Medicaid Adult and Child Workgroups In-Person Meeting

Day 2: May 9, 2018

Welcome

Medicaid Adult and Child Workgroups NQF Staff Support Team

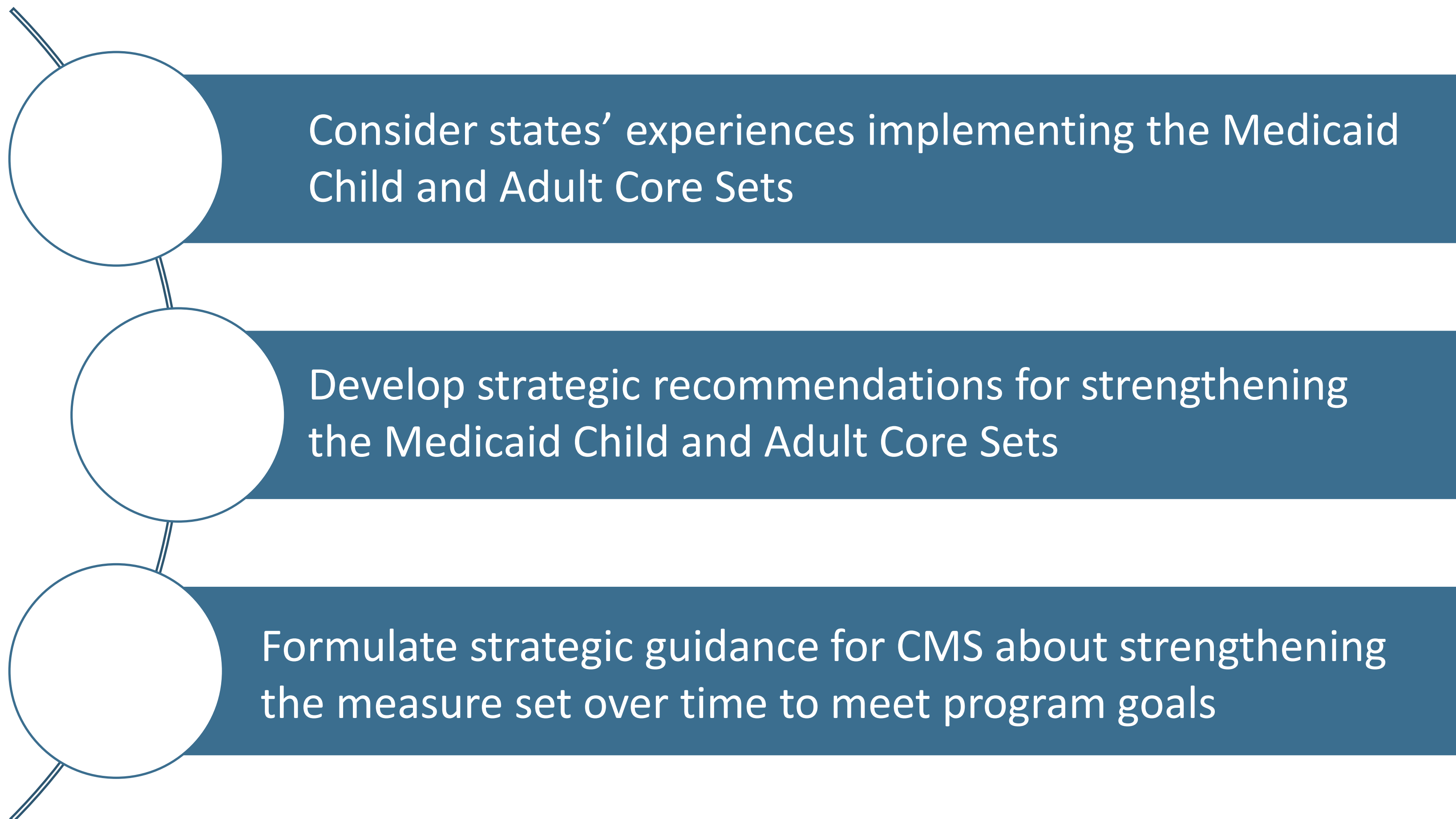
- Debjani Mukherjee: Senior Director
- Shaconna Gorham: Senior Project Manager
- May Nacion: Medicaid Child Project Manager
- Miranda Kuwahara: Medicaid Adult Project Manager

Welcome

- **Restrooms**
  - Exit main conference area, past elevators, on right.
- **Breaks**
  - 10:40am – 15 minutes
  - 1:00pm – Lunch provided by NQF
- **Laptops and cell phones**
  - Wi-Fi network
    - » User name: **guest**
    - » Password: **NQFguest**
  - Please mute your cell phone during the meeting
- **Public comment period**
  - Dedicated times for public comment
  - Comment via chat box at any time and comments will be shared during dedicated times

Review of Meeting Objectives

Meeting Objectives



Structure of May Workgroup Deliberations

May 8
Child Workgroup Only
- State Medicaid Presentation
- Child Core Set Measures

May 9
Joint Meeting
- Shared Measures and Strategic Issues
-State Medicaid Presentation

May 10
Adult Workgroup Only
- State Medicaid Presentation
- Adult Core Set Measures

May 2018 In-Person Meeting

Today's Action Items: Combined Adult and Child Workgroup Discussion

- Issues of Shared Importance:
  - Strengthening the Core Sets – Alignment of Measures
  - Behavioral Health Measures – Depression Measures Across the Core Sets

Highlights from Day #1

Introductions of Workgroup Members and Disclosures of Interest

NQF Medicaid Adult Workgroup Membership

- Harold Pincus, MD (Co-Chair)
- Marissa Schlaifer, RPh, MS (Co-Chair)

Organizational Members (voting)	Organizational Representative
American Association on Health and Disability	Clarke Ross, DPA
American Association of Retired Persons (AARP)	Lynda Flowers, JD, RN, MSN
American College of Obstetricians and Gynecologists (ACOG)	Michelle H. Moniz, MD, MSc
American Association of Nurse Practitioners (AANP)	Sue Kendig, JD, WHNP-BC, FAAPN
American Occupational Therapy Association	Joy Hammel, PhD
Association for Community Affiliated Plans (ACAP)	Deborah Kilstein, RN, MBA, JD
Human Services Research Institute	David Hughes, PhD
Intermountain Health	Jesse Spencer, MD
National Association of Medicaid Directors (NAMD)	Rachel La Croix, PhD
Ohio Department of Medicaid	Mary Applegate, MD

NQF Medicaid Adult Workgroup Membership

Individual Subject Matter Experts (voting)
Kim Elliott, PhD, CPHQ
Diana Jolles, PhD, CNM, FACNM
SreyRam Kuy, MD, MHS, FACS
Julia Logan,MD
Lisa Patton, PhD
Janice Tufte
Judy Zerzan, MD

Federal Government Members (non-voting)

Agency	Agency Representative
Centers for Medicare & Medicaid Services (CMS)	Marsha Smith, MD, MPH, FAAP
Health Resources and Services Administration	Suma Nair, MS, RD
Substance Abuse and Mental Health Services Administration	Laura Jacobus-Kantor, PhD

Medicaid Adult and Child Workgroup Overview

Key Changes for 2017-2018

MAP Medicaid Evolution from Taskforces to Workgroups

- In 2017-2018 the MAP Medicaid Adult and Child committees convened as Workgroups. Members have been seated through a formal nominations process.
- The Workgroups convene twice to complete annual review of the core sets (January via webinar and May in-person)

Charge of the Medicaid Adult and Child Workgroups

- Each year, the Medicaid Workgroups provide input to the MAP Coordinating Committee on recommendations to HHS for strengthening the Adult and Child Core Sets of measures by:
  - Reviewing states' experiences voluntarily reporting measures
  - Refining previously identified measure gap areas
  - Recommending potential measures for addition or removal from the sets, with a focus on addressing high-priority measure gap areas

Medicaid Annual Review of Measures

- The Workgroups' annual review began January 2018 and ends with a report due to CMS by August 2018.
- HHS uses the Workgroups' recommendations to inform the statutorily required annual updates of the Adult and Child Core Sets
- Guided by MAP's Measure Selection Criteria (MSC), a Medicaid specific preliminary analysis algorithm and feedback from the most recent year of state implementation, the Workgroups review measures in the current Core Sets.
- Guided by state feedback, review of state reporting, and data on prevalent conditions affecting the Medicaid and CHIP populations, the Workgroups identify and prioritize gaps for programs and settings

Measure Review and Voting Process

- Staff compiled measures that address existing high-priority gap areas in the Core Sets.
- Measures are suggested for review by workgroup members and comprise the measures for consideration list for the in-person meeting
- Measure descriptions are included in a discussion guide used during the in-person meeting
- Voting on Measures
  - Workgroup members who recommended measures for discussion are designated lead discussants during the in-person meeting
  - Ensuing discussions will include all workgroup members
  - Public comments will be solicited following workgroup discussions
  - After discussion of each measure and public comments, the Workgroup will vote on the measure

Measure Voting Process

- The Workgroup must reach a decision about every measure discussed
  - Each decision should be accompanied by one or more statements that explain why each decision was reached

- Tallying the votes:
  - Quorum—66% of Workgroup required to be present for voting
  - >60% of votes denote the result of voting

CMS Goals: Child and Adult Core Sets

Three-part goal for Adult and Child Core Sets:

- Increase number of states reporting Core Set measures
- Increase number of measures reported by each state
- Increase number of states using Core Set measures to drive quality improvement

How CMS Uses Core Set Data

- Core set data used to obtain a snapshot of quality across Medicaid and CHIP (Children's Health Insurance Program):
  - Annual Child Health Quality Report
  - Annual Adult Health Quality Report
  - Chart pack and other analyses
  - Inform policy and program decisions

Questions?

