NATIONAL QUALITY FORUM

Memo

April 29, 2019

To: Behavioral Health and Substance Use Standing Committee

From: NQF staff

Re: Post-comment web meeting to discuss public comments received and NQF member expression of support

Purpose of the Call

The Behavioral Health and Substance Use Standing Committee will meet via web meeting on May 3, 2019 from 1:00 pm to 3:00 pm ET. The purpose of this call is to:

- Review and discuss comments received during the post-evaluation public and member comment period from the fall 2018 review cycle;
- Provide input on proposed responses to the post-evaluation comments;
- Review and discuss NQF members' expression of support of the measures under consideration; and
- Determine whether reconsideration of any measures or other courses of action are warranted.

Standing Committee Actions

1. Review this briefing memo, and as you need to refer back to our draft report pertaining to fall 2018 measure reviews.
2. Review and consider the full text of all comments received and the proposed responses to the post-evaluation comments.
3. Review the NQF members' expressions of support of the submitted measures.
4. Be prepared to provide feedback and input on proposed post-evaluation comment responses.

Conference Call Information

Please use the following information to access the conference call line and webinar:

Speaker dial-in #: 800-768-2983
Access code: 3772061
Web link: https://core.callinfo.com/callme/?ap=8007682983&ac=3772061&role=p&mode=ad

Background

The Behavioral Health and Substance Use project aims to endorse measures of accountability for improving the delivery of behavioral health and substance use services and achieving better health outcomes for the U.S. population. The 23-member Standing Committee oversees NQF's portfolio of Behavioral Health and Substance Use measures that includes measures pertaining to serious mental illnesses (e.g., schizophrenia, mania, major depression), dysthymia, anxiety, ADHD and other learning behavioral problems, alcohol and

illegal drug use, tobacco dependence, care coordination (between and within the spheres of psychiatric, substance use, and related physical illness), medication use, and patient care experience. This portfolio contains 54 measures: 45 process measures, eight outcome and resource use measures, and one composite measure. The Standing Committee evaluated two newly submitted measures and two measures undergoing maintenance review against NQF's standard evaluation criteria. The Committee recommended three measures for endorsement and did not recommend one measure. The Standing Committee recommended the following three measures:

- 0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment
- 2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling
- 3453 Continuity of Care After Inpatient or Residential Treatment for Substance Use Disorder (SUD)

The Committee did not recommend the following measure:

- 3451 Non-Acute Mental Health Services Utilization for Dual Eligible Beneficiaries

Comments Received

NQF solicits comments on measures undergoing review in various ways and at various times throughout the evaluation process. First, NQF solicits comments on endorsed measures on an ongoing basis through the Quality Positioning System (QPS). Second, NQF solicits member and public comments during a 16-week comment period via an online tool on the project webpage.

Pre-evaluation Comments

NQF solicits comments prior to the evaluation of the measures via an online tool on the project webpage. For this evaluation cycle, the pre-evaluation comment period was open from November 29, 2018 to February 25, 2019 for the measures under review. Only one comment was submitted and shared with the Committee prior to the measure evaluation meetings. This comment pertained to measure 0004 *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment* and encouraged the full inclusion of residential treatment levels of care in the measure's specifications.

Post-evaluation Comments

The draft report was posted on the project webpage for public and NQF member comment on March 11 for 30 calendar days. During this commenting period, NQF received 16 comments from four member organizations:

Member Council	# of Member Organizations Who Commented
Consumer	0
Health Plan	1

Member Council	# of Member Organizations Who Commented
Health Professional	0
Provider Organization	0
Public/Community Health Agency	0
Purchaser	0
Quality Measurement, Research and Improvement (QMRI)	3
Supplier/Industry	0

We have included all comments (both pre- and post-evaluation) in the comment table (excel spreadsheet) posted to the Committee SharePoint site. This comment table contains the commenter's name, comment, associated measure, topic (if applicable), and—for the post-evaluation comments—draft responses (including measure steward/developer responses) for the Committee's consideration. Please review this table before the meeting and consider the individual comments received and the proposed responses to each.

