | |
| 1661 Sub-1 Alcohol Use Screening | X | | | | |

| Measure Title | SUD | BCN | CI-LTSS | PMH | Medicaid Adult and/or Child Core Set |
|---|---|---|---|---|---|
| 1663 Sub-2 Alcohol Use Brief Intervention Provided or Offered and Sub-2a Alcohol Use Brief Intervention | X | | | | |
| 1664 SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge | X | | | | |
| 1768 Plan All-Cause Readmissions (PCR) | | X | | | Medicaid Adult Core Set |
| 1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia | | | | X | |
| 1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder | | | | X | |
| 1922 HBIPS-1 Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths Completed | | | | X | |
| 1927 Cardiovascular Health Screening for People with Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications | | | | X | |
| 1932 Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) | | | | X | Medicaid Adult Core Set |
| 1933 Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC) | | | | X | |
| 1934 Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD) | | | | X | |
| 1937 Follow-Up After Hospitalization for Schizophrenia (7- and 30-day) | | | | X | |
| 2152 Preventive Care and Screening: Unhealthy Alcohol Use | X | | | | |
| 2371 Annual Monitoring for Patients on Persistent Medications (MPM) | | X | | | Medicaid Adult Core Set |
| 2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient | | X | | | |
| 2483 Gains in Patient Activation (PAM) Scores at 12 Months | | X | X | | |
| 2597 Substance Use Screening and Intervention Composite | X | | | | |
| 2599 Alcohol Screening and Follow-Up for People with Serious Mental Illness | X | | | X | |

| Measure Title | SUD | BCN | CI-LTSS | PMH | Medicaid Adult and/or Child Core Set |
|---|---|---|---|---|---|
| 2600 Tobacco Use Screening and Follow-Up for People with Serious Mental Illness or Alcohol or Other Drug Dependence | X | | | X | |
| 2602 Controlling High Blood Pressure for People with Serious Mental Illness | | | | X | |
| 2603 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Testing | | | | X | |
| 2604 Diabetes Care for People with Serious Mental Illness: Medical Attention for Nephropathy | | | | X | |
| 2605 Follow-Up After Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence | X | X | | X | Medicaid Adult Core Set |
| 2607 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) | | | | X | Medicaid Adult Core Set |
| 2609 Diabetes Care for People with Serious Mental Illness: Eye Exam | | | | X | |
| 2940 Use of Opioids at High Dosages in Persons without Cancer | X | | | | Medicaid Adult Core Set |
| 2950 Use of Opioid from Multiple Providers in Persons without Cancer | X | | | | |
| 2951 Use of Opioids at High Dosages from Multiple Providers in Persons without Cancer | X | | | | |
| 2967 CAHPS® Home and Community Based Services (HCBS) Measures | | | X | | Recommended for inclusion in the 2018 Medicaid Adult Core Set |
| 3148 (formerly 0418) Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan | | | | X | Medicaid Adult Core Set; Recommended for inclusion in the 2018 Medicaid Child Core Set |
| 3225 (formerly #0028) Preventative Care and Screening: Tobacco Use: Screening and Cessation | X | | | | |
| Adult Access to Preventive/Ambulatory Care 20-44, 45-64, 65+ | X | X | X | X | |
| Annual Hepatitis C Virus (HCV) Screening for Patients Who Are Active Injection Drug Users | X | | | | |
| Behavioral Health Risk Assessment (for Pregnant Women) (BHRA) | | | | X | Medicaid Child Core Set |
| Combined BH-PH Inpatient 30-Day Readmission Rate for Individuals with SMI | | | | X | |

| Measure Title | SUD | BCN | CI-LTSS | PMH | Medicaid Adult and/or Child Core Set |
|---|---|---|---|---|---|
| Depression Remission or Response for Adolescents and Adults | | | | X | |
| Documentation of Signed Opioid Treatment Agreement | X | | | | |
| Evaluation or Interview for Risk of Opioid Misuse | X | | | | |
| Follow-Up after Emergency Department Visit for Alcohol and Other Drug Dependence (FUA) | X | X | | | |
| Follow-Up After Emergency Department Visit for Mental Illness | | | | X | |
| Home- and Community-Based Long Term Services and Supports Use Measure Definition (HCBS) | | | X | | |
| Individualized Plan of Care Completed | | | X | | |
| Medication Reconciliation Post-Discharge: Percentage of Discharges from January 1 to December 1 of the Measurement Year for Members 18 Years of Age and Older for Whom Medications Were Reconciled the Date of Discharge Through 30 Days After Discharge (31 total days) | | X | | | |
| Mental Health Service Penetration | | | | X | |
| Mental Health Utilization: Number and Percentage of Members Receiving the Following Mental Health Services During the Measurement Year: Any Service, Inpatient, Intensive Outpatient or Partial Hospitalization, and Outpatient or ED | | | | X | |
| Mental Health/Substance Abuse: Mean of Patients' Overall Change on the BASIS 24-Survey | X | | | | |
| National Core Indicators (NCI) | | | X | | |
| National Core Indicators – Aging and Disability (NCI-AD) | | | X | | |
| Number And Percent of Waiver Participants Who Had Assessments Completed by the MCO That Included Physical, Behavioral, and Functional Components to Determine the Member's Needs | | | X | | |
| PACT Utilization for Individuals with Schizophrenia | | | | X | |
| Percent of Patients Prescribed a Medication for Alcohol Use Disorder | X | | | | |

| Measure Title | SUD | BCN | CI-LTSS | PMH | Medicaid Adult and/or Child Core Set |
|---|---|---|---|---|---|
| Percent of Patients Prescribed a Medication for Opioid Use Disorders (OUD) | X | | | | |
| Percentage of Short-Stay Residents Who Were Successfully Discharged to the Community | | | X | | |
| Post-Partum Follow-Up and Care Coordination | | | | X | |
| Potentially Preventable Emergency Room Visits | | X | | | |
| Potentially Preventable Emergency Room Visits (for persons with BH diagnosis) | | X | | | |
| Potentially Preventable Readmissions | | X | | | |
| Presence of Screening for Psychiatric Disorder | X | | | | |
| Prevention Quality Indicators #90 (PQI #90) | | X | | | |
| Primary Care Visit Follow-Up | X | | | | |
| Psychiatric Inpatient Readmissions – Medicaid (PCR-P) | | X | | | |
| Substance Use Disorders: Percentage of Patients Aged 18 Years and Older with a Diagnosis of Current Alcohol Dependence Who Were Counseled Regarding Psychosocial AND Pharmacologic Treatment Options for Alcohol Dependence Within the 12 Month Reporting Period | X | | | | |
| Substance Use Disorders: Percentage of Patients Aged 18 Years and Older with a Diagnosis of Current Substance Abuse or Dependence Who Were Screened for Depression Within the 12 Month Reporting Period | X | | | | |
| Substance Use Disorder Treatment Penetration (AOD) | X | | | | |
| The Percentage of Adolescents 12 to 20 Years of Age with a Primary Care Visit During the Measurement Year for Whom Tobacco Use Status Was Documented and Received Help with Quitting If Identified as a Tobacco User | X | | | | |

# APPENDIX F:
## Additional Measures Considered

The CC considered several measures that did not pass the consensus threshold (>60 percent of voting members) to gain support for use in the program areas. The CC also considered, but ultimately decided to exclude, measures recommended by the TEPs. The CC needed to limit the number of measures it supported to address parsimony and practicality; lack of support for one of these measures does not indicate that the measure is flawed or unimportant.

| Measure Number | Measure Title | Measure Steward | Program Area |
|---|---|---|---|
| **1888** | Workforce Development Measure Derived from Workforce Development Domain of the C-CAT | American Medical Association | Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs |
| | | | Supporting Physical and Mental Health Integration |
| | | | Promoting Community Integration through Community-Based Long-Term Services and Supports |
| **N/A** | Clinical Risk Score | N/A | Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs |
| | | | Supporting Physical and Mental Health Integration |
| **N/A** | Referral To Community Based Health Resources | N/A | Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs |
| | | | Supporting Physical and Mental Health Integration |
| | | | Promoting Community Integration through Community-Based Long-Term Services and Supports |
| **N/A** | Adherence to Antipsychotics for Individuals with Schizophrenia | N/A | Supporting Physical and Mental Health Integration |
| **N/A** | Follow-Up After All-Cause Emergency Department Visit | NCQA | Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs |
| **N/A** | Potentially Avoidable Emergency Department Utilization | NYU Wagner | Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs |
| **0648** | Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) | AMA-PCPI | Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs |
| | | | Promoting Community Integration through Community-Based Long-Term Services and Supports |