CMS Policy Objectives for the Medicaid & CHIP Child and Adult Core Sets

National Quality Forum, (NQF) Medicaid Measures Application Partnership (MAP)

Karen Matsuoka, PhD
Chief Quality Officer
Center for Medicaid and CHIP Services (CMCS

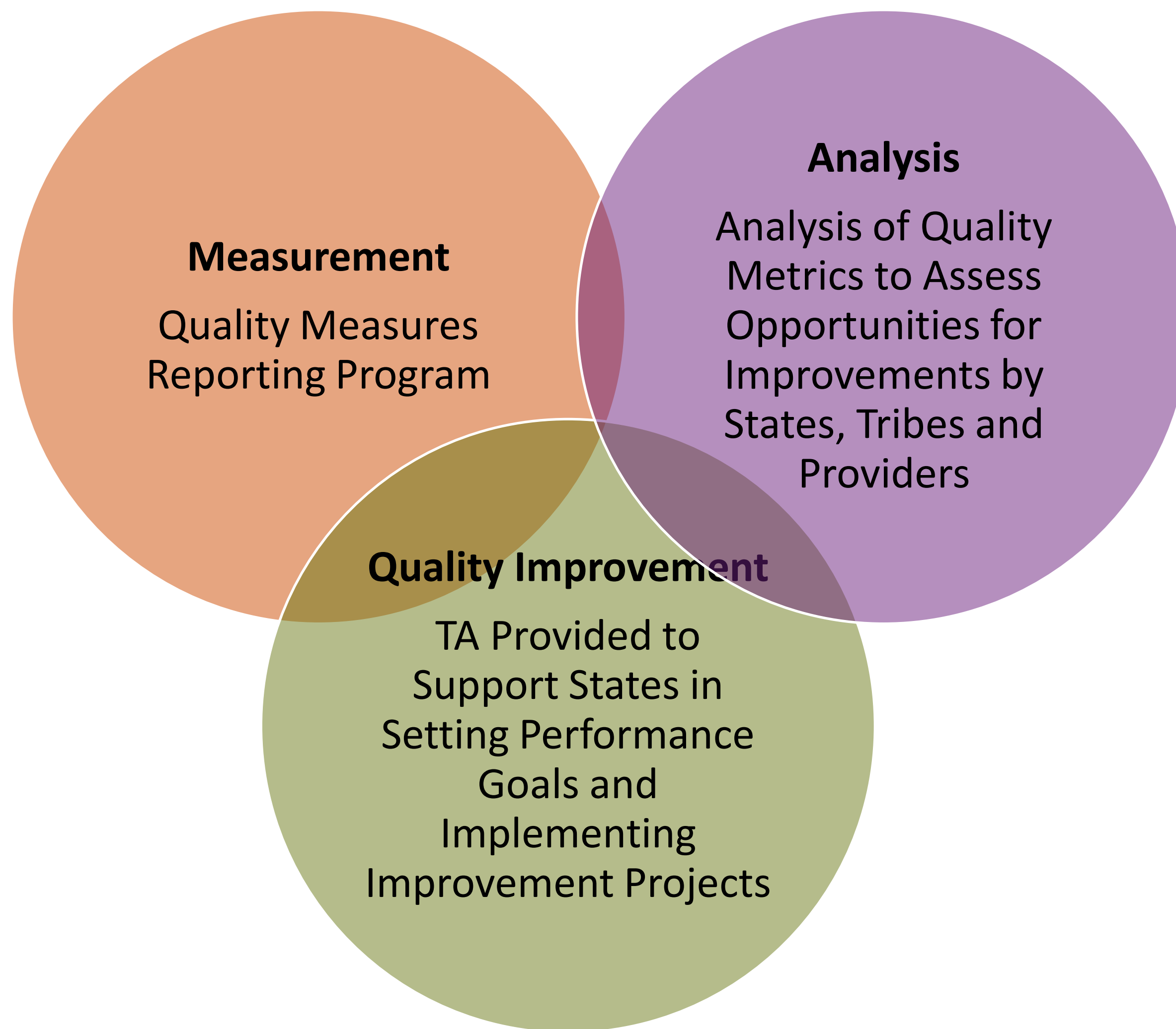
Overview

- What is the charge for the Medicaid Measure Applications Partnership (MAP) Work Group?
- What are the Medicaid & CHIP Child and Adult Core Sets?
- How do CMS and states use the Medicaid Child and Adult Core Sets?
- Opportunities to Boost State-Level Measurement through Streamlining
- What is the timeline?
- Important considerations

MAP Medicaid Work Group Charge

- The charge of the MAP Medicaid Work Group is to advise the MAP Coordinating Committee on recommendations to CMS for strengthening and revising measures and the identification of high priority measure gaps in the Core Sets of Health Care Quality Measures for Adult and Children enrolled in Medicaid and CHIP.
- MAP can assist CMS in identifying ways to strengthen the Medicaid Adult and Child Core Sets through incremental annual updates
  - Adding measures to fill gaps
  - Retiring current measures that no longer reflect current clinical guidance, are retired by a measure steward, or are recommended by stakeholders for removal
  - Aligning with other CMS/HHS programs
- MAP will convene the Work Group beginning May 2018 with a report due to CMS by August 2018.

Building a Foundation for Quality Measurement and Improvement in Medicaid and CHIP…



What are the Medicaid & CHIP Child & Adult Core Sets?

- **Voluntary quality reporting by states on consistent metrics across these domains**
  - Primary Care Access and Preventive Care
  - Perinatal Health
  - Care of Acute and Chronic Conditions
  - Behavioral Health Care
  - Dental and Oral Health Services (Child Core Set)
  - Experience of Care
- **Child Core Set (26 measures in the 2018 Core set)**
  - Initial Core Set released in 2010
  - States have completed the 8th year of voluntary reporting
  - 50 States reported on at least one Child Core Measure (median = 18 measures) for FFY2016 (term "states" includes the 50 states and the District of Columbia)
- **Adult Core Set (33 measures in the 2018 Core Set)**
  - Initial Core Set released in 2012
  - States have completed the 5th year of voluntary state reporting
  - 41 states reported on at least one Adult Core Measure for FFY2016 (median = 17)

CMCS Goals for Measurement and Reporting

- Increase number of states reporting Core Set measures through technical assistance and outreach to states
- Increase number of measures reported by each state
- Improve the quality of the data reported (completeness, accuracy)
- Streamline data collection and reporting processes
- Support states to drive improvements in health care quality and health outcomes using Core Set data

Number of States Reporting the Child Core Set Measures, FFY 2016

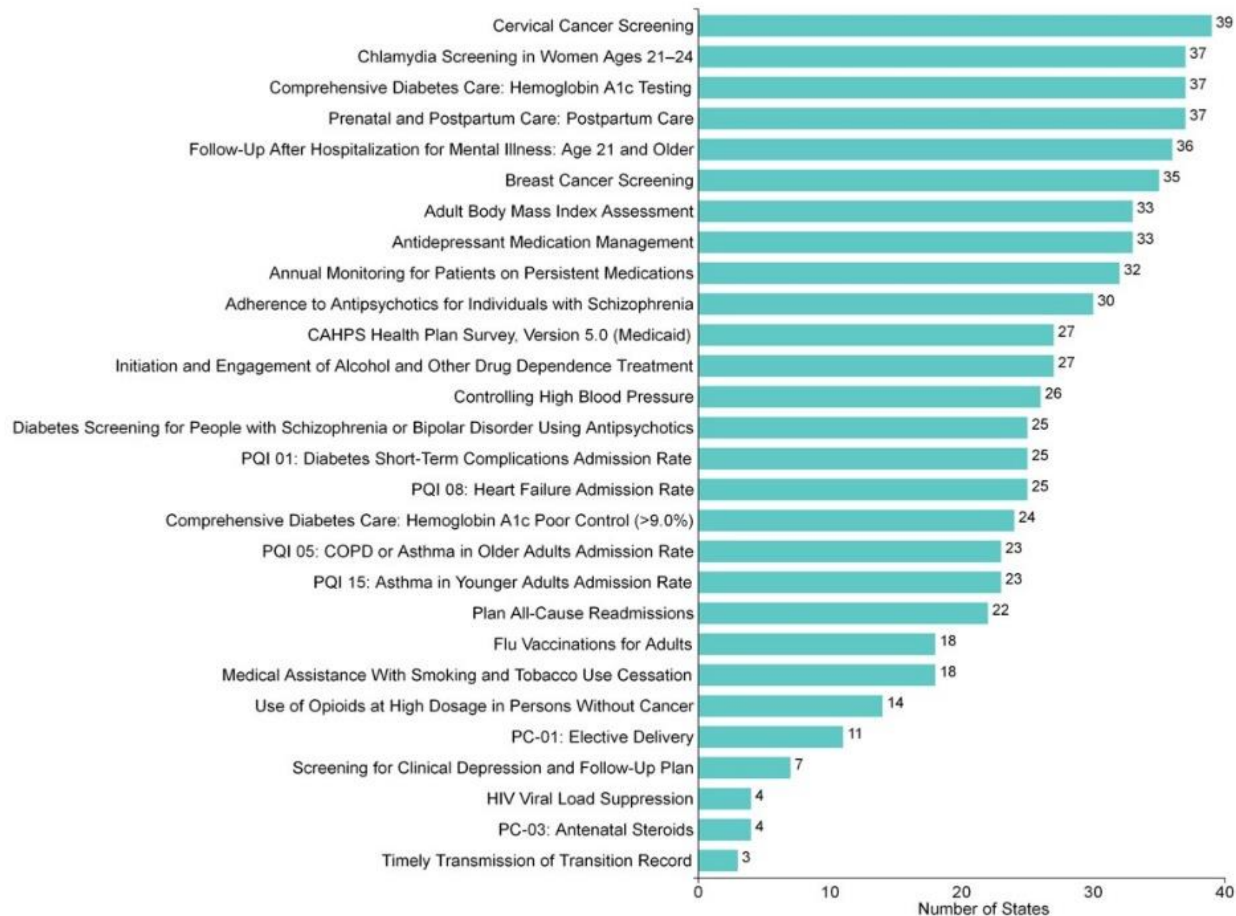
Measure	Number of States
Percentage of Eligibles Who Received Preventive Dental Services	50
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	47
Adolescent Well-Care Visit	46
Children and Adolescents' Access to Primary Care Practitioners	46
Well-Child Visits in the First 15 Months of Life	46
Ambulatory Care: Emergency Department (ED) Visits	45
Childhood Immunization Status	45
Chlamydia Screening in Women Ages 16–20	45
Immunizations for Adolescents	44
Follow-Up After Hospitalization for Mental Illness: Ages 6–20	42
Human Papillomavirus Vaccine for Female Adolescents	42
Medication Management for People with Asthma	41
CAHPS Health Plan Survey 5.0H, Child Version (Medicaid)	40
Follow-Up Care for Children Newly Prescribed ADHD Medication	40
Prenatal and Postpartum Care: Timeliness of Prenatal Care	40
Body Mass Index Assessment for Children and Adolescents	39
Dental Sealants for 6-9 Year-Old Children at Elevated Caries Risk	34
Frequency of Ongoing Prenatal Care	33
Use of Multiple Concurrent Antipsychotics in Children and Adolescents	32
Live Births Weighing Less Than 2,500 Grams	30
Developmental Screening in the First Three Years of Life	26
PC-02: Cesarean Section	18
Behavioral Health Risk Assessment (for Pregnant Women)	6
Audiological Evaluation No Later than 3 Months of Age	1
Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment	1