To facilitate discussion, most of the post-evaluation comments have been categorized into major topic areas or themes by NQF staff. Although all comments are subject to discussion, the intent is not to discuss each individual comment on the May 3 post-comment call. Instead, we will spend much of the time considering the three themes discussed below and the set of comments as a whole. Please note that the organization of the comments into major topic areas is not an attempt to limit Committee discussion. Additionally, measure stewards/developers were asked to respond where appropriate, and those responses are included below. Where possible, NQF staff has proposed draft responses for the Committee to consider.

Comments and Responses

Themed Comments

Three major themes were identified in the post-evaluation comments, as follows:

1. Measure specification considerations
2. Data limitations
3. Measure gaps

Theme 1 - Measure Specification Considerations

Six comments specific to measure specifications were received for measures 0004 *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment* and 3453 *Continuity of Care After Inpatient or Residential Treatment for Substance Use Disorder (SUD)*. Some commenters supported the continued endorsement of the measures but expressed concerns about changes in the specifications. For measure 0004, a commenter noted concern that the post-initiation engagement period was extended from 30 to 34 days and suggested measuring the frequency of persons who refused treatment. Another commenter supported the update of the engagement period from 30 to 34 days but requested clarification on why the decision was reached. The commenter also suggested the measure be updated to reflect DSM-5 terminology

("substance use disorder" rather than "abuse" or "dependence") and disagreed that a psychotherapeutic or therapeutic code should be required with a MAT-approved medication code to meet the initiation numerator. One comment noted support for the specification updates: inclusion of pharmacotherapy, inclusion of telehealth services, and extension of the post initiation engagement period to 34 days. For measure 3453, a commenter recommended that the developer include peer support services and case management as continuity of care visits in the numerator. Another commenter suggested the specifications be harmonized with the related measures identified (e.g., follow-up time period). The commenter noted that existing measures that focus on follow-up could be re-specified to include patients with SUD and also expressed concern that the measure could potentially limit access to treatment for Medicaid beneficiaries if SUD is only specified as the primary condition.

Measure Steward/Developer Response:

Measure 3453: Peer support services are a growing resource with the potential to enhance an individual's care experience and quality of care; however, based on a review of the literature, there is currently limited empirical evidence that peer support services for individuals with SUD are related to improved outcomes. We acknowledge that case management could count as continuity of care. We will review the evidence and consider adding peer support services and care coordination for the annual update.

Measure Steward/Developer Response:

Measure 3453: We acknowledge the concerns about assessing whether appropriate follow-up care for those with substance use disorder (SUD) should occur as the primary condition alone. To clarify, for continuity (follow-up) services, the measure allows either a primary or secondary diagnosis of substance use disorder.

NQF 3453 is harmonized with related measures to the extent possible. Differences between NQF 3453 and other measures are the result of important conceptual differences between the measures, stakeholder input from a public comment period hosted by the Centers for Medicare & Medicaid Services, discussions with stakeholders, and input from the measure developer's technical expert panel (TEP). For example, NQF 3453 and to NQF 0576 *Follow-Up After Hospitalization for Mental Illness (FUH)* target different populations. NQF 3453 targets beneficiaries with SUD as a principal diagnosis and NQF 0576 *FUH* targets beneficiaries with mental illness as a principal diagnosis. In the original conceptualization of the measure, the measure developers considered 7- and 30-day follow-up; however, based on the input received through stakeholder interviews, a public comment period, and from the TEP, the measure developers changed the specifications to 7- and 14-day follow-up to address concerns that beneficiaries would discontinue treatment if they were not immediately connected to follow-up care. Nonetheless, we agree that further efforts to harmonize across measures are important and that the set of related measures should be considered together.

Measure Steward/Developer Response:

Measure 0004: During the 2017 re-evaluation of the *Initiation and Engagement of Alcohol and Other Drug Abuse and Dependence Treatment* measure, NCQA added the

dispensing or administration of pharmacotherapy for the treatment of alcohol and opioid use disorders to the list of allowable services for the measure numerators. Guidelines for treatment for those with substance use disorders recommend early engagement in treatment but are not specific with regards to a timeframe. Current timeframes for initiation and engagement of treatment used in this measure are based on expert consensus. With the proposed addition of pharmacotherapy for the treatment of alcohol and opioid used disorders as appropriate treatment, NCQA proposed a slight increase in the engagement timeframe from 30 days to 34 days to account for scheduling of appropriate dosing for all included medications (including monthly injectables) as well as potential lags in claims processing. This proposed change was brought to NCQA expert panels and public comment, where it received strong support.