# APPENDIX G:
## Measures and Alignment with Other Programs and Measure Sets

## Coordinating Committee Measure Recommendations for Program Areas

### Reducing Substance Use Disorders

**0004 Endorsed**

**Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)**

**Measure Steward:** NCQA

**Alignment**: PQRS; QRUR; VBM; QRS; Medicaid Adult Core Set; Reported in the following states;

- California
- Colorado
- Connecticut
- Delaware
- Dist. of Columbia
- Georgia
- Illinois
- Iowa
- Kentucky
- Louisiana
- Maryland
- Massachusetts
- Minnesota
- Mississippi
- Missouri
- New Hampshire
- New York
- North Carolina
- Ohio
- Oregon
- Pennsylvania
- Rhode Island
- South Carolina
- Tennessee
- Texas
- Vermont
- Washington

**1654 Endorsed**

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

**Measure Steward:** The Joint Commission

**Alignment**: Hospital Compare; IPFQR

**1656 Endorsed**

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

**Measure Steward:** The Joint Commission

**Alignment**: Hospital Compare; IPFQR

**1661 Endorsed**

**SUB-1 Alcohol Use Screening**

**Measure Steward:** The Joint Commission

**Alignment**: N/A

**1663 Endorsed**

**SUB-2 Alcohol Use Brief Intervention Provided or Offered and SUB-2a Alcohol Use Brief Intervention**

**Measure Steward:** The Joint Commission

**Alignment**: N/A

**1664 Endorsed**

**SUB-3 Alcohol and other Drug Use Disorder Treatment Provided or Offered at Discharge**

**Measure Steward:** The Joint Commission

**Alignment**: N/A

**2152 Endorsed**

**Preventive Care and Screening: Unhealthy Alcohol Use**

**Measure Steward:** AMA-convened Physician Consortium for Performance Improvement

**Alignment**: PQRS; QRUR; VBM

**2597 Endorsed**

**Substance Use Screening and Intervention Composite (Composite Measure)**

**Measure Steward:** ASAM

**Alignment**: N/A

**2599 Endorsed**

**Alcohol Screening and Follow-up for People with Serious Mental Illness**

**Measure Steward:** NCQA

**Alignment**: N/A

**2600 Endorsed**

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

**Measure Steward:** NCQA

**Alignment**: N/A

**2605 Endorsed**

Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence

**Measure Steward:** NCQA

**Alignment**: MAP Dual Eligibles Family of Measures (2016); Reported in Vermont

**2940 Endorsed**

Use of Opioids at High Dosage in Persons Without Cancer

**Measure Steward:** PQA

**Alignment**: CMS Medicare Part D Drug Benefit

**2950 Endorsed**

Use of Opioids from Multiple Providers in Persons Without Cancer

**Measure Steward:** PQA

**Alignment**: CMS Medicare Part D Drug Benefit

**2951 Endorsed**

Use of Opioids at High Dosages from Multiple Providers in Persons with Cancer

**Measure Steward:** PQA

**Alignment**: CMS Medicare Part D Drug Benefit

**3225 (formerly #0028) Endorsed**

Preventative Care and Screening: Tobacco Use: Screening and Cessation Intervention

**Measure Steward:** AMA-convened Physician Consortium for Performance Improvement

**Alignment**: PQRS, MSSP, Million Hearts, Physician Compare, QRUR, VBM

**Not NQF-endorsed**

Adult Access to Preventive/Ambulatory Care 20-44, 45-64, 65+

**Measure Steward:** NCQA

**Alignment**: N/A

**Not NQF-endorsed**

Documentation of Signed Opioid Treatment Agreement

**Measure Steward:** American Academy of Neurology

**Alignment**: Medicare

**Not NQF-endorsed**

Evaluation or Interview for Risk of Opioid Misuse

**Measure Steward:** American Academy of Neurology

**Alignment**: Medicare

**Not NQF-endorsed**

Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)

**Measure Steward:** NCQA

**Alignment**: HEDIS; Reported in New York

**Not NQF-endorsed**

Mental Health/Substance Abuse: Mean of Patients' Overall Change on the BASIS 24-Survey

**Measure Steward:** Eisen, Susan V., PhD.

**Alignment**: N/A

**Not NQF-endorsed**

Percent of Patients Prescribed a Medication for Alcohol Use Disorder

**Measure Steward:** ASAM

**Alignment**: N/A

**Not NQF-endorsed**

Percent of Patients Prescribed a Medication for Opioid Use Disorders (OUD)

**Measure Steward:** ASAM

**Alignment**: N/A

**Not NQF-endorsed**

The Percentage of Adolescents 12 to 20 Years of Age with a Primary Care Visit During the Measurement Year for Whom Tobacco Use Status Was Documented and Received Help with Quitting If Identified as a Tobacco User

**Measure Steward:** NCQA

**Alignment**: Medicare

**Not NQF-endorsed**

Annual Hepatitis C Virus (HCV) Screening for Patients who are Active Injection Drug Users*

**Measure Steward:**

**Alignment**: Medicare

**Not NQF-endorsed**

Presence of Screening for Psychiatric Disorder*

**Measure Steward:** ASAM

**Alignment**: N/A

**Not NQF-endorsed**

**Primary Care Visit Follow-Up***

**Measure Steward:** ASAM

**Alignment**: N/A

**Not NQF-endorsed**

**Substance Use Disorders: Percentage of Patients Aged 18 Years and Older with a Diagnosis of Current Alcohol Dependence Who Were Counseled Regarding Psychosocial AND Pharmacologic Treatment Options for Alcohol Dependence Within the 12 Month Reporting Period***

**Measure Steward:** American Psychiatric Association, NCQA, Physician Consortium for Performance Improvement

**Alignment**: N/A

**Not NQF-endorsed**

**Substance Use Disorders: Percentage of Patients Aged 18 Years and Older with a Diagnosis of Current Substance Abuse or Dependence Who Were Screened for Depression Within the 12-Month Reporting Period***

**Measure Steward:** American Psychiatric Association, NCQA, Physician Consortium for Performance Improvement

**Alignment**: N/A

**Not NQF-endorsed**

**Substance Use Disorder Treatment Penetration (AOD)***

**Measure Steward:** Washington State Department of Social and Health Services

**Alignment**: Reported in Washington State

**Measure Concept*

## Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs

**N0097 Endorsed**

### Medication Reconciliation Post-Discharge

**Measure Steward:** National Committee for Quality Assurance (NCQA)

**Alignment**: MAP Dual Eligible Beneficiaries Family of Measures; Merit-Based Incentive Payment System (MIPS); Reported in Colorado

**0105 Endorsed**

### Antidepressant Medication Management (AMM)

**Measure Steward:** NCQA

**Alignment**: 2016 Medicaid Adult Core Set; MAP Dual Eligible Beneficiaries Family of Measures; Reported in the following states:

- Alabama
- Arkansas
- California
- Colorado
- Connecticut
- Delaware
- Dist. of Columbia
- Georgia
- Illinois
- Iowa
- Kentucky
- Louisiana
- Massachusetts
- Michigan
- Minnesota
- Mississippi
- Missouri
- New Hampshire
- New Mexico
- New York
- North Carolina
- Ohio
- Oklahoma
- Pennsylvania
- Rhode Island
- Tennessee
- Texas
- Vermont
- Virginia
- Washington

**0576 Endorsed**

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

**Measure Steward:** NCQA

**Alignment**: Medicaid Adult and Child Core Sets (2017); MAP Dual Eligibles Family of Measures (Last Modified 2015); Reported in Oregon's coordinated care organizations (CCOs); MIPS; Inpatient Psychiatric Facility Quality Reporting Program (IPFQR); Reported in the following states:

- Alabama
- Arkansas
- California
- Colorado
- Connecticut
- Delaware
- Dist. of Columbia
- Georgia
- Illinois
- Iowa
- Kentucky
- Louisiana
- Massachusetts
- Minnesota
- Mississippi
- Missouri
- New Hampshire
- New Mexico
- New York
- Ohio
- Oklahoma
- Oregon
- Pennsylvania
- Rhode Island
- South Carolina
- Tennessee
- Texas
- Vermont
- Virginia
- Washington
- West Virginia

**0709 Endorsed**

### Proportion of Patients with a Chronic Condition That Have a Potentially Avoidable Complication During a Calendar Year

**Measure Steward:** Altarum Institute

**Alignment**: MAP Dual Eligible Beneficiaries Family of Measures

**1598 Endorsed**

### Total Resource Use Population-based PMPM Index

**Measure Steward:** HealthPartners

**Alignment**: N/A

**1604 Endorsed**

### Total Cost of Care Population-based PMPM Index

**Measure Steward:** HealthPartners

**Alignment**: N/A

**1768 Endorsed**

### Plan All-Cause Readmissions (PCR)

**Measure Steward:** NCQA

**Alignment**: Medicaid Adult Core Set (2017); MAP Dual Eligibles Family of Measures (2016); Reported in the following states:

- Alabama
- Arizona
- Arkansas
- California
- Colorado
- Connecticut
- Delaware
- Georgia
- Iowa
- Louisiana
- Michigan
- Minnesota
- Missouri
- New Mexico
- New York
- North Carolina
- Ohio
- Oklahoma
- Oregon
- Rhode Island
- South Carolina
- Tennessee
- Vermont
- Washington

**2371 Endorsed**

### Annual Monitoring for Patients on Persistent Medications (MPM)

**Measure Steward:** NCQA

**Alignment**: 2017 Medicaid Adult Core Set; Reported in the following states:

- Arkansas
- California
- Colorado
- Connecticut
- Delaware
- Dist. of Columbia
- Georgia
- Illinois
- Iowa
- Kentucky
- Louisiana
- Maryland
- Massachusetts
- Michigan
- Minnesota
- Mississippi
- Missouri
- Montana
- New Hampshire
- New Jersey
- New Mexico
- New York
- North Carolina
- Oklahoma
- Pennsylvania
- Rhode Island
- South Carolina
- Tennessee
- Texas
- Vermont
- Washington
- West Virginia

**2456 Endorsed**

### Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient

**Measure Steward:** Brigham and Women's Hospital

**Alignment**: MAP Dual Eligible Beneficiaries Family of Measures

**2483 Endorsed**

### Gains in Patient Activation (PAM) Scores at 12 Months

**Measure Steward:** Insignia Health

**Alignment**: Reported in Colorado's Rocky Mountain Regional Care Collaborative Organization

**2605 Endorsed**

### Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence

**Measure Steward:** NCQA

**Alignment**: MAP Dual Eligibles Family of Measures (2016); Reported in Vermont

**Not NQF-endorsed**

### Adult Access to Preventive/Ambulatory Care 20-44, 45-64, 65+

**Measure Steward:** NCQA

**Alignment**: N/A

**Not NQF-endorsed**

### Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)

**Measure Steward:** NCQA

**Alignment**: HEDIS; Reported in New York

**Not NQF-endorsed**

### Medication Reconciliation Post-Discharge: Percentage of Discharges from January 1 to December 1 of the Measurement Year for Members 18 Years of Age and Older for Whom Medications Were Reconciled the Date of Discharge Through 30 Days After Discharge (31 total days)

**Measure Steward:** NCQA

**Alignment**: N/A

**Not NQF-endorsed**

### Potentially Preventable Emergency Room Visits

**Measure Steward:** 3M

**Alignment:** Reported in New York

**Not NQF-endorsed**

### Potentially Preventable Readmissions

**Measure Steward:** 3M

**Alignment:** Reported in New York

**Not NQF-endorsed**

### Prevention Quality Indicators #90 (PQI #90)

**Measure Steward:** N/A

**Alignment**: California DHCS in 1115 waiver; Reported in New York, Texas

**Not NQF-endorsed**

### Psychiatric Inpatient Readmissions – Medicaid (PCR-P)

**Measure Steward:** Washington State Department of Social and Health Services

**Alignment**: Reported in Washington State Common Measure Set

**Not NQF-endorsed**

### Potentially Preventable Emergency Room Visits (for persons with BH diagnosis)*

**Measure Steward:** 3M

**Alignment:** Reported in New York

**Measure Concept*

## Promoting Community Integration through Community-Based Long-Term Services and Supports

**0097 Endorsed**

### Medication Reconciliation Post-Discharge

**Measure Steward:** National Committee for Quality Assurance (NCQA)

**Alignment**: MAP Dual Eligible Beneficiaries Family of Measures; Merit-Based Incentive Payment System (MIPS); Reported in Colorado

**0101 Endorsed**

### Falls: Screening for Fall Risk

**Measure Steward:** NCQA

**Alignment**: PQRS; MSSP; QRUR; VBM

**0326 Endorsed**

### Advance Care Plan

**Measure Steward:** NCQA

**Alignment**: MIPS; PQRS

**0419 Endorsed**

### Documentation of Current Medications in the Medical Record

**Measure Steward:** CMS

**Alignment**: PQRS; MSSP; QRUR; VBM

**0647 Endorsed**

### Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

**Measure Steward:** PCPI

**Alignment**: IPFQR

**2483 Endorsed**

### Gains in Patient Activation (PAM) Scores at 12 Months

**Measure Steward:** Insignia Health

**Alignment**: Reported in Colorado's Rocky Mountain Regional Care Collaborative Organization

**2967 Endorsed**

### CAHPS® Home and Community Based Services (HCBS) Measures

**Measure Steward:** CMS

**Alignment**: N/A

**Not NQF-endorsed**

### Adult Access to Preventive/Ambulatory Care 20-44, 45-64, 65+

**Measure Steward:** NCQA

**Alignment**: N/A

**Not NQF-endorsed**

### Home- and Community- Based Long Term Services and Supports Use Measure Definition (HCBS)

**Measure Steward:** Washington State Department of Social and Health Services

**Alignment**: Reported in Washington Medicaid

**Not NQF-endorsed**

### Percentage of short-Stay Residents who were Successfully Discharged to the Community

**Measure Steward:** N/A

**Alignment**: Five-Star Quality Rating System

**Not NQF-endorsed**

### Individualized Plan of Care Completed*

**Measure Steward:** N/A

**Alignment**: N/A

**Not NQF-endorsed**

### National Core Indicators*

**Measure Steward:** Human Services Research Institute (HSRI) and The National Association of State Directors of Developmental Disabilities Services (NASDDDS)

**Alignment**: NY State Managed Long Term Care Measures

**Not NQF-endorsed**

### National Core Indicators – Aging and Disability*

**Measure Steward:** Human Services Research Institute (HSRI) and The National Association of State Directors of Developmental Disabilities Services (NASDDDS)

**Alignment**: N/A

**Not NQF-endorsed**

### Number and Percent of Waiver Participants Who Had Assessments Completed by the MCO That Included Physical, Behavioral, and Functional Components to Determine the Member's Needs*

**Measure Steward:** N/A

**Alignment**: KanCare; additional states' Managed Care

**Measure Concept*

## Supporting Physical and Mental Health Integration

**0097 Endorsed**

### Medication Reconciliation Post-Discharge

**Measure Steward:** National Committee for Quality Assurance (NCQA)

**Alignment**: MAP Dual Eligible Beneficiaries Family of Measures; Merit-Based Incentive Payment System (MIPS); Reported in Colorado

**0105 Endorsed**

### Antidepressant Medication Management (AMM)

**Measure Steward:** NCQA

**Alignment**: 2016 Medicaid Adult Core Set; MAP Dual Eligible Beneficiaries Family of Measures; Reported in the following states:

- Alabama
- Arkansas
- California
- Colorado
- Connecticut
- Delaware
- Dist. of Columbia
- Georgia
- Illinois
- Iowa
- Kentucky
- Louisiana
- Massachusetts
- Michigan
- Minnesota
- Mississippi
- Missouri
- New Hampshire
- New Mexico
- New York
- North Carolina
- Ohio
- Oklahoma
- Pennsylvania
- Rhode Island
- Tennessee
- Texas
- Vermont
- Virginia
- Washington

**0419 Endorsed**

### Documentation of Current Medications in the Medical Record

**Measure Steward:** CMS

**Alignment**: PQRS; MSSP; QRUR; VBM

**0576 Endorsed**

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

**Measure Steward:** NCQA

**Alignment**: Medicaid Adult and Child Core Sets (2017); MAP Dual Eligibles Family of Measures (2016); Reported in Oregon's coordinated care organizations (CCOs); MIPS; Inpatient Psychiatric Facility Quality Reporting Program (IPFQR); Reported in the following states:

- Alabama
- Arkansas
- California
- Colorado
- Connecticut
- Delaware
- Dist. of Columbia
- Georgia
- Illinois
- Iowa
- Kentucky
- Louisiana
- Massachusetts
- Minnesota
- Mississippi
- Missouri
- New Hampshire
- New Mexico
- New York
- Ohio
- Oklahoma
- Oregon
- Pennsylvania
- Rhode Island
- South Carolina
- Tennessee
- Texas
- Vermont
- Virginia
- Washington
- West Virginia

**0710 Endorsed**

### Depression Remission at Twelve Months

**Measure Steward:** Minnesota Community Measurement

**Alignment**: PQRS, MSSP, QRUR, VBM, CA 1115 waiver – PRIME

**1879 Endorsed**

### Adherence to Antipsychotic Medications for Individuals with Schizophrenia

**Measure Steward:** CMS

**Alignment**: PQRS; QRUR; VBM; PA DHS Integrated Care Pay for Performance Program; Reported in the following states:

- Alabama
- Arkansas
- California
- Colorado
- Connecticut
- Delaware
- Dist. of Columbia
- Georgia
- Illinois
- Iowa
- Kentucky
- Louisiana
- Massachusetts
- Missouri
- New Mexico
- New York
- North Carolina
- Pennsylvania
- Rhode Island
- South Carolina
- Tennessee
- Texas
- Vermont
- Washington
- West Virginia