Axis: 0, 10, 20, 30, 40, 50 — Number of States

50 states voluntarily reported at least one Child Core Set measure for FFY 2016

Sources: Mathematica analysis of MACPro reports and Form CMS-416 reports for the FFY 2016 reporting cycle.
Notes: The term “states” includes the 50 states and the District of Columbia. The 2016 Child Core Set includes 26 measures. This chart excludes the CLABSI measure, which is obtained from CDC’s National Healthcare Safety Network.

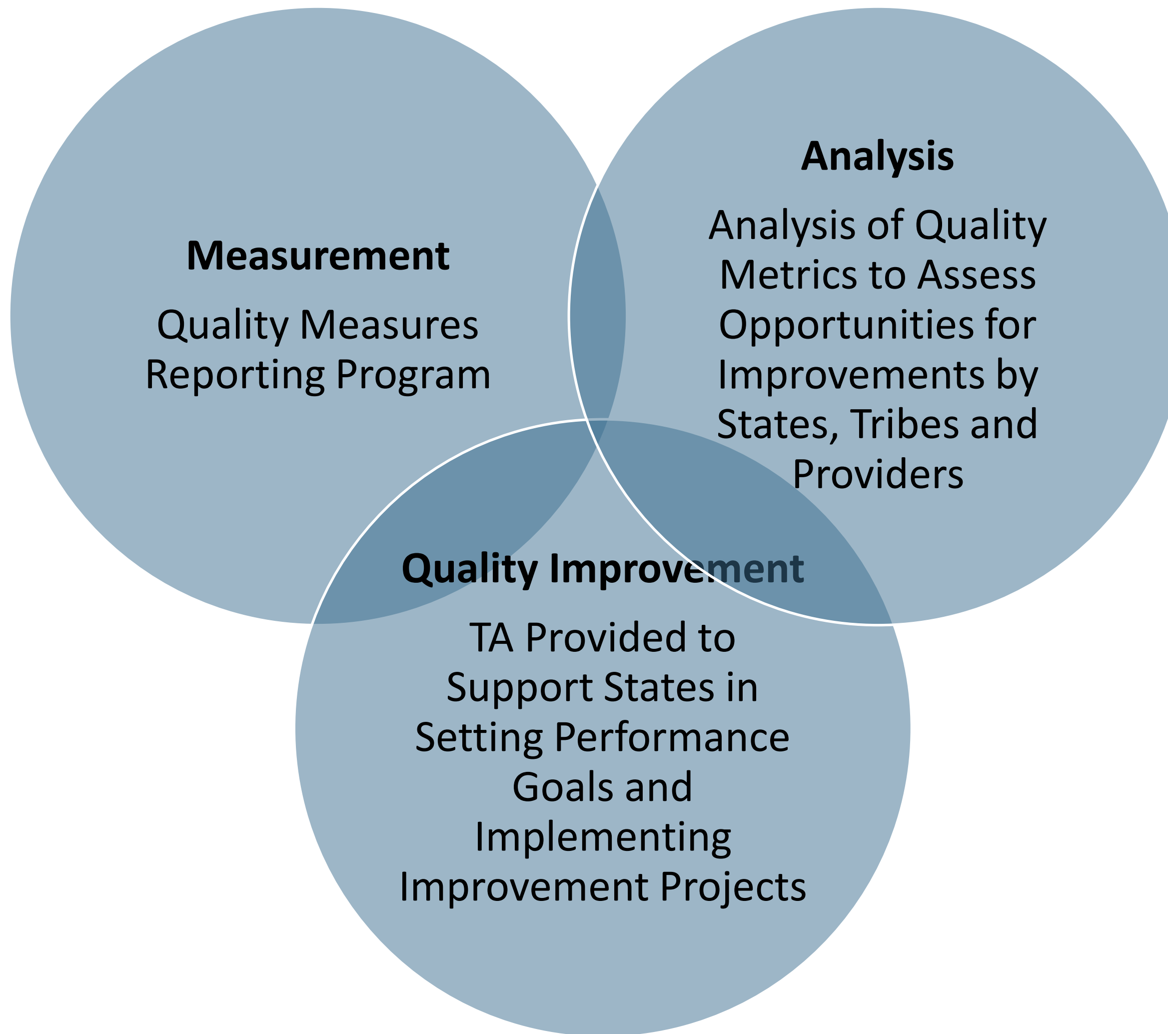
Number of States Reporting the Adult Core Set Measures, FFY 2016



41 states voluntarily reported at least one Adult Core Set measure for FFY 2016

Source: Mathematica analysis of MACPro reports for the FFY 2016 reporting cycle.
Notes: The term “states” includes the 50 states and the District of Columbia.

Building a Foundation for Quality Measurement and Improvement in Medicaid and CHIP…cont.

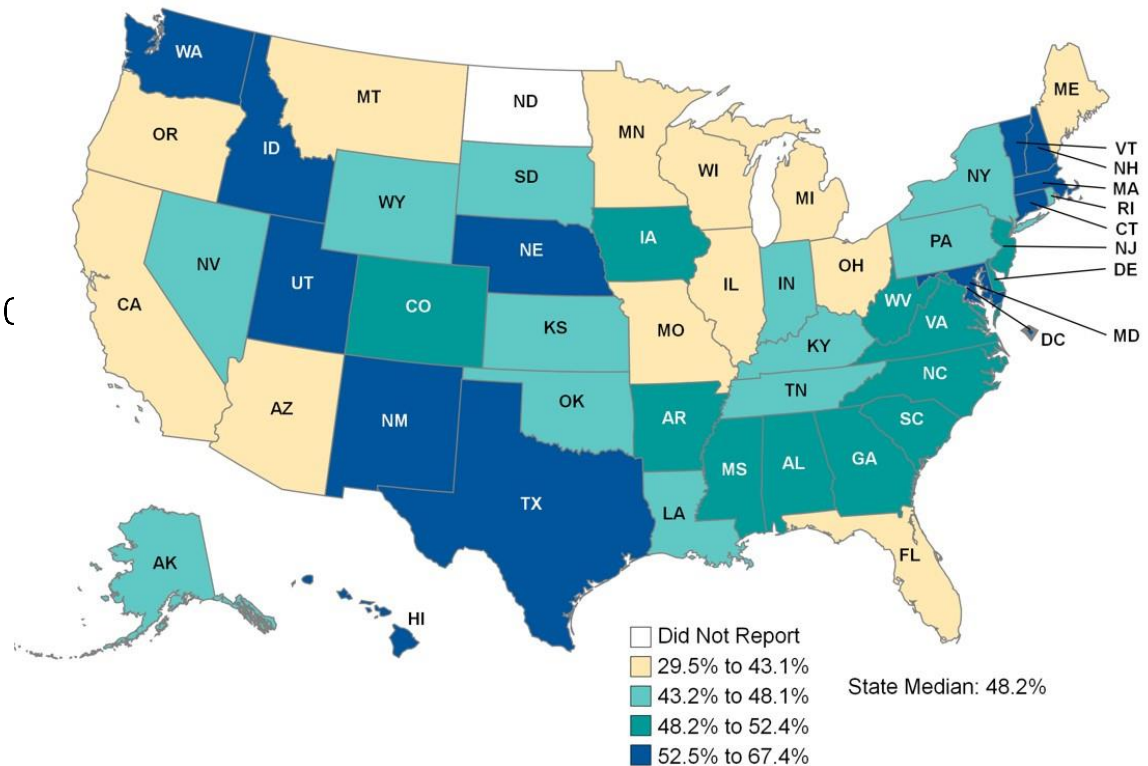


Preventive Dental Services

Tooth decay, or dental caries, is one of the most common chronic diseases of children. The disease is almost entirely preventable through a combination of good oral health habits at home, a healthy diet, and early and regular use of preventive dental services. This measure assess the percentage of children ages 1 to 20 that received preventive dental services.