Measure Steward/Developer Response:

Measure 0004: Thank you for your detailed commentary on this measure. APAF's suggestion to modify the language used in the measure from substance "abuse and dependence" to "substance use disorder" is one that is already underway at NCQA. As this small change in nomenclature impacts multiple HEDIS measures, users can likely expect to see it reflected in the *Initiation and Engagement* measure during the next NQF endorsement cycle.

The purpose of the 2017 measure re-evaluation was to better align the measure with the most recent clinical practice guidelines for the treatment of patients with substance use disorders. Those guidelines recommend the use of medication-assisted treatment (MAT), or pharmacotherapy used in conjunction with psychosocial services, for the treatment of substance use disorders. In the coming years, NCQA will evaluate emerging evidence and guidelines to determine if it is appropriate to further modify this measure to allow for the use of pharmacotherapy alone to satisfy numerator requirements. NCQA will also look to evidence and our expert panels to determine if other measure criteria (e.g., negative lookback period) are still aligned with the most recent clinical guidelines and standard methodology.

During the 2017 re-evaluation of the measure, NCQA also lengthened the "engagement" timeframe from 30 to 34 days. The rationale for this timeframe extension was to account for scheduling of appropriate dosing for all newly included medications (including monthly injectables) as well as potential lags in claims processing. This proposed change was brought to NCQA expert panels and public comment, where it received strong support.

Regarding your comment about screening members for substance use disorders, this is a comment that we have received in the past and one that we are interested in exploring further. NCQA currently maintains a measure, *Unhealthy Alcohol Use Screening and Follow-Up*, based on the USPSTF "B" recommendation statement that

assesses the percentage of members 18 years of age and older who were screened for unhealthy alcohol use using a standardized instrument and, if screened positive, received appropriate follow-up care. At this time, however, we do not currently have any measures related to screening and referral to treatment for those with opioid or other drug use disorders. We look forward to the USPSTF completing its review on screening for drug use in the coming years.

Finally, with regard to your comment about a provider-level measure, we apologize for the confusion caused by the NQF submission form, we should have only checked "health plan" for NQF 0004. The commenter is correct that a provider-level version of the measure is used in the MIPs program and can be found here: https://ecqi.healthit.gov/system/files/ecqm/measures/CMS137v7.html. This eMeasure has been specifically adapted and tested for use at the provider level.

Proposed Committee Response:

Thank you for your comments. The Committee will review these comments during its deliberations on the Post-Comment Call scheduled on May 3, 2019.

Theme 2 - Data Limitations

Five commenters referenced data limitations for measures 0004 *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment,* 3453 *Continuity Of Care After Inpatient or Residential Treatment for Substance Use Disorder (SUD),* and 2152 *Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling.* Commenters for each of these measures noted concerns with using claims data as the primary and/or only data source. For measure 3453, one commenter noted concerns with using Medicaid claims as the only data source because non-billable services are covered by a variety of sources depending on the state. Other commenters noted that some of the services of interest may not be captured by claims data, especially for integrated clinics. Another commenter expressed that claims data do not provide enough clinical information to confirm the adequacy of follow-up care, and thus they suggested registry as a potential source for more detailed information. For measure 0004 the commenter noted that health plans may not get claims early enough (e.g., if the initial diagnosis is made in the emergency department) to refer the appropriate patients to treatment in the timeframe required by the numerator. For measure 2125 commenters noted concerns that brief interventions are often not charted since they are not billable and therefore are not captured by claims data. The commenter also suggested cross walking the measure with SBIRT codes.

Measure Steward/Developer Response:

Measure 3453: Any services (outpatient visit, telehealth encounter, and pharmacotherapy) that the integrated clinics bill to Medicaid will be included in the numerator. Moreover, same-day-as-discharge services (with the exception of pharmacotherapy) are not included in the numerator, so the fact that these services are not billable will not influence measure results. We will monitor opportunities to harmonize with related measures on which services should be included on the same day or day after discharge and revisit this issue in the annual update.