**1880 Endorsed**

### Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

**Measure Steward:** CMS

**Alignment**: NYS Medicaid Value Based Payment

**1922 Endorsed**

### HBIPS-1 Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths Completed

**Measure Steward:** The Joint Commission

**Alignment**: N/A

**1927 Endorsed**

Cardiovascular Health Screening for People With Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications

**Measure Steward:** NCQA

**Alignment**: Reported in Arkansas Medicaid

**1932 Endorsed**

Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

**Measure Steward:** NCQA

**Alignment**: Medicaid

**1933 Endorsed**

Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)

**Measure Steward:** NCQA

**Alignment**: Reported in Arkansas Medicaid

**1934 Endorsed**

Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)

**Measure Steward:** NCQA

**Alignment**: Reported in Arkansas Medicaid

**1937 Endorsed**

Follow-Up After Hospitalization for Schizophrenia (7- and 30-day)

**Measure Steward:** NCQA

**Alignment**: N/A

**2599 Endorsed**

Alcohol Screening and Follow-up for People with Serious Mental Illness

**Measure Steward:** NCQA

**Alignment**: N/A

**2600 Endorsed**

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

**Measure Steward:** NCQA

**Alignment**: N/A

**2602 Endorsed**

Controlling High Blood Pressure for People with Serious Mental Illness

**Measure Steward:** NCQA

**Alignment**: N/A

**2603 Endorsed**

Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Testing

**Measure Steward:** NCQA

**Alignment**: N/A

**2604 Endorsed**

Diabetes Care for People with Serious Mental Illness: Medical Attention for Nephropathy

**Measure Steward:** NCQA

**Alignment**: N/A

**2605 Endorsed**

Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence

**Measure Steward:** NCQA

**Alignment**: MAP Dual Eligibles (2016); Reported in Vermont

**2607 Endorsed**

Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)

**Measure Steward:** NCQA

**Alignment**: N/A

**2609 Endorsed**

Diabetes Care for People with Serious Mental Illness: Eye Exam

**Measure Steward:** NCQA

**Alignment**: N/A

**3148 (formerly 0418) Endorsed**

Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan

**Measure Steward:** Centers for Medicare & Medicaid Services (CMS)

**Alignment**: Medicaid; Medicare Physician Quality Reporting System (PQRS); Medicare Shared Savings Program (MSSP); Physician Compare; Physician Feedback/Quality and Resource Use Reports (QRUR);

Physician Value-Based Payment Modifier (VBM); Reported in the following states:

- Oregon CCO
- CA 1115 waiver – PRIME
- Georgia
- Colorado
- Rhode Island
- Alabama
- Delaware

**Not NQF-endorsed**

### Adult Access to Preventive/Ambulatory Care 20-44, 45-64, 65+

**Measure Steward:** NCQA

**Alignment**: N/A

**Not NQF-endorsed**

### Behavioral Health Risk Assessment (for Pregnant Women) (BHRA)

**Measure Steward:** American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)

**Alignment**: Georgia Department of Community Health

**Not NQF-endorsed**

### Combined BH-PH Inpatient 30-Day Readmission Rate for Individuals With SMI Eligible Population, Denominator and Numerator Specifications

**Measure Steward:** IPRO

**Alignment**: Reported in Pennsylvania Medicaid

**Not NQF-endorsed**

### Depression Remission or Response for Adolescents and Adults

**Measure Steward:** NCQA

**Alignment**: N/A

**Not NQF-endorsed**

### Follow-Up After Emergency Department Visit for Mental Illness

**Measure Steward:** NCQA

**Alignment**: CA Whole Person Care Pilot

**Not NQF-endorsed**

### Mental Health Service Penetration

**Measure Steward:** Washington State DSHS

**Alignment**: Washington State Medicaid Demo

**Not NQF-endorsed**

### Mental Health Utilization: Number and Percentage of Members Receiving the Following Mental Health Services During the Measurement Year: Any Service, Inpatient, Intensive Outpatient or Partial Hospitalization, and Outpatient or ED

**Measure Steward:** NCQA

**Alignment**: N/A

**Not NQF-endorsed**

### Post-Partum Follow-up and Care Coordination

**Measure Steward:** AHRQ

**Alignment**: PQRS

**Not NQF-endorsed**

### PACT Utilization for Individuals with Schizophrenia*

**Measure Steward:** American Psychiatric Association

**Alignment**: N/A

**Measure Concept*

# APPENDIX H:
## Public Comments and Committee Responses

## General Comments

**American Academy of Neurology**

**Amy Bennett**

The American Academy of Neurology (AAN) an association of more than 28,000 neurologists and neuroscience professionals appreciates the opportunity to comment on the 2017 NQF Medicaid Innovation Accelerator Project. The AAN supports the use of the documentation of signed opioid treatment agreement and evaluation or interview for risk of opioid misuse measures in the Reducing Substance Use Disorders measure set.

**>Committee Response:**

Thank you for your comment.

**American Association on Health and Disability**

**E. Clarke Ross**

Where are the beneficiary-participant-consumer-patient engagement measures?

A frustration with the excellent work of the NQF is the frequent inability to cross-reference other NQF projects. For example, in its March 15, 2017 NQF MAP report to HHS & CMS, 6 "high value measures" are identified and explained. Two of the 6 are patient-reported outcome measures and measures addressing the patient experience. These patient-beneficiary-participant-consumer experience measures are generally missing from the Medicaid innovation report.

The NQF Medicaid innovation report acknowledges the CAHPS HCBS Experience Survey and includes the National Core Indicators (NCI) survey managed by NASUAD. But other CAHPS surveys are largely not discussed. The NCI managed by NASDDDS is not included. Personal Outcomes Measures by CQL is not discussed. The ECHO is not discussed. The Medicaid innovation report needs a much greater cross walk with the NQF MAP recommendations and NQF work on beneficiary-participant-consumer-patient measures, and how they apply to Medicaid and Medicaid innovation.

American Association on Health and Disability and Lakeshore Foundation, Clarke Ross, part 1

**>Committee Response:**

Thank you for your comment and measure recommendations. The Committee understands the importance of patient engagement measures and agrees more surveys with performance measures are needed.

**American Association on Health and Disability**

**E. Clarke Ross**

Community Integration Through Community-Based Long Term Services and Supports – pages 23-28
The Medicaid innovation report identifies and discusses many important topics such as: Population Diversity within the CB-LTSS program – page 24; Measures focused on the medical component, and not on quality of life nor community integration & rebalancing – page 24; CAHPS HCBS Experience Survey – pages 25-27; and National Core Indicators administered by NASUAD – pages 27-28 and 75.

Physical and Mental Health Integration – pages 28-38

The Medicaid innovation report makes helpful observations about barriers – pages 28-29; acknowledges too many process measures and few outcome measures – page 29; and includes (PACT) Programs for Community Assertive Treatment, as a measure concept – page 38.

American Association on Health and Disability and Lakeshore Foundation, Clarke Ross, part 2

**>Committee Response:**

Thank you for your supportive comments regarding the Coordinating Committee discussion topics, such as identified barriers and acknowledgement of too many process measures.

### Federation of American Hospitals

**Jayne Chambers**

The Federation of American Hospitals ("FAH") appreciates the opportunity to comment on the National Quality Forum Medicaid Accelerator Innovation report. FAH supports the intent of this report and offers comments in an effort to further enhance the work.

FAH is concerned with the number of measures and potential duplication currently included within each topic area. Several measures are duplicative and/or look at very narrow topics and populations. For example, there are four measures that look at medication reconciliation – two measures are from the same measure developer and appear to be identical; one is currently in the Centers for Medicare and Medicaid Services (CMS) Merit-based Incentive Payment System (MIPS) and the 2017 benchmark data shows that performance is almost topped out; and the fourth examines what occurred with unintentional medication discrepancies during a hospitalization. In addition, many of these measures require chart abstraction or extraction from an electronic health record system (EHRS), which may prove overly burdensome. FAH is concerned that providing so many duplicative or similar measures with the data collection requirements will not assist Medicaid programs in selecting and using those measures that can have a positive impact on the health of the people served.

Additional explanations on why some of these measures were included would be helpful. At times, the rationale paragraph outlines the committees' concerns but does not provide information on what then persuaded them to continue to recommend the measure's inclusion. FAH also notes that endorsement was removed for Measure #0647, Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care). We question why a measure that no longer is endorsed continues to be recommended.

It is also not clear how the measures identified across the four topic areas are intended to be used or align with the Measures Applications Partnership Medicaid Adult and Child Core Sets. Additional information on the advantages and disadvantages on the differences between the measure sets and how Medicaid programs are intended to use the information across these activities would be helpful.