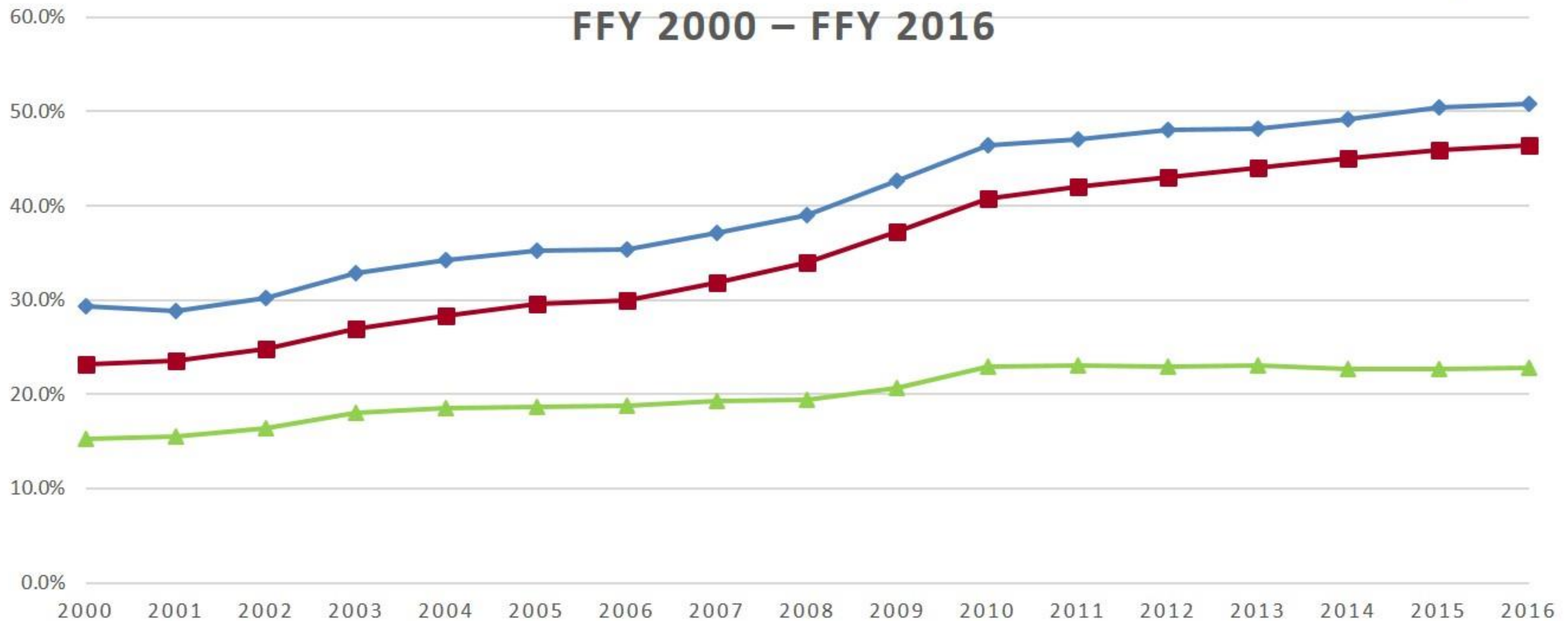
48 percent of Children ages 1 to 2(received a preventive dental service (50 states

Percentage of Eligibles Who Received Preventive Dental Services, FFY 2016 (n = 50 states)



Source: Mathematica analysis of Form CMS-416 reports (annual EPSDT report), Lines 1b and 12b, for the FFY 2016 reporting cycle.

Steady Progress on Access to Dental Care



Source: FFY 2000-2016 CMS-416 reports, Lines 1, 1b, 12a, 12b, and 12c
Note: Data reflect updates as of 9/11/2017.

1 With the exception of FL and OH, the national FFY 2011 percentage used FFY 2011 data reported by states to CMS as of May 28, 2013. Due to errors in FL's FFY 2011 data that could not be corrected, the state's FFY 2012 data were used in the FFY 2011 national percentage. As FFY 2011 data for OH were reported after May 28, 2013, these data were not included in the FFY 2011 national percentage.

2 With the exception of CT and OH, the national FFY 2012 percentage used data reported by states to CMS as of April 10, 2014. FFY 2011 data for CT were used in the FFY 2012 national percentage because final FFY 2012 data for CT were not available as of April 10, 2014. As FFY 2011 data for OH were not used in the FFY 2011 national percentage, OH's FFY 2012 data were similarly excluded from the FFY 2012 national percentage.

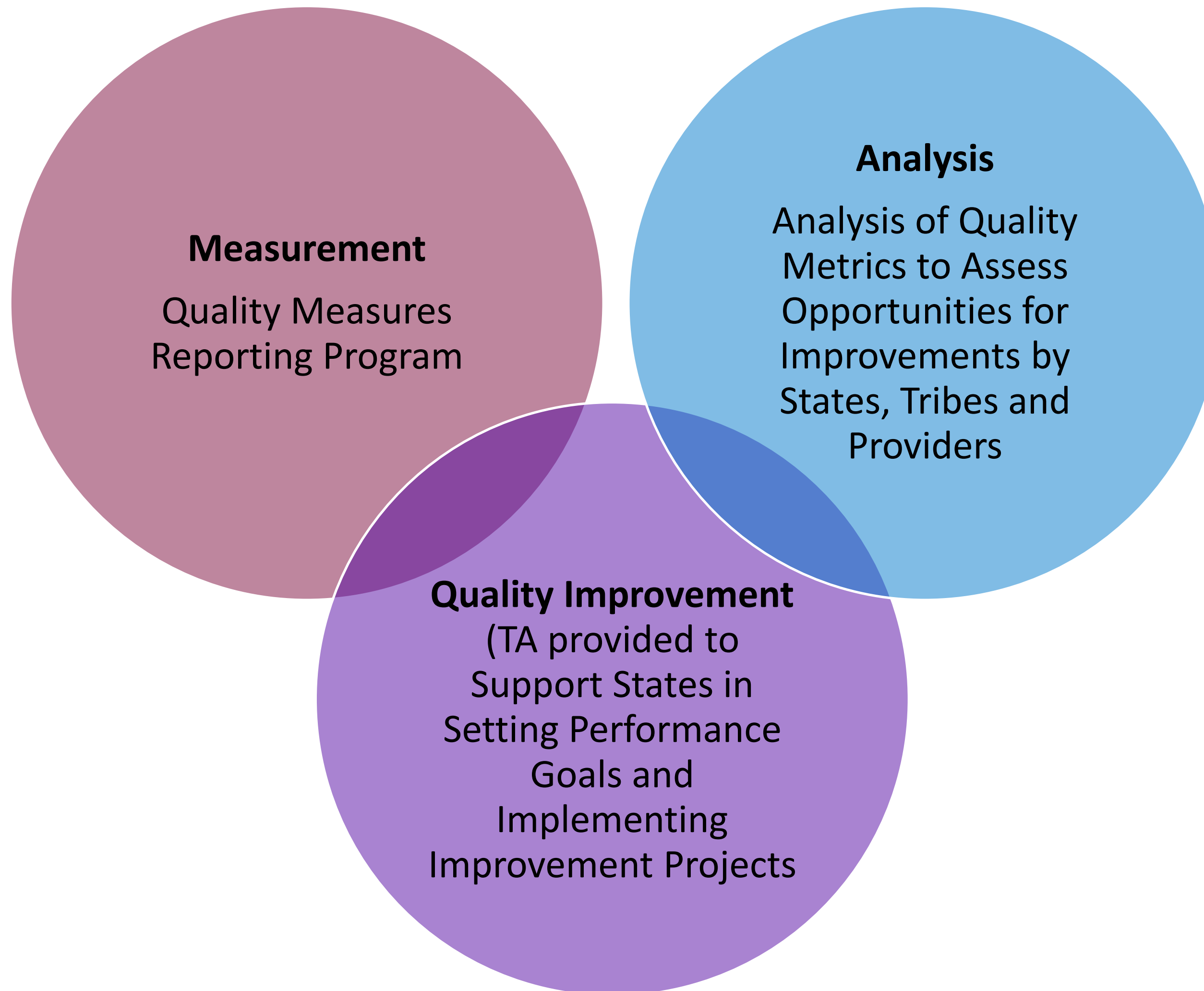
3 With the exception of OH, the national FFY 2013 percentage used data reported by states to CMS as of December 15, 2014. As FFY 2011 data for OH were not used in the FFY 2011 national percentage, OH's FFY 2013 data were similarly excluded from the FFY 2013 national percentage.

4 With the exception OH, the national FFY 2014 percentage used data reported by states as of October 1, 2015. As FFY 2011 data for OH data were not used in the FFY 2011 national percentage, OH's FFY 2014 data were similarly excluded from the FFY 2014 national percentage.

5 With the exception OH, the national FFY 2015 percentage used data reported by states as of September 29, 2016. As FFY 2011 data for OH data were not used in the FFY 2011 national percentage, OH's FFY 2015 data were similarly excluded from the FFY 2015 national percentage.

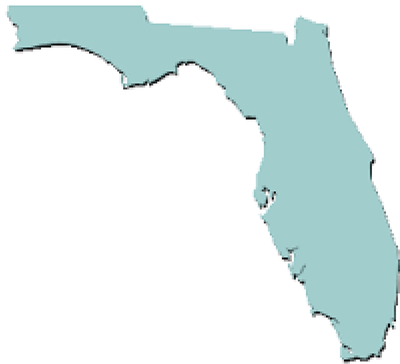
6 With the exception OH, the national FFY 2016 percentage used data reported by states as of September 11, 2017. As FFY 2011 data for OH data were not used in the FFY 2011 national percentage, OH's FFY 2016 data were similarly excluded from the FF Y2016 national percentage. Due to system challenges, data from North Dakota is not included in FFY 2016 analysis.

Building a Foundation for Quality Measurement and Improvement in Medicaid and CHIP…cont'd



Examples of Work in Two States

- **Florida 2013:** CMS used 1115 waiver approval process to get provisions in the STCs focused on improving stakeholder engagement and data quality, and requiring oral health Performance Improvement Projects.
- State placed PDENT improvement targets and sanctions in MCO contract.
- PDENT performance has improved from 19% in FY 12 to 36% in FY 16.



- **California 2015:** CMS used 1115 delivery system reform process to get $740M allocated to dental improvement over five years.
- Focus will be primarily on provider incentives for PDENT and continuity of care through provider incentives.
- At least 10 percentage points of improvement required by 2020; state can earn additional $10M by exceeding targets, up to 15 percentage points of improvement.