Measure Steward/Developer Response:
Measure 3453: We acknowledge that Medicaid data doesn't contain the level of detail found in clinical registries and that more fine-grained clinical information about the quality of the continuity service would be useful. In the future, a continuity of care measure based on electronic clinical data systems may be feasible. This Medicaid claims-based measure provides a feasible and important opportunity to understand and improve the extent to which states provide continuity of care to beneficiaries with SUD.

Measure Steward/Developer Response:
Measure 3453: We agree that there could be missing information because of out-of-pocket payment or grant funding, and that the extent of this issue will vary by state. Based on discussions with stakeholders, some states that are implementing alternate payment models or are funding services through state block grants are creating state specific strategies to track use of certain SUD services. Other states may choose to take a similar approach. Regardless, we agree that states should understand the service coverage and reimbursement policies within their state.

Measure Steward/Developer Response:
Measure 2152: The PCPI's measure development and maintenance projects are each guided by a content-specific technical expert panel (TEP). The TEPs are considering the addition of telehealth codes for future iterations of the measures, pending a discussion about the impact of making this change. The TEP wants to ensure that the use of telehealth codes is appropriate within the context of assessment and brief counseling for unhealthy alcohol use. We will ask our TEP to evaluate SBIRT codes and determine revisions to the measure specifications.

Proposed Committee Response:
Thank you for your comments. The Committee will review these comments during its deliberations on the Post-Comment Call scheduled on May 3, 2019.

Theme 3 – Measure Gaps

One comment on the general draft report was received about gaps in measurement. The commenter advocated to designate serious mental illness (SMI) as a health disparities category, essentially building SMI into measure development as a diagnostic cluster and risk category. The commenter also noted the lack of quality of life measures—measures related to use of antipsychotic long acting injectable medications, measures related to the full continuum of treatment for people with SMI and/or SUD, and measures that rely on data sources beyond claims data.

Proposed NQF Response:
Thank you for your comment. NQF agrees that addressing gaps related to mental health and substance use disorders is a unique challenge and uniquely important to overall health. While NQF does not develop measures, we do support measure developers in various ways (e.g., the NQF Measure Incubator™ and National Quality Partners (NQP) SMI Action Team). Additionally, and quite distinct from the incubator and NQP efforts, the Behavioral Health and Substance Use Standing Committee has identified several gap areas in the Behavioral Health and Substance Use portfolio, which the Committee

members disseminate jointly in their annual and public reports to HHS and individually as thought leaders in behavioral and related healthcare enterprises.

Measure-Specific Comments

3451: Non-Acute Mental Health Services Utilization for Dual Eligible Beneficiaries

Three comments were received on this measure during the post-evaluation commenting period. Although commenters noted the dearth of measures available for the dual eligible (i.e., Medicaid and Medicare beneficiary population), they supported the Standing Committee's decision not to recommend this measure for endorsement. One commenter noted the current specifications may not be tightly coupled enough to positive behavioral outcomes for it to be a useful quality measure. Other commenters reiterated Committee concerns about the inadequate degree of sensitivity and specificity of this measure to evidence-based behavioral healthcare which appropriately couples diagnoses and sustained treatments.

Measure Steward/Developer Response:

Thank you for your comment. In reviewing the evidence for the measure concept, we found numerous studies that demonstrate a significant proximal link between access to and use of non-acute mental health services for individuals with a mental health service need with increased quality of life, as well as a reduction in negative outcomes such as homelessness, hospitalization, incarceration, and episodes of violence. Please note that the measure is not intended to assess the appropriateness, adequacy, or intensity of care, but rather whether beneficiaries with mental health needs have access to non-acute mental health services. Our testing results and the review of the evidence indicate that there is a substantial gap in such access, which leaves many individuals in the measure population at increased risk for negative consequences related to non-treatment of mental health conditions.

Measure Steward/Developer Response:

Thank you for your comment. We agree that the measure lacks specificity but note that this is by design to support the measure's intent to provide a metric of access to non-acute mental health services for individuals with a mental health need. During the development of the measure, we received feedback through a public comment period, expert work group meeting, and a technical expert panel meeting that a broad definition of mental health need was most appropriate for a measure intended to capture access to non-acute mental health services. We also received feedback from a technical expert panel that limiting the measure to capture only those mental health encounters where a mental health condition was listed as the primary diagnosis was an appropriate restriction on the sensitivity of the measure. This is because the measure is intended to capture only those encounters in which a mental health condition is actually treated. Reports from the field indicate that many providers use secondary or tertiary diagnosis fields to capture conditions that are present during an encounter but were not necessarily treated during that encounter.