FAH thanks the Committee for their thoughtful report. The comments we provide are intended to further improve and refine this work.

**>Committee Response:**

Thank you for your comments. The CC's role was to identify measures that could potentially be used within the Medicaid population. These measures and measures concepts will be submitted to CMS for their final review and consideration. The alignment with other programs is included in the report to highlight those measures that align with existing programs.

The CC discussed measure #0647, which lost NQF endorsement after the CC's deliberations. Several CC members noted that this measure is in use in their states. The CC decided to move forward with the recommendation because it is an important patient centered measure.

### HMA

**Izanne Leonardhaak**

Thank you for the opportunity to comment

Organizing the measures: We suggest segregating the measures in some way to assist states in understanding how to use them (e.g. outcome, process, structure measures)

Measures are not all publicly available: Many of the measures listed require states to pay for access, and may have restrictions on use/sharing/publication. We recommend this be made more clear in the introduction of the paper

Measure separation implies limited use: Although Appendix E shows where measures might be used across all four IAP programs, this point is not brought out earlier in the paper or in the individual program section. Conversely some are not listed for a given program, but could be (e.g. some additional integration measures are helpful to BCN)

More guidance needed: Some measures in the BCN area, for example, seem to have a global measure and then subset measures (e.g. potentially preventable readmissions, and psychiatric inpatient admissions). More explanations should be given to make it clear when you should use one over another, or when to

find a more appropriate subset (rather than general measure).

Emphasis on telemedicine may be beneficial: 0105, and 0576 have been approved by NCQA for telemedicine. States may find this helpful to know, particularly in areas with rural access issues.

Some links appear not to be operable or available at all: E.g. 1598 and 2456 are two examples where links did not seem to work, and potentially preventable admission (3M) was not linked at all.

Medicaid risk-adjusted measure: It is not clear whether these measures are risk-adjusted or apply to Medicaid populations.

Mentioning steward may be confusing: It may be helpful to mention steward only for non-NQF measures. Some of the NQF-endorsed or -enumerated measures list a steward, even though it has an NQF number. The NQF site should be the system of record, if that is the intent. The steward should be the primary resource only when the measure is not in the NQF database.

t. Hope our Feedback is helpful.

**>Committee Response:**

Thank you for your comments. Staff will make the appropriate changes to the report.

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**Human Services Research Institute**

**Valerie Bradley**

NQF Draft of Measures for the Medicaid Innovation Accelerator Program

Human Services Research Institute

p. 24 —The report states that "CB-LTSS is a nascent field that lacks performance measures." For 20 years, HSRI and NASDDDS have supported NCI –built on a consensus among public managers and stakeholders regarding the domains and indicators that align with quality and consumer experience in LTSS for individuals with I/DD. NCI data have been used to illuminate many important issues, to document performance in HCBS waiver evidence submissions, to track the implementation of the HCBS Settings Rule, and to provide state comparisons. NCI-AD began in 2012; currently there are as many as 20 states either collecting data or preparing for the next data cycle.

p. 24 – The report notes "Significant gaps remain . . . including care plans and lack of care plan delivery, choice and control, delivery of services, and workforce shortage." NCI and NCI-AD include domains that address choice and control and delivery of services. NCI also includes a workforce survey of providers regarding wages, recruitment, turnover, and vacancy rates in 21 states.

p. 24 – In the table, National Core Indicators mistakenly identifies the NASUAD as one of the stewards. It should read NASDDDS and HSRI.

p. 26 –The report states CAHPS ". . . is one of the first tools to assess HCBS quality from the perspective of the individuals receiving support." As we note above, NCI was launched in 1997.

p. 27 – The report states that LTSS plans should be person centered. Both NCI and NCI-AD address person centered practices, particularly with respect to person-centered planning and associated outcomes. The indicators were revised to align with the planning requirements in the CMS HCBS settings rule.

p. 27 – The heading for NCI mistakenly lists NASUAD as the responsible organization. It should read NASDDDS and HSRI.

p. 28 – In addition to NASUAD, HSRI should also be listed as responsible organization for NCI-AD.

p. 28 –There is significant overlap in domains and indicators in NCI and NCI—AD.

Appendix G. – It is noted in the chart that NCI is "aligned with" a New York managed care tool. It is not clear what "aligned with" means and why or how the New York tool was chosen. Many other tools align with NCI and NCI-AD. This choice seems arbitrary.

Finally, in the introduction to the document, it is stated that, "State Medicaid programs face. . . challenges in finding . . . standardized measures to evaluate quality within states and compare . . . across providers, states and payers." NCI and NCI-AD are tools that were purposely developed to allow for cross-state comparisons.

**>Committee Response:**

Thank you for your comments. Staff corrected the stewards for NCI. The committee recognizes the contributions of the NCI in collecting information directly from individuals, families and caregivers

on key topics such as quality of life, community integration, The report also highlights that 46 states currently participate in collecting data through surveys. The report also stated that work is underway in the development of Patient Reported Outcome Measures through the stewards of NCI and NCI-AD.

### NASDDDS

**Mary Lou Bourne**

NASDDDS has these additional comments on the Draft Report on Medicaid Innovation Accelerator Program, July21,2017, specifically the sections related to NCI as a measure concept within the Promoting Community Integration through Community Based Long Term Services and Supports Program Areas Measure Recommendations.

Page 28:

Under the heading of National Core Indicators, the final sentence states: "The NCI and NCI-AD address all individuals with disabilities." NCI addresses individuals with intellectual and developmental disabilities. NCI-AD is a separate and distinct measure set, addressing people receiving support through a states aging and physical disability service systems. We suggest the references to NCI and NCI-AD be separated under this heading.

Page 28:

Under the heading of National Core Indicators, the final sentence states: "The NCI and NCI-AD address all individuals with disabilities." NCI addresses individuals with intellectual and developmental disabilities. NCI-AD is a separate and distinct measure set, addressing people receiving support through a states aging and physical disability service systems. We suggest the references to NCI and NCI-AD be separated under this heading.

Appendix G:

It is noted in the chart that NCI is "aligned with" a New York managed care tool. It would be helpful to note the definition of "alignment" used in the report. It is not clear why or how the New York tool was chosen for inclusion in the table. A number of other efforts align with NCI, assuming the definition references measures which work in a complementary fashion, or which provide similar measures at different organizational level (private agencies for example). In general, the report could be more clear in how it chooses to reference additional measure sets in "alignment" so as to avoid misunderstanding on the part of the public.

**>Committee Response:**

Thank you for your comments. NQF staff will amend the report and clarify the distinction between NCI and NCI-AD. For the purposes of this report, NQF staff examined measures that are in use in public reported programs as well as those currently used in states. NQF staff relied on information provided from a variety of sources included Committee members who assisted them in identifying appropriate sources.

### NASDDDS

**Mary Lou Bourne**

NASDDDS acknowledge and appreciate the workgroups recognition of NCI as a measure concept within the CB-LTSS programs. With respect to the details of NCI, we submit the following comments:

Page 24:

The report states that "CB-LTSS is a nascent field that lacks performance measures." We disagree with this statement. NCI has provided performance measures to the Developmental Disabilities systems for 20 years, with benchmarks on outcomes specifically related to choice, community integration, service coordination and access. NCI data has also served as the foundation for many articles in peer reviewed journals and as support for researchers across the country who are interested in the ID/DD field. The NCI suite of tools also includes a workforce survey that canvasses providers regarding wages, recruitment, turnover, and vacancy rates in 21 states.

Table 3 MEASURES/CONCEPTS RECOMMENDED FOR INCLUSION IN THE CB-LTSS MEASURE SET identifies NCI stewards as Human Service Research Institute (HSRI) and The National Association of States United for Aging and Disabilities. This is inaccurate. HSRI and the National Association of State Directors of Developmental Disabilities Services are the stewards of NCI.

Page 26:

In the discussion of the CAHPS HCBS survey, the report states: "The CC supported the inclusion of this measure for several reasons. First, this measure

is part of a suite of CAHPS surveys. States have accepted and have experience implementing CAHPS surveys. Second, it is one of the first tools to assess HCBS quality from the perspective of the individuals receiving support. Third, it focuses on supports needed to live independently, instead of many current measures adapted from clinical and medical care..'' As we note above, 46 states plus the District of Columbia have accepted and have experience implementing NCI surveys, and of equal importance, using the national and state specific reports which are generated from the data. Second, NCI launched in 1997, and therefore should be noted as the first tool to assess HCBS from the perspective of individual receiving support through this Medicaid program. Third, NCI's primary focus is on the supports delivered to people with intellectual and developmental disabilities to live, work, and socialize as members of their community, rather than on clinical or acute medical care measures. If these are the criteria for supporting the inclusion of the measure set, we strongly believe the report should note that NCI meets these same criteria.