CMCS Goals for Measurement and Reporting…

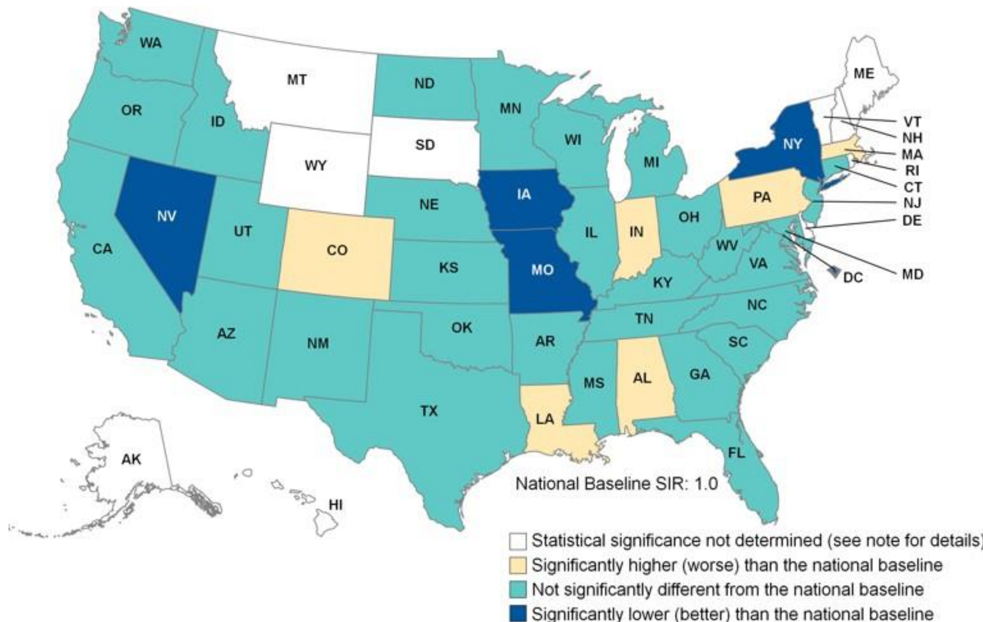
- Increase number of states reporting Core Set measures through technical assistance and outreach to states
- Increase number of measures reported by each state
- Improve the quality of the data reported (completeness, accuracy)
- **Streamline data collection and reporting processes**
- Support states to drive improvements in health care quality and health outcomes using Core Set data

Examples of Streamlining Already Underway

CLABSI measure

Central Line-Associated Blood Stream Infections (CLABSIs) in Neonatal Intensive Care Units (NICUs), 2015 (n = 42 states)

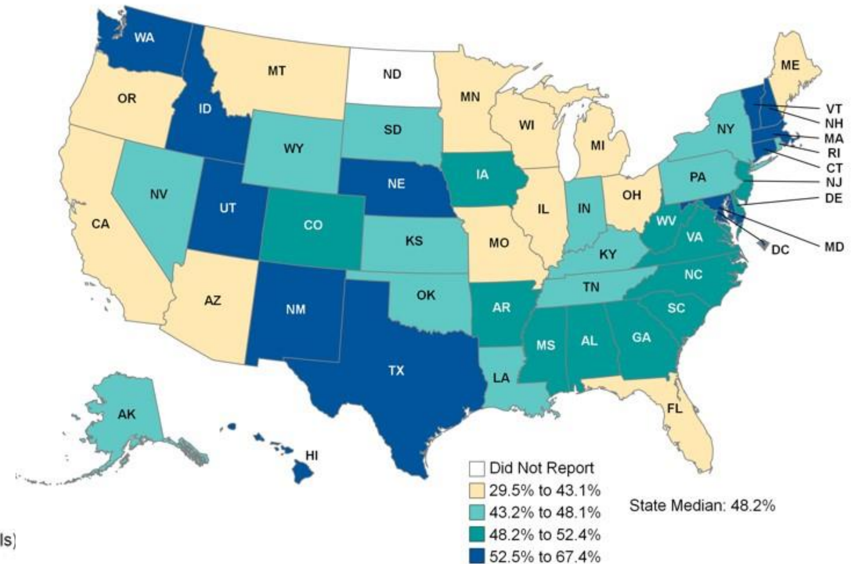
Source: Centers for Disease Control and Prevention, 2015 National and State Healthcare-Associated Infections Standardized Infection Ratio Report, Table 3d



PDENT measure

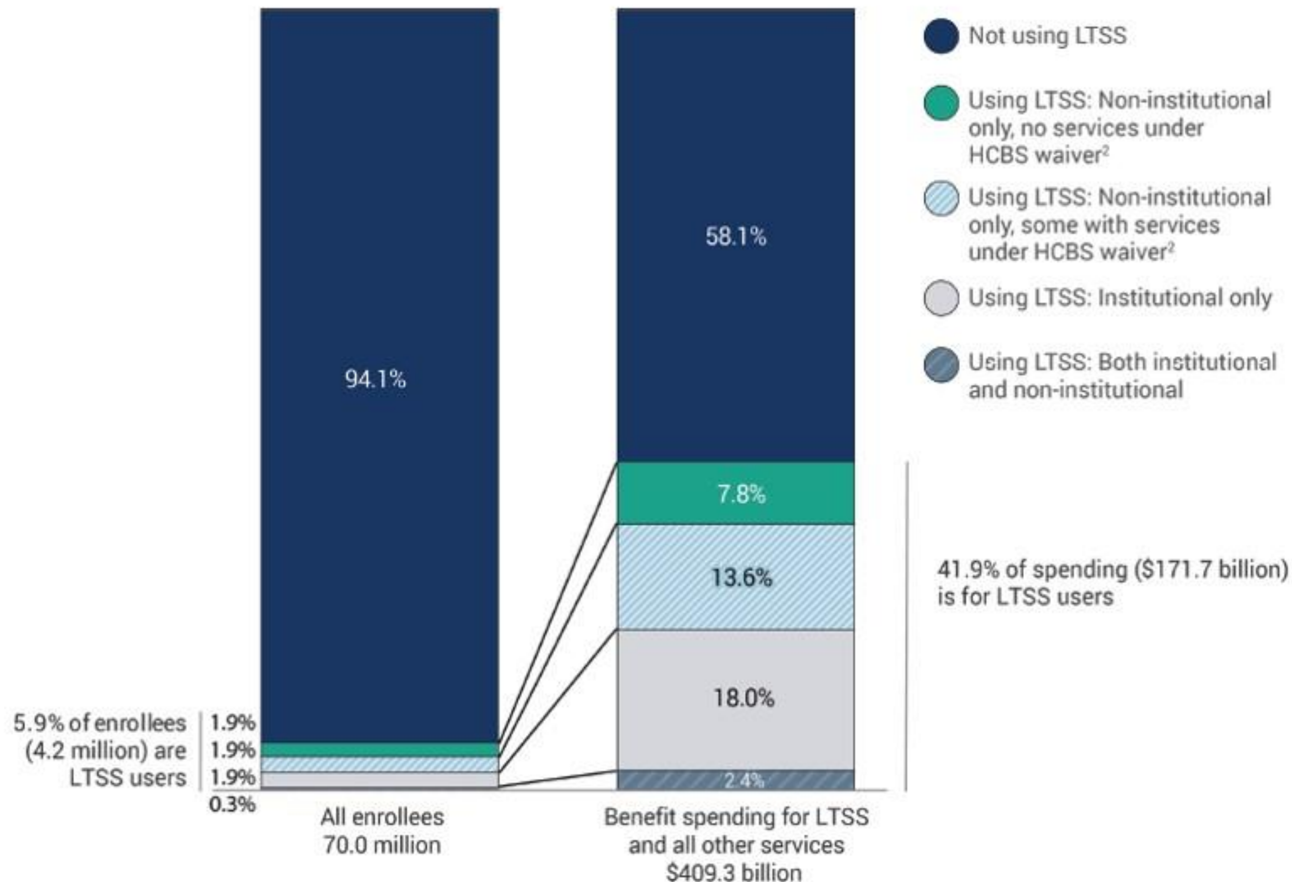
Percentage of Eligibles Who Received Preventive Dental Services, FFY 2016 (n = 50 states)

Source: Mathematica analysis of Form CMS-416 reports (annual EPSDT report), Lines 1b and 12b, for the FFY 2016 reporting cycle



Streamlining to Fill High Priority Population Gap in the Adult Core Set

Distribution of Medicaid Enrollment and Benefit Spending by Users and Non-Users of Long-Term Services and Supports, Updated FY2013



Source: MACPAC 2017 analysis of MSIS data as of December 2016 and CMS-64 Financial Management Report net expenditure data.
https://www.macpac.gov/publication/distribution-of-medicaid-enrollment-and-benefit-spending-by-users-and-non-users-of-long-term-services-and-supports/

The Minimum Data Set (MDS) 3.0

- The MDS 3.0 is one component of a federally-required standardized assessment, Resident Assessment Instrument (RAI), consisting of a core set of screening, clinical and functional status elements, that collects health, functional, psychosocial and preference information for residents receiving post-acute and long-term care in Medicare and/or Medicaid certified nursing homes and non-critical access swing bed facilities, regardless of the individual's payer source.
- Federal RAI requirements are not applicable to individuals residing in non-certified units of long-term care facilities or licensed-only facilities, however this does not preclude a State from mandating the RAI for residents who live in these units.
- MDS assessments are completed at specified intervals to meet Omnibus Budget Reconciliation Act of 1987 (OBRA '87) and/or Medicare Prospective Payment System (PPS) requirements.
- While facilities must complete all Federally required MDS 3.0 items, States have some flexibility in adding additional items to Section S.