Proposed Committee Response:

Thank you for your comments. The Committee is appreciative of the interest in a measure regarding Medicare and Medicaid dual eligible beneficiaries and hopes the

developer revises their measure to capture more precisely appropriate mental health services accessed by this population.

Action Item:
No Committee action required.

2152: Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling
One comment noted support for the measure concept but inquired about the level of analysis in which the measure should be used. The commenter also questioned whether the denominator kappa statistic value of 0.31 was enough to demonstrate reliability. Another comment expressed support for the measure as proposed.

Measure Steward/Developer Response:
While previous testing stated that the data were not captured at the physician level, more recent testing included in the testing attachment uses aggregated data that contain both individual provider level data as well as providers reporting as a group. The strong testing results using this dataset indicate that this measure can be used to publicly report performance for both group practices and solo practitioners. The reliability results referenced were also a part of previous testing done on the measure. The kappa statistic value of 0.31, defined as fair agreement, was an example of the limitation of the kappa statistic. While agreement can be high, if one classification category dominates, kappa can be significantly reduced. The testing attachment includes updated reliability using a signal to noise ratio which reports an overall average reliability of 0.98 out of 1.00 indicative of very high reliability.

1. (Warrens MJ, A Formal Proof of a Paradox Associated with Cohen's Kappa. *Journal of Classification*. 27:322-332, 2010; Feinstein AR, Cicchetti DV. High Agreement but Low Kappa: I. The Problems of Two Paradoxes. *Journal of Clinical Epidemiology*. 43:543-549, 1990)

Proposed NQF Response:
NQF criteria require that empirical testing of reliability and validity at the data element or score level is conducted. Such methods and results are then reviewed by the standing committees as an essential part of the measure evaluation and endorsement process. The standing committees certainly regard and judge statistical magnitudes in their evaluation. However, specific thresholds are not prescribed; instead, the standing committees are asked to determine if the totality of the reliability (or validity) presentation is sufficient for the measure to be endorsed.

Proposed Committee Response:
Thank you for your comments. Despite the somewhat low Kappa statistic for one data element (the denominator), the Committee felt that the measure overall had good reliability for the performance enhancement purposes intended. The Committee did not feel that "fair" sensitivity to a screening event of interest substantially compromised the reliability of follow-up screening events which were identified.

Action Item:
No Committee action required.

NQF Member Expression of Support

Throughout the 16-week continuous public commenting period, NQF members had the opportunity to express their support ('support' or 'do not support') for each measure submitted for endorsement consideration to inform the Committee's recommendations. One NQF member provided an expression of support: See Appendix A.

Appendix A: NQF Member Expression of Support Results

One NQF member organization provided an expression of support. Two of four measures under consideration received support from NQF members. Results for each measure are provided below.

0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (National Committee for Quality Assurance)

Member Council	Support	Do Not Support	Total
Consumer	0	0	0
Health Plan	0	0	0
Health Professional	0	0	0
Provider Organization	0	0	0
Public/Community Health Agency	0	0	0
Purchaser	0	0	0
QMRI	1	0	1
Supplier/Industry	0	0	0

2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling (PCPI Foundation)

Member Council	Support	Do Not Support	Total
Consumer	0	0	0
Health Plan	0	0	0
Health Professional	0	0	0
Provider Organization	0	0	0
Public/Community Health Agency	0	0	0
Purchaser	0	0	0
QMRI	1	0	1
Supplier/Industry	0	0	0

3451 Non-Acute Mental Health Services Utilization for Dual Eligible Beneficiaries (CMS/Mathematica Policy Research, Inc.)

Member Council	Support	Do Not Support	Total
Consumer	0	0	0
Health Plan	0	0	0

Member Council	Support	Do Not Support	Total
Health Professional	0	0	0
Provider Organization	0	0	0
Public/Community Health Agency	0	0	0
Purchaser	0	0	0
QMRI	0	1	1
Supplier/Industry	0	0	0