Page 27:

The heading for National Core Indicators mistakenly identifies the NASUAD as the responsible organization. It should read NASDDDS and HSRI.

**>Committee Response:**

Thank you for your comments. Staff will amend the report to include correct information regarding NCI stewards. The committee recognizes the contributions of the NCI in collecting information directly from individuals, families and caregivers on key topics such as quality of life and community integration. These surveys are widely used by 46 states across the country to capture this valuable information directly from the consumer of services. The report has been amended to reflect that the HCBS CAHPS survey is the first survey with performances measures. The Committee also recognized the work underway in the development of Patient Reported Outcome Measures through the stewards of NCI and NCI-AD.

**National Association of States United for Aging and Disabilities**

**Camille Dobson**

NASUAD represents the nation's 56 state and territorial agencies on aging and disabilities and supports visionary state leadership, the advancement of state systems innovation and the articulation of national policies that support home and community based services for older adults and individuals with disabilities. NASUAD's expertise lies in home and community based services and supports. We have therefore focused our comments on the Community-Based Long-Term Services and Supports (CB-LTSS) IAP program area.

GENERAL COMMENTS

We are deeply disappointed that the IAP Coordinating Committee (CC) virtually ignored the work of the NQF HCBS Quality Committee and the framework for quality measures that was published in 2016. That framework laid out 11 domains of measures and identified promising measures in a number of those domains. Instead the CC focused on the CMS National Quality Strategy and the 6 domains of measurement included therein. While we acknowledge that those domains are more appropriate for the other 3 IAP areas – being that they are all clinically focused – it does not seem unreasonable for the NQF staff, CMS and the CC to recognize the lack of relevance for those domains to HCBS quality measures and use the HCBS framework. It does not appear to us that those approaches are inconsistent. Two years of work on the HCBS Quality Framework was generally ignored – both in the TEP and CC work as well as in this draft report. It was a missed opportunity to use an approach that is being used by other quality measurement/development efforts in the country. It has resulted in a set of recommended measures and measure concepts that generally do not speak to the key elements of HCBS quality.

We vigorously dispute the characterization included at the top of page 24 that CB-LTSS is a nascent field that lacks performance measures. CB-LTSS or HCBS as it is more commonly known has been delivered by states to Medicaid consumers for over 30 years. Because HCBS are unique to each person, standardized measures – such as those found in the

health care sector – are challenging. Nonetheless, while there may be few NQF-endorsed HCBS measures, there are indeed a number of quality measures in place in every state with HCBS waiver programs. We recommend the rephrasing of that phrase.

Finally, we do not understand Appendix G. In general, the selection of other programs and measure sets to demonstrate alignment in this Appendix seems rather arbitrary and can be misleading. If alignment is going to be addressed, it should be more expansive and inclusive of all the resources that NQF staff reviewed.

**>Committee Response:**

Thank you for your comments regarding the importance of the work in the Quality Home and Community -Based Services report. NQF Staff used the NQF HCBS Quality Framework as well as other NQF projects as a source of measures for this project.

**RTI International**

**Tami Mark**

Page 7 says. "The CC recommends that CMS consider 24 measures and five concepts for the SUD program area measure set (Table 1). However, Table 1 has less than 24 measures. Where are the other measures that are mentioned (e.g. the 2 outcome measures?)

There doesn't appear to have been an effort to harmonize the SUD measures with the measures that have been used for decades under SAMHSA programs such as the NOMs measures and the more recent measures being used under the Certified Community Behavioral Health Center Demonstration. SUD specialty providers have lots of experience with the block grant measures. Why were these not reviewed and considered?

There seems to be a lack of recognition in the discussion of harmonization and the measure selection that the measures appropriate for the addiction specialty sector, will typically not be appropriate for primary care, and vice-versa.

The BASIC seems to be the only SUD outcome measures selected. It wasn't clear why this measures was selected. To my knowledge it is not validated for SUD. There are other SUD outcome measures that have a much larger evidence base regarding their validity and reliability, and are used in practice.

The alcohol medication penetration measure was recommended even though the NQF behavioral health committee did not endorse it as a measure.

The committee appeared to encourage the use of a measure to ensure that behavioral therapy was provided a long with OUD medications, but the research evidence suggests therapy does not always improve outcomes when provided with OUD medications, and what type of therapy, works for whom, when is still very unclear.

**>Committee Response:**

Thank you for your comment. Staff reviewed the report and ensured that the measure totals and the tables are aligned. As noted in the report, these measure recommendations serve as a menu of available measure options and are not prescribed as one measure set. States may choose which measures to use based on their specific needs and resources.

**Texas Health and Human Services Commission**

**Beren Dutra**

Texas HHSC was pleased to see the inclusion of several process measures in the recommendation: measures 0418, 1922, 1927, 1932, 1933, 1934, 2599, 2600, 2602, 2603, 2604, 2607, 2609, BHRA, Behavioral Health Risk Assessment for Pregnant Women, and Post-Partum Follow-Up and Care Coordination. These measures were heavy in process and light in outcome. While there are important process measures, outcome measures such as the recommended NQF measure Controlling High Blood Pressure for People with Serious Mental Illness are important. We strongly support the inclusion of outcome measures. HHSC has identified measures of structural integration as a gap. We are pleased to see the inclusion of measures 0097 and 0419 in the recommendation. We hope that additional measures can be created to monitor structural integration, such as formal data sharing agreements between primary care and behavioral health providers, information sharing protocols among different specialties, and care coordination activities. HHSC was pleased to see the inclusion of the IPRO measure, Combined BH-PH Inpatient 30-Day Readmission Rate for Individuals with SMI, included in the list of suggested measures. HHSC is working to identify individuals with co-occurring physical and behavioral health

conditions who experience a PPE, as well as descriptive information on the people meeting this criteria and the reason for the PPE. Staff noticed that potentially preventable emergency room visits are listed as a measure in Appendix E for the program area Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs. We believe that this measure and other potentially preventable event (PPE) measures could also be included as suggested integration measures. Staff also hope that measures can be created to capture social determinants of health for individuals with co-occurring physical and behavioral health conditions, such as housing, employment, jail diversion, and functional status. Some diagnoses codes exist in the ICD-10 identifying these types of determinants, specifically Z55 - Z65. HHSC recognizes that some measures focus on adults while others focus on children. Staff believe that the creation of integration measures over the lifecourse of an individual would be helpful in improving health outcomes for members with co-occurring conditions. HHSC has found several measures are difficult to use for purposes of integration. For example, the following measures may capture some encounters in which a physical health provider provides a behavioral health service, but more likely a behavioral health provider will deliver the service. While each of these is an important behavioral health measure, it is difficult to identify how these measures are related to integration without data analysis to identify the types or providers who provide these services: 0105, 0576, 1879, 1880, 1937, 2605, and Follow-Up after Emergency Department Visit for Mental Illness.

**>Committee Response:**

Thank you for your comments. The Committee agrees with the measurement gaps identified, and notes the lack of outcome measures available within the field in the report.

### The SCAN Foundation

**Megan Burke**

The SCAN Foundation believes person-centered care should be implemented across the spectrum of care (e.g., medical, LTSS, behavioral), and are pleased to see characteristics of person-centered care being incorporated into measures recommended by the Coordinating Committee. The Patient Activation Measure (PAM) provides a good example of applying person-centered measures across the BCN and LTSS program areas. Acknowledging that the Coordinating Committee makes recommendations in accordance with what measures currently exist, we believe there is more work to be done to incorporate person-centered measures that address an individual's goals, values and preferences. Work is currently underway by the National Committee for Quality Assurance (NCQA), funded by The SCAN Foundation and the John A. Hartford Foundation, to develop person-driven outcome measures1 that focus on outcomes identified by the individual. This body of work tests two promising methods for documenting person-driven outcomes in a standardized format, and could form a basis for building person-driven quality metrics in the future. We recommend NQF review NCQA's work, and give consideration of person-driven outcome measures when available in three years. Additionally, a panel of national experts articulated four Essential Attributes2 of a high-quality system of care, centering on person-centered care concepts. We recommend that NQF incubate new quality measures that directly relate to the Essential Attributes framework and specifically address the integration of medical and non-medical services for people with complex care needs.

1. NCQA, Person-Driven Outcomes - http://www.ncqa.org/hedis-quality-measurement/research/measuring-what-matters-most

2. Essential Attributes of a High-Quality System of Care for Adults with Complex Care Needs - http://www.thescanfoundation.org/what-matters-most-essential-attributes-high-quality-system-care-adults-complex-care-needs?platform=hootsuite

**>Committee Response:**

Thank you for your comment. The Committee has noted your support of NQF #2483 Gains in Patient Activation (PAM) Scores at 12 Months.

Thank you for sharing information about work in progress regarding measure development that integrates medical and non-medical services for people with complex care needs.