MDS Long-Stay Measures

Data Source	Measure Title	NQF #
MDS 3.0	Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)	0674
MDS 3.0	Percent of Residents Who Self-Report Moderate to Severe Pain (Long Stay)	0677
MDS 3.0	Percent of High Risk Residents with Pressure Ulcers (Long Stay)	0679
MDS 3.0	Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (Long-Stay)	0681
MDS 3.0	Percent of Residents Assessed and Appropriately Given the Pneumococcal Vaccine (Long Stay)	0683
MDS 3.0	Percent of Residents With a Urinary Tract Infection (Long Stay)	0684
MDS 3.0	Percent of Low Risk Residents Who Lose Control of Their Bowel or Bladder (Long Stay)	0685
MDS 3.0	Percent of Residents Who Have/Had a Catheter Inserted and Left in Their Bladder (Long Stay)	0686
MDS 3.0	Percent of Residents Who Were Physically Restrained (Long Stay)	0687
MDS 3.0	Percent of Residents Whose Need for Help with Activities of Daily Living Has Increased (Long Stay)	0688
MDS 3.0	Percent of Residents Who Lose Too Much Weight (Long Stay)	0689
MDS 3.0	Percent of Residents Who Have Depressive Symptoms (Long Stay)	0690
MDS 3.0	Percent of Long-Stay Residents Who Received An Antipsychotic Medication	N/A
MDS 3.0	Percentage of Long-Stay Residents Who Received An Antianxiety Or Hypnotic Medication	N/A
MDS 3.0	Percentage of Long-Stay Residents Whose Ability To Move Independently Worsened	N/A

Source: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIQualityMeasures.html

Quality measure specifications are available in the MDS 3.0 QM Users' Manual

Outcome and Assessment Information Set (OASIS)

- The OASIS regulations apply to Home Health Agencies (HHAs) that must meet the home health Medicare Conditions of Participation (CoP).
- Medicare-certified HHAs are required to collect a standard set of data items, known as OASIS (Outcome and Assessment Information Set), as part of a comprehensive assessment of all patients who are receiving skilled care covered by Medicare or Medicaid.
- OASIS data elements must be collected and transmitted for all Medicare, Medicaid, and Advantage patients.

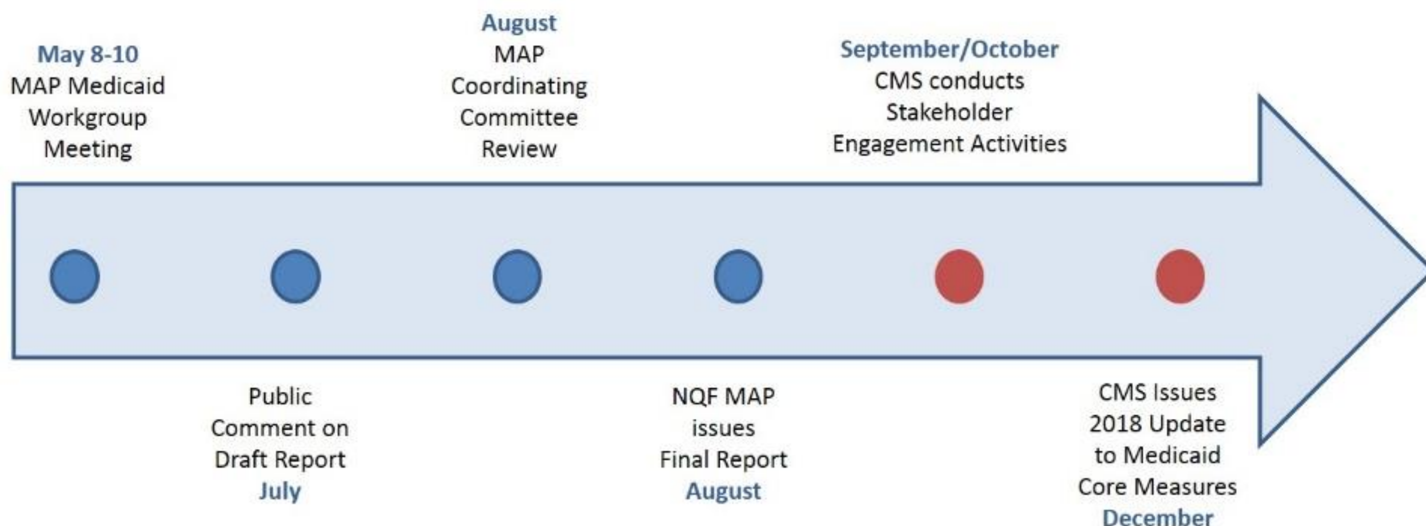
OASIS in Home Health Quality Reporting

Data Source	Measure Title	NQF #
OASIS	Improvement in Ambulation- Locomotion	0167
OASIS	Improvement in Bathing	0174
OASIS	Improvement in Bed Transferring	0175
OASIS	Improvement in Management of Oral Medications	0176
OASIS	Improvement in Pain Interfering with Activity	0177
OASIS	Improvement in Status of Surgical Wounds	0178
OASIS	Timely Initiation of Care	
OASIS	Multifactor Fall Risk Assessment Conducted for All Patients who Can Ambulate	
OASIS	Diabetic Foot Care and Patient / Caregiver Education Implemented during All Episodes of Care	
OASIS	Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened	Application of 0678
OASIS	Depression Assessment Conducted	
OASIS	Changes in Skin Integrity Post-Acute care	
OASIS	Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)	Application of 0674
OASIS	Improvement in Dyspnea	
OASIS	Drug Education on All Medications Provided to Patient/Caregiver during All Episodes of Care	
OASIS	Influenza Immunization Received for Current Flu Season	
OASIS	Pneumococcal Polysaccharide Vaccine Ever Received	
OASIS	Drug Regimen Review Conducted with Follow-Up for Identified Issues	
OASIS	Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function	Application of 2631

Source: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Home-Health-Quality-Measures.html

Next Steps (after MAP feedback process)

- **CMS reviews MAP feedback with various internal/external stakeholders:**
  - Internal discussions at the Center for Medicaid and CHIP Services
  - Broader discussions with CMS's agency-level Quality Measures Task Force
  - State level stakeholder feedback



Annual updates to both Core Sets to be released by January 1, 2019

Input Requested for 2018

- MAP can assist CMS to identify ways to strengthen the Child & Adult Core Set:
  - Which measures can be added to fill key gap areas
  - Which measures to retire (i.e. measures that no longer reflect current clinical guidance, are retired by a measure steward, or are recommended by stakeholders for removal)
  - Ways to better align with other CMS/HHS programs
- Focus on incremental changes
  - CMS and states continue to learn about current Child & Adult Core Set measures
    - Connecting existing data to measures
    - Using data for quality improvement
  - Consider state staff time and resources it takes to learn/incorporate new measures

Important Considerations

- The Core Sets are tools states can use to monitor and improve the quality of Eligible Beneficiary Workgroup) health care provided to Medicaid and CHIP enrollees
  - *They are intended for quality improvement not payment purposes*
- The Core Sets are for state-level reporting, not provider-level reporting
- Under statute, state reporting on these measure sets is currently voluntary
- Alignment with other quality measure programs (such as CMS-American Health Insurance Plans (AHIP) Core Sets, Health Homes Core Set, and Dual
  - Trade-off between measure alignment across programs and fit-for-purpose of state-level program

CMCS Measurement Resources

- **State-Level Medicaid & CHIP Measures**
  - Medicaid & CHIP Child Core Measures
  - Medicaid Adult Core Measures
- **Plan-Level Medicaid & CHIP Measures**
  - Medicaid & CHIP Managed Care Quality Rating System
- **Provider-Level CMS Measures**
  - Health Homes Core Measures
  - Home and Community Based Services CAHPS
  - Behavioral Health Clinics Core Measures
  - CCSQ/AHIP Core Quality Measures Collaborative
    - Adult Core Sets
    - Pediatric Core Set

forthcoming

Questions & Contact Information

Questions?

Karen Matsuoka, PhD
Medicaid & CHIP Chief Quality Officer
Karen.Matsuoka@cms.hhs.gov

Quality Improvement in Minnesota Medicaid

Measures and Programs that Matter
Social Determinants and Tiered Measures

Jeff Schiff, MD MBA | Medical Director | Minnesota Department of Human Services

DEPARTMENT OF HUMAN SERVICES

Part 1 – Social Determinants of Health - This is hard

- The accountability is not entirely in the health care system…..
- But it is not entirely outside of the health care system

So,

- Maybe we learn from the data
- And try out some new accountability models

Why is this so hard?

- What is the scope of social determinants?
- Why are they health care's problem?
- What can legitimately be done in health care to impact them?
- What is the right approach?

The Scope of Social Determinants

- Modifiable
  - Family Functioning – Mental illness, Substance use disorder, child protection involvement, child abuse, parental incarceration (most of the Adverse Childhood Experiences – ACEs)
  - Family economic – Homelessness, food insecurity, lack of transportation, deep poverty

- Non-modifiable
  - Culture and ethnicity
  - Gender
  - GLBTQ status

National Academy of Medicine model

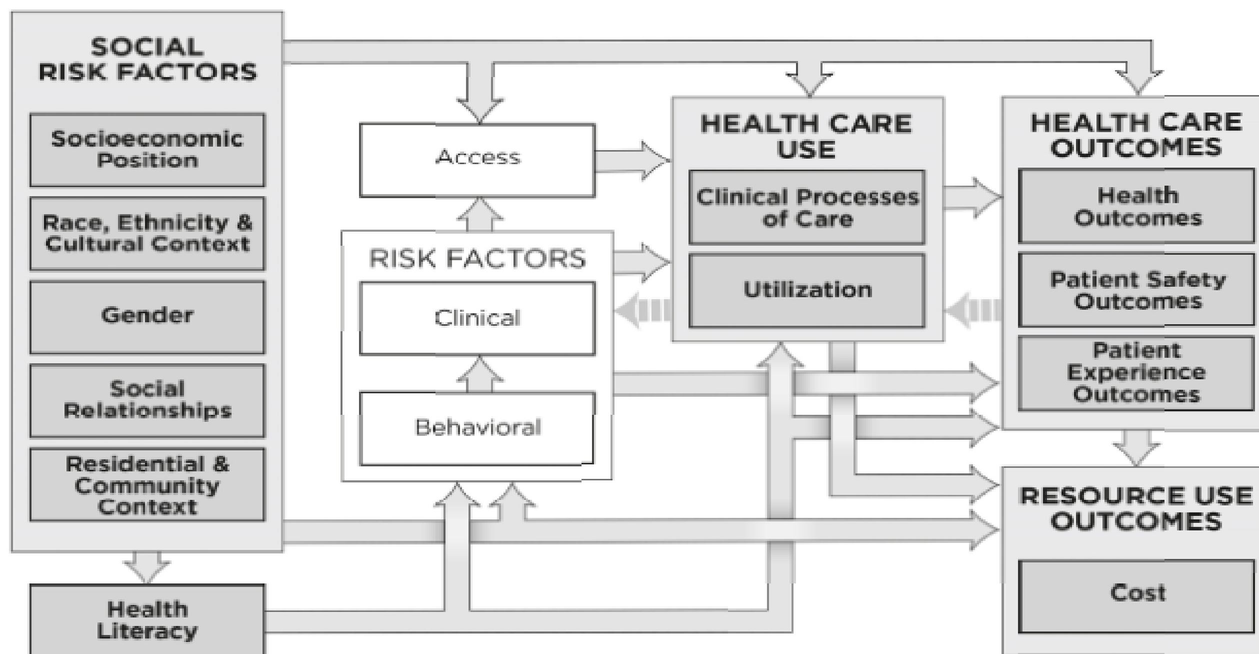


FIGURE 1-1 Conceptual framework of social risk factors for health care use, outcomes, and cost.
NOTE: This conceptual framework illustrates primary hypothesized conceptual relationships.