**The SCAN Foundation**

**Megan Burke**

The Coordinating Committee elevated the challenges related to measuring integration of physical and behavior health services, especially in states where behavioral health is "carved-out" of Medicaid Managed Care plan services. California is one such state, and evaluation of the state's dual eligible financial alignment demonstration (Cal MediConnect) has provided the opportunity to examine the challenges presented by the "carve-out" of behavioral health services. A newly released report, The Coordination of Behavioral Health Care Through Cal MediConnect,1 identifies barriers and potential solutions to better coordinating physical and behavioral health services. The information provided in this report could be useful to identifying areas for measure development to help improve integration.

The Coordination of Behavioral Health Care Through Cal MediConnect - http://www.thescanfoundation.org/evaluating-medicare-medicaid-integration

**>Committee Response:**

Thank you for your comment.

**Treatment Research Institute**

**Mady Chalk**

While the NQF Report acknowledges that most of the recommended measures are process measures and that there are few outcome measures (pg 29) there are no recommendations about how the IAP as well as NQF might begin to address this critical issue. It is also very frustrating not to see more reference and cross-walking of the discussions from the NQF MAP and BH Standing Committee in this report.

Of particular concern are two or the Joint Commission measures that are recomended (1663,1664) which require a check mark only and accept as a standard that if the service is offered that is sufficient. These measures should not be viewed as adequate for accountabilitiy by purchasers.

With regard to patient-centered measures CAHPS and the NCI are recognized but their limitations for SUD are not discussed, nor is the ECHO discussed or other patient-centered surveys. The need for patient-engagement measures is also not identified as an issue that needs to be addressed---the PAM is costly for many treatment programs and questions about its utility have been raised by many programs.

**>Committee Response:**

Thank you for your comment. The CC agrees there are many areas lacking adequate quality measures. The CC encourages development in these areas. The measure recommendations will be submitted to CMS on September 14th for consideration.

NQF Staff used the NQF Behavioral Health project as well as other NQF projects as a source of measures for this project. The CC also discussed comments in favor and those not in favor of the PAM measure. Ultimately deciding to move forward with the recommendaiton to include the measure in both the BCN and CI-LTSS program areas. The CC noted that the recommendations provide states with a menu of options, not a mandate, and states should use the measure only if feasible, taking the cost into consideration. The CC also noted that the PAM provides value in other outcomes besides activation itself, including ED use and admissions. The PAM is NQF endorsed and is in active use across multiple states.

## Recommended Measures

**American Occupational Therapy Association**

**Jeremy Furniss**

The American Occupational Therapy Association appreciates the work and effort of the group to develop recommendations for the Innovation Accelerator Program. We believe it is important to harmonize efforts to measure progress in Medicaid programs across states. Thank you for allowing us to provide a brief comment on the measures identified in the report.

CB-LTSS

AOTA would urge the project to consider adding the functional ability as a measurement concept. The work being completed under the Functional Assessment Standardized Items (FASI) project can be informative in this area. Functional ability is often a predictor of transitioning out of the community and the need for higher level of services for support.

AOTA supports the inclusion of NQF 0101, 0419, and the inclusion of a patient experience measure.

PMH

AOTA also supports the inclusion of NQF 0418 in the PMH recommendations.

**>Committee Response:**

Thank you for your comment.

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**Community Health Center Network**

**Laura Miller**

I am writing to support the position that the PAM be removed from the recommended list of metrics. My organization, Community Health Center Network (CHCN) developed a complex case management program called Care Neighborhood, focusing on high-risk high-need Medi-Cal patients in our member clinics. We focus not only on medical issues, but also on the social determinants of health. Our population faces significant challenges -- food and housing insecurity, lack of transportation, history of trauma, structural inequality to name a few. The resilience of our patients in the face of these challenges is impressive.

In 2014, my organization was the only organizations participating in the Pacific Business Group on Health's Intensive Outpatient Care Program (IOCP) that served a primarily low income, Medicaid population.

A requirement for participation in this pilot was to use the Patient Activation Measure (PAM) tool. Our team did not find that PAM scores were meaningful markers of progress or reliable indicators of patient engagement. When our complex care program continued after completion of the IOCP grant, we elected to discontinue use of the PAM.

While the concept of patient activation is a critical concept to measure and track for high-cost/high-risk patients, the PAM does not accurately measure this in the Medicaid population where activation is influenced by numerous competing demands and other social vulnerabilities.

I strongly recommend that the coordinating committee removes the patient activation measure from the recommended list of metrics for the final version of this report.

**>Committee Response:**

Thank you for your comment. The CC discussed concerns regarding NQF #2483 Gains in Patient Activation (PAM) Scores at 12 Months and decided to move forward with its recommendation. While the the CC noted that there are pros and cons to using the measure, the CC determined that the PAM addressed an important gap in measurement in the BCN and CI-LTSS measure lists. The CC addressed the measure's limitations within the BCN population and noted that the the measure has only recently been used in that population and that no definitive results are available yet. The CC also noted that the PAM provides value in other outcomes besides activation itself, including ED use and admissions. The PAM is also NQF endorsed and is in active use across multiple states. On the matter of how the PAM addresses social determinants, the CC noted that the measure focuses on internal self-management rather than external assistance needed and that other external measures are not ready for imediate use.

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**Hassanah**

**Janice Tufte**

Reading through the measures I was curious as to why the all- domain adult access to preventative/ amulatory care starts at 20, rather than 18. (20-44,45-64,65+). I noticed later BCN post discharge medication reconciliation is 18 and above.

**>Committee Response:**

Thank you for your comment. The Committee is unable to alter measure specifications as measure changes are at the discretion of the developer.

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**Hassanah**

**Janice Tufte**

I am new to this commenting on measures in development, though I am curious as to why NQF #1879 Adherence to antipsychotic medications for individuals with Schizophrenia is listed in Appendix E as a Recomended Measure, also is included in Appendix F under Additional Measures Considerd. (only difference I notice between the two is the additional word "medication" in Appendix E(RecommendedM) both were listed in PHMH domain area.

**>Committee Response:**

Thank you for your comment. Staff has reviewed the report and ensured that the measure is in the correct appendices.

**Hassanah**

**Janice Tufte**

When I read through the measurements the PAM measure jumped out at me. I understand it is a preferred survey tool for measuring patient engagement. It is my understanding that use of PAM also comes with a price tag? I heard like $2 a survey. I might be wrong though my concerns were that cost could be prohibitive for some states. I too understand this is a valid respected measure, maybe referencing alternative measurement opportunities might benefit the users as well

**>Committee Response:**

Thank you for your comment. The CC has decided to move forward with the recommendation of NQF #2483 Gains in Patient Activation (PAM) Scores at 12 Months. While the the CC considered public concerns and noted both favorable and unfavorable experiences implementing the PAM, the CC determined that the PAM addressed an important gap in measurement and in the BCN and CI-LTSS measure lists. On the issue of cost, the CC noted that the recommendations serve as a menu for states, not a mandate, and states should only use the measure if feasible, factoring the cost into their decision.

**Hassanah**

**Janice Tufte**

Regarding the CC SUD recommended measures, specifically the Primary Care Follow Up ASAM (measure concept) I personally think the 6 month time frame is important, of course 1-2 months is as well. By 6 months there may be an escalation in SUD use, higher doses, multiple prescribers etc I am glad you kept the 6 month measure concept . Thank you

**>Committee Response:**

Thank you for your comment. The Committee is unable to alter measure specifications as measure changes are at the discretion of the developer.

**Hassanah**

**Janice Tufte**

#NQF 0419 Documentation of Current Medications in the Medical Record (CMS) I was just curious who would qualify as an "eligible professional" who attests to documenting a list of current medications. It seems to me that a family member, a CNA, etc might also be able to do this ?

**>Committee Response:**

Thank you for your comment.

**Hassanah**

**Janice Tufte**

It seems to me that NQF #0576 (BCN) might benefit from merging the NQF #0647 measure to effectively document transition from in patient care to residential care services

**>Committee Response:**

Thank you for your comment. The Committee is unable to alter measure specifications as measure changes are at the discretion of the developer.

**Nancy Burke**

We recommend that the NQF remove the Patient Activation Measure (PAM) from the list of recommended measures in the Medicaid IAP Draft Report. While measuring the concept of "activation" is critical to "improving care for Medicaid beneficiaries with complex care needs and high costs," the PAM is not an appropriate measure for this population.

We are conducting a mixed methods study of complex care management (CCM) programs in two urban safety net institutions. CCM staff reported that the PAM is an ineffective measure in their patient populations—all of whom have complex care needs and high costs, and many of whom are on Medicaid. Despite patients exhibiting clear, discernible progress in their understanding of their disease conditions and self-management strategies, repeated measure of patients' PAM scores show no change.

We reviewed the PAM literature to determine to what extent the measures have been administered in populations whose characteristics mirror those of CCM patients and whether the measures could discern changes in activation in this population. After systematic review of 114 articles, our results, published in the Journal of Urban Health in June (doi: 10.1007/s11524-017-0159-9), reported that research using PAM has rarely been conducted on high needs

high cost patients who receive care in safety net settings; therefore, there were few opportunities to assess the appropriateness of the PAM in such populations. While studies using the PAM have documented its ability to predict patient satisfaction, hospitalizations and ED use, and overall cost of care, PAM studies are still by and large conducted among White, college educated, and insured samples reporting higher incomes and good to excellent health.

While only 9 PAM studies (8%) in our review included participants similar to those receiving care in the urban safety net, several expressed concerns with the potential unreliability and inappropriate nature of the PAM on multimorbid, older, and low-literacy patients. These studies suggest that PAM may not be appropriate for chronically ill, older, and low-literacy populations of color.

Assessing progress in the urban safety net requires measures that accurately discern improvements in health literacy, understanding of self-management strategies, and capacity to implement them, while accounting for the range of activation levels found in these populations. If patient activation metrics are to be deployed system-wide by CMS, we must ensure that those measures meaningfully capture patients' knowledge, skills, and confidence, and be capable of detecting changes over time. We strongly believe, based on our systematic review and on data from our ongoing study, that PAM does not meet these criteria, and therefore is not an appropriate tool for measuring patient engagement among those with complex care needs and high costs.

**>Committee Response:**

Thank you for your comment. The CC discussed concerns regarding NQF #2483 Gains in Patient Activation (PAM) Scores at 12 Months and decided to move forward with its recommendation. While the the CC noted that there are pros and cons to using the measure, the CC determined that the PAM addressed an important gap in measurement in the BCN and CI-LTSS measure lists. The CC addressed the measure's limitations within the BCN population and noted that the the measure has only recent been used in that population and that no definitive results are available yet. The CC also noted that the PAM provides value in other outcomes besides activation itself, including ED use and admissions. The PAM is NQF endorsed and is in active use across multiple states. While some treatment programs have questioned the measure, others have recommended the measure and highlight it as a good example. The CC also stated that while there is a cost associated with the PAM measure, states are not required to use the measure and should do so only if feasible.

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**National Association of States United for Aging and Disabilities**

**Camille Dobson**

NQF #2967 CAHPS® Home and Community Based Services (HCBS) Measures (CMS). The report states that "it is one of the first tools to assess HCBS quality from the perspective of the individuals receiving support." This is not an accurate statement. The National Core Indicators Adult Survey has been implemented in states since 1997, while the Council on Quality and Leadership (CQL) has been measuring participant experience and outcomes since the Outcome Based Performance Measures were introduced in 1993 and subsequently modified in 1997. The National Core Indicators – Aging and Disabilities has been in operation since 2014. While the CAHPS HCBS survey includes NQF-endorsed performance measures, NQF endorsement is not the only barometer of reliability, validity and broad use.

Percentage of Short-Stay Residents who were Successfully Discharged to the Community (CMS). The last sentence describing this measure is confusing. Managed care plans, by definition, do not serve fee-for-service consumers. We suggest rewriting this sentence to read "States can modify the denominator to include the specific populations they wish to measure".

National Core Indicators (NCI) (The National Association of States United for Aging and Disabilities) – Measure Concept. The responsible organization(s) for this survey tool is the National Association of State Directors of Developmental Disability Services and Human Services Research Institute, not NASUAD.

National Core Indicators – Aging and Disability (NCI-AD) (The National Association of States United for Aging and Disabilities) – Measure Concept. Along with NASUAD, HSRI is also responsible for NCI-AD.

TECHNICAL CORRECTIONS

P. 23, footnotes 33 and 34 - Updated data on total Medicaid HCBS spending – reflecting FY 2015 was released in April 2017 and is now available. We suggested that data be used instead of FY 2014 data.

The report is available here: https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpendituresffy2015final.pdf

P. 24 – In the table on this page, the reference to National Core Indicators mistakenly identifies NASUAD as one of the stewards. Please replace NASUAD with NASDDDS.

**>Committee Response:**

Thank you for your comments. The Committee recognizes that it is more accurate to state that the CAHPS is one of the first surveys with performance measures to assess quality from the perspective of the individuals receiving support. The report has been amended to reflect this statement. Thank you for clarifying the organizations responsible for both surveys.

### Pharmacy Quality Alliance

**Bill Lademann**

PQA (Pharmacy Quality Alliance) supports the NQF Coordinating Committee's (CC) recommendation that CMS consider including the following PQA Opioid measures in the Medicaid Reducing Substance Use Disorders measure set:

NQF #2940 Use of Opioids at High Dosage in Persons Without Cancer

NQF #2950 Use of Opioids from Multiple Providers in Persons Without Cancer

NQF #2951 Use of Opioids at High Dosages from Multiple Providers in Persons without Cancer

PQA agrees the inclusion of the three opioid measures within the measure set provides an additional resource for state Medicaid agencies to improve the overall population health of their Medicaid beneficiaries.

PQA is pleased to provide information to address any concerns noted by the CC regarding the development, details or possible unintended consequences of these measures. It may be helpful to note the opioid measures were developed prior to publication of the CDC guidelines.

Should NQF re-convene the multi-stakeholder CC, PQA recommends the review of two new PQA-endorsed measures. These measures will be submitted to NQF for endorsement consideration in the future as they address important measure gaps.

Concurrent Use of Opioids and Benzodiazepines

The percentage of individuals 18 years and older with 30 days or more of cumulative concurrent use of prescription opioids and benzodiazepines

Patients in hospice care and those with a cancer diagnosis are excluded.

Treatment of Chronic Hepatitis C: Completion of Therapy

The percentage of individuals 18 years and older who initiated antiviral therapy during the measurement year for treatment of chronic Hepatitis C, and who completed the minimum

intended duration of therapy with no significant gap(s) in therapy

**>Committee Response:**

Thank you for your comment.

### Texas Health and Human Services Commission

**Dan Culica**

Appendix G, page 64: Potentially Preventable Emergency Room Visits, Potentially Preventable Readmissions and Prevention Quality Indicators #90, are also reported in Texas.

Thank you.

**>Committee Response:**

Thank you for your comment, the Committee will amend Appendix G to include the additional use information on Potentially Preventable Emergency Room Visits, Potentially Preventable Readmissions and Prevention Quality Indicators #90.

### The SCAN Foundation

**Megan Burke**

Promoting Community Integration through Community-Based Long-Term Services and Supports Program Area Measure Recommendations

Individualized Plan of Care Completed (Measure Concept): The SCAN Foundation agrees with the

Coordinating Committee's recommendation for measure specification and definition of an individual plan of care (ICP) as the term is not necessarily synonymous with a person-centered plan. Evaluation results from California's financial alignment demonstration, in particular, the Cal MediConnect Health System Response Study(1) stressed the importance of clearly defining person-centered care to ensure the health plans elicit individuals' goals in the HRA process. As this ICP measure is being developed, we recommend incorporating a person-centered definition using key characteristics of person-centered care(2) or drawing on the essential attributes of a high-quality system of care (3) developed by a panel of national experts.

Cal MediConnect: Health System Response Key Findings and Recommendations - http://www.thescanfoundation.org/sites/default/files/cal_mediconnect_health_system_key_findings.pdf

Key Characteristics of Person-Centered Care - http://www.thescanfoundation.org/learn-more-about-person-centered-care

What Matters Most: Essential Attributes of a High-Quality System of Care for Adults with Complex Care Needs - http://www.thescanfoundation.org/what-matters-most-essential-attributes-high-quality-system-care-adults-complex-care-needs?platform=hootsuite

Number and percent of waiver participants who had assessments completed by the MCO that included physical, behavioral, and functional components to determine the member's needs (Measure Concept): The Foundation believes that quality outcomes can be achieved through person-centered care coordination based on a comprehensive assessment that informs the care plan. An individualized assessment process that addresses health, behavioral health, and functional items can be used to evaluate one's needs and create a care plan tailored to that person's strengths, needs, and service/support preferences. This information can be utilized not only for service delivery purposes, but also to support quality measurement by gathering information that can be used to construct LTSS quality measures. We agree with the Coordinating Committee recommendation to include this measure concept regarding administration of comprehensive assessments that include functional status and behavioral health needs.

**>Committee Response:**

Thank you for your comment.

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**Treatment Research Institute**

**Mady Chalk**

Too many screening measures. Too few follow-up after hosptalization or ER visit for SUD. No transition from withdrawal management (detoxifcation) to admission to treatment measures. No adherence to medication measures.

**>Committee Response:**

Thank you for your comment. The Committee agrees there are many areas lacking adequate quality measures. Please note the SUD measure recommendations include two measures of follow-up after emergency department visit and one for follow-up after a primary care visit.

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