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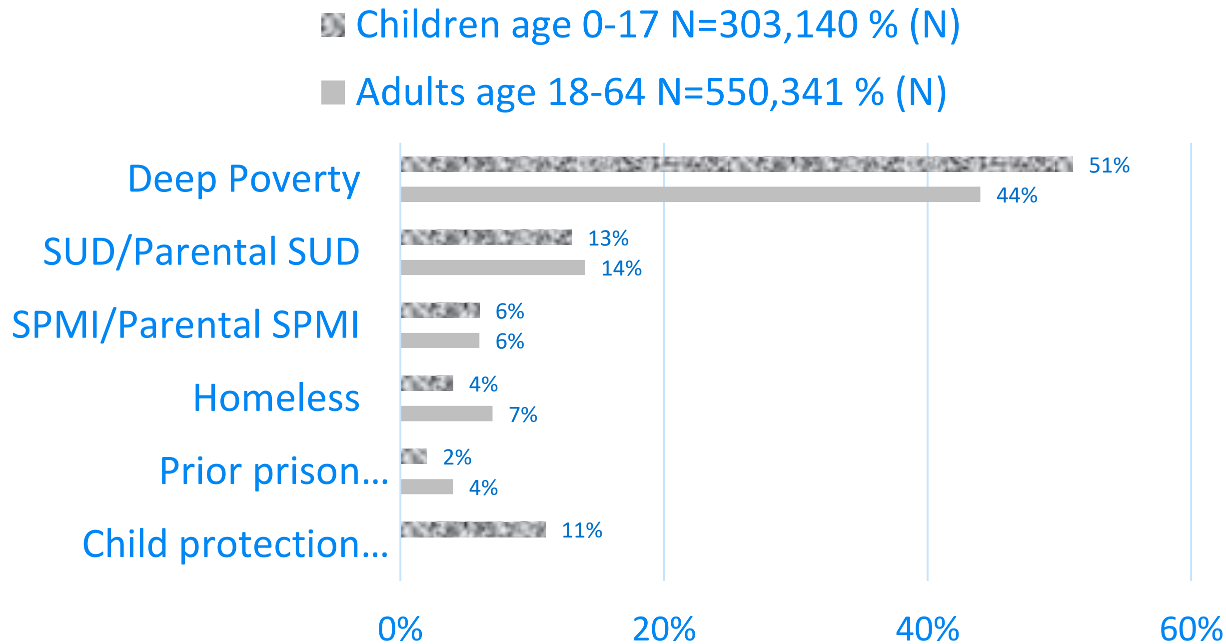
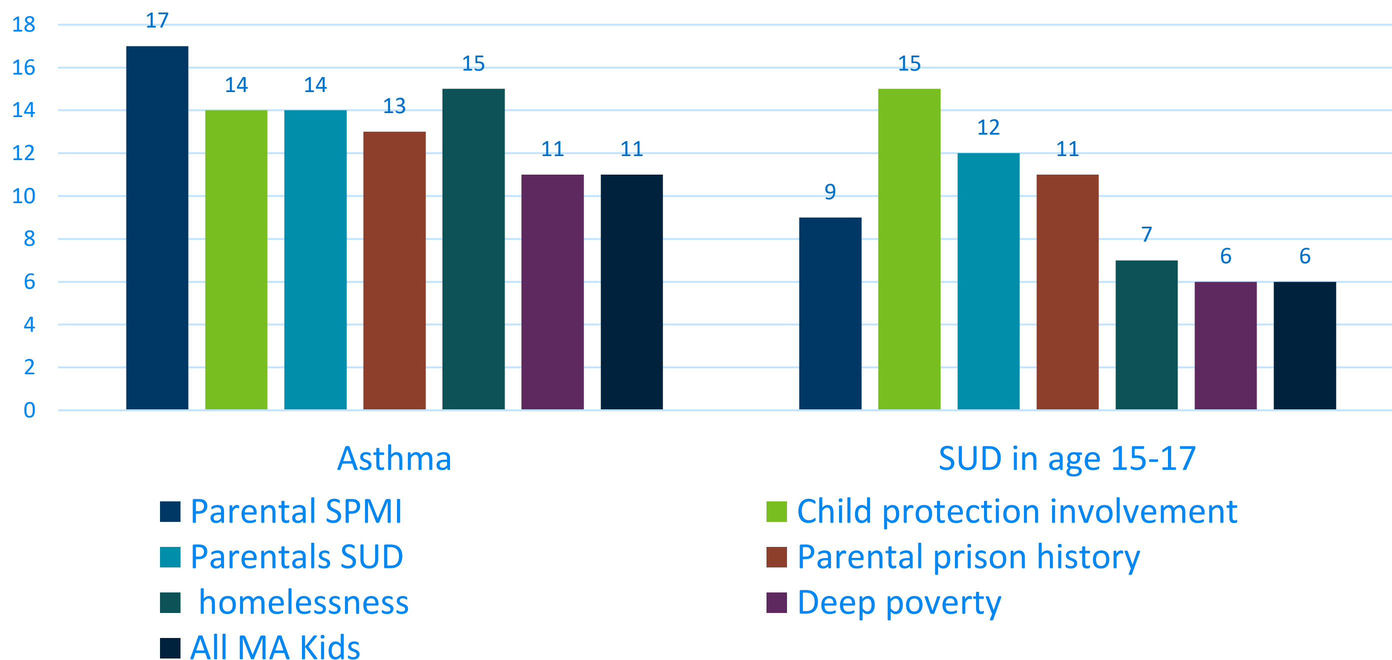
Prevalence of social risk factors among MA enrollees, 2014



Prevalence of Chronic Conditions among MA children with each social risk factor, compared with all MA children



And now a word from our sponsor- HEALTH

- Clinical Care
  - Done by providers or their agents - mostly
- POPULATION HEALTH
  - The great wide chasm
    - Done by whom
      - CHWs, Doulas, Community organizations, health care organizations?, Medicaid?
    - Is an integrated community / health care perinatal program population health? What about a diabetes prevention program – at an FQHC? At the Y? At a church?
- Public health
  - Surveillance, primary prevention
  - What about secondary prevention, tertiary

WHERE SHOULD WE GO TO IMPACT HEALTH?

WILL HEALTH CARE BASED INTERVENTIONS TO IMPROVE SDOH MATTER?

Why is it healthcare's problem?

- We have most of the money
- We aren't buying enough health for those dollars
- And we resist being in the room to be accountable for the health and well being outcomes (measures) – like diabetes prevalence, premature birth unless they are entirely in our purview

Minnesota Medicaid enrollees with Social Determinants of Health: How can we reduce their health disparities?

Coming shortly

So what can legitimately be done in health care to Impact SDoH

Legitimately inside only

- Screening brief intervention and referral to treatment, trauma informed mental health care

Integrated work with other areas

- Screening and referral

  Food insecurity, housing

- Populations based interventions
  - Diabetes Prevention
- Community and culturally based initiatives in which health care is a partner

So what is the right approach?

Two initiatives in Minnesota

- IHP = Integrated Health Partnership
- ICHiRP = Integrated Care for High Risk Pregnancies

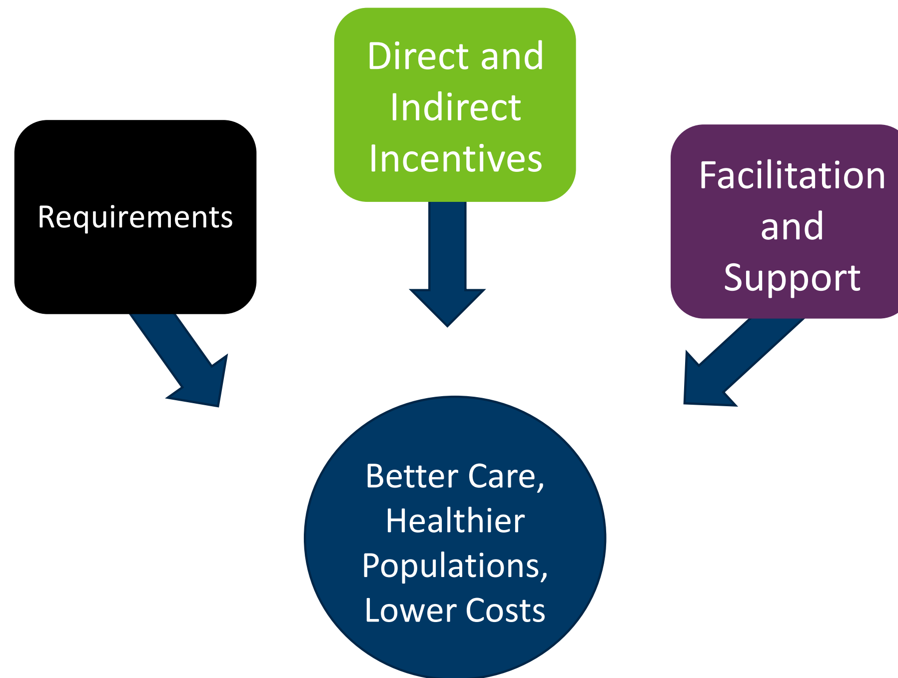
Integrated Health Partnership - Core Concepts and Accountability

Medicaid and **MinnesotaCare; FFS** and **Managed Care**
Primary care centric, but with built-in **flexibility**
IHP system is responsible for:

- Defined **core set of health care services**
- **Population-based** payment to support innovate care delivery, care coordination, and infrastructure (Tracks 1 and 2)
- Potential **Total Cost of Care (TCOC) shared risk** (savings and losses) (Track 2 only)
- **Robust quality metrics** – clinical, utilization, and health equity

DHS acts as **facilitative partner**, providing detailed data analytics and reports

Integration of Social Determinants into IHP Model



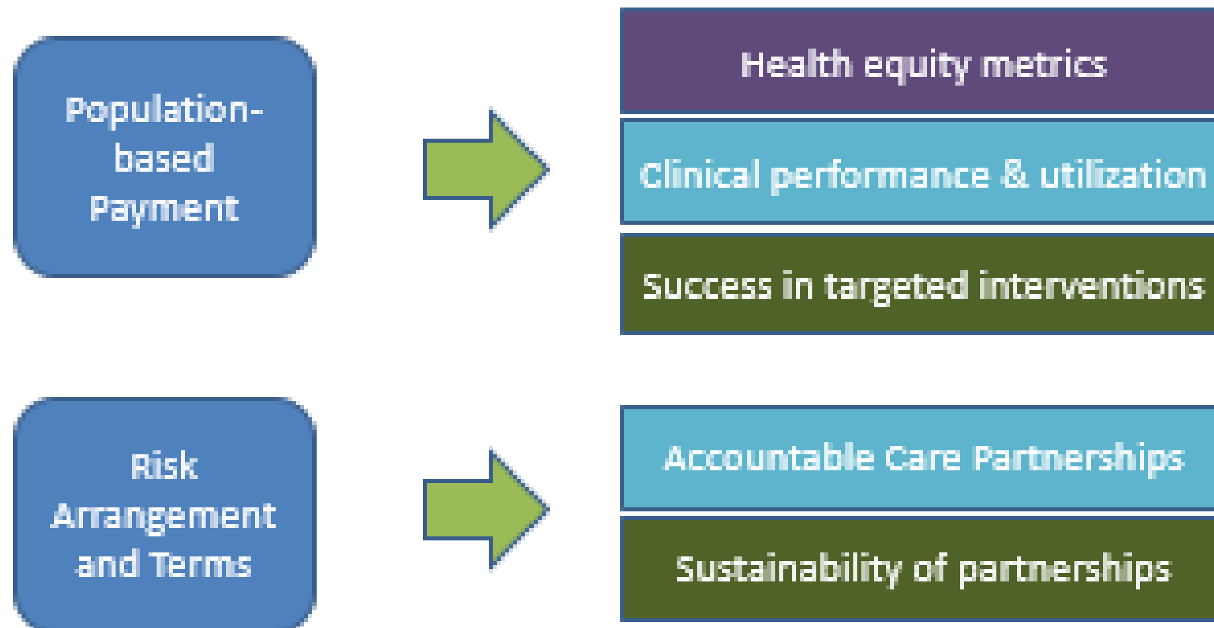
Integration of Social Determinants - Require

PCMH, ACO or similar certification

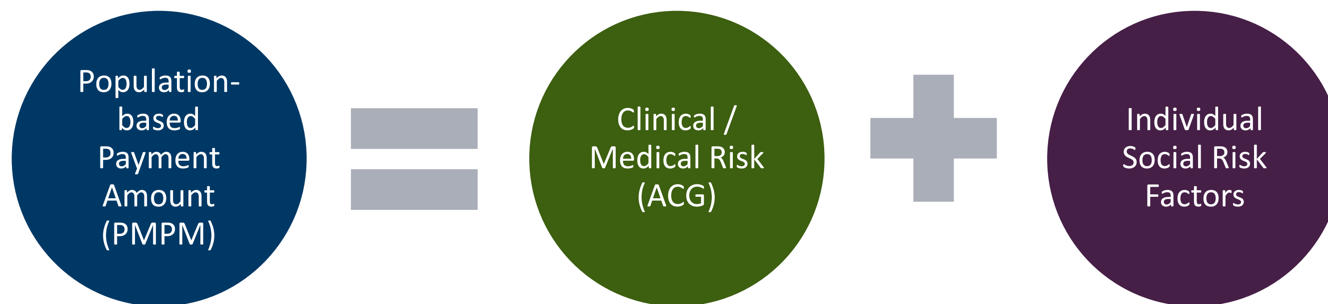
Demonstrated partnerships

Meaningfully engage patients & families

Integration of Social Determinants - Incent



Integration of Social Determinants - Facilitate



Integrated Care for High Risk Pregnancies - ICHiRP

Funded through a grant to decrease Low Birth Weight in American born African American babies and Neonatal Abstinence Syndrome in American Indian babies

- Based on the ability to bring down health care costs

Effects of Historical Trauma

ICHRP Collaboratives include Key Service Providers and have Community-based Leadership

- Prenatal care providers
- Social services
- Substance use treatment providers
- Local public health
- Child welfare
- Mental health providers
- Family court
- Community-based organizations as lead administrative entity

ICHRP: to improve birth outcomes by mitigating psychosocial risk

- Substance use
- Mental health
- Housing
- Partner abuse
- Financial instability
- Social isolation
- Vocational preparedness

Supports and Services need to be Culturally Accessible

Community and cultural response

- Centering pregnancy groups
- Local case finding and triage
- Local paraprofessionals via the health care sector in that community
- Support for African American men
- Trust and explicit discussions about race

Overall Measures around SDoH

Structure and process measures for accountability

- Integrated program
- Screening

Surveys of health status, resiliency for joint accountability

Health outcomes to learn (and for the system to be accountable)

- Diabetes rates
- Low Birth Rates

Part 2 – The Opioid crisis and tiered measures

Our focus in this program is on prescriber behavior, not the rest of the crisis inside health care (other work addresses other aspects of the crisis)

- Most opioid use disorder starts with pills

Wide variation in prescribing

- Some is normal, some out of normal lines
- Cultural expectations were created and now need to be changed

Our program components

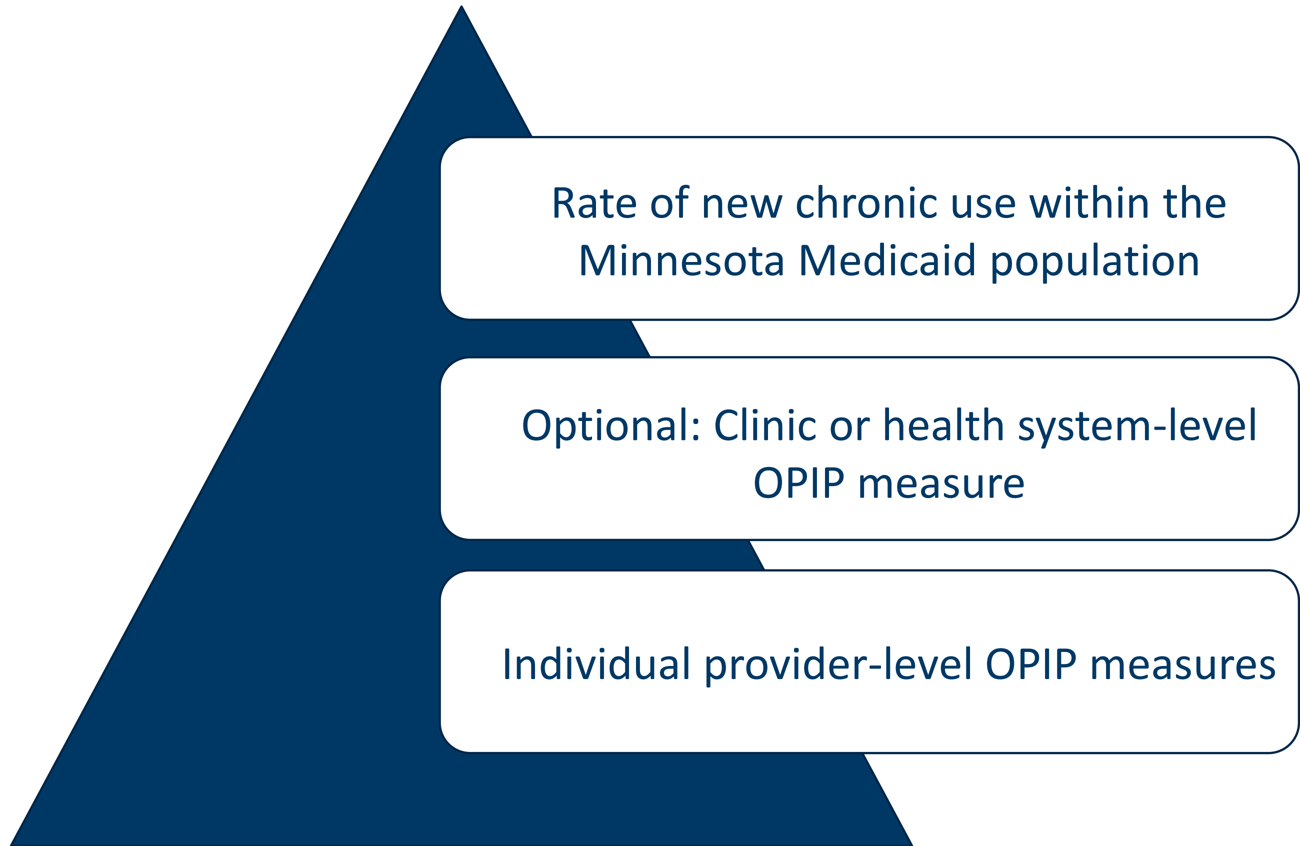
- Guidelines
- Measures
- Thresholds
- Quality Improvement
- Disenrollment

A different set of levers

Measures

- New Chronic User – system measure
- Prescribing behavior measures – individual prescriber

Multi-level measures of opioid prescribing behavior



Where can MN take a stand? New chronic use (NCU)

- Goal: Develop a clinically useful outcome measure that would support quality improvement efforts to prevent chronic opioid use
- Definition: An enrollee who has not taken any opioids for 3 months (opioid naïve) before an index prescription, and then received more than a 45-day supply over the next 3 months
- **Over 5,000 individuals per year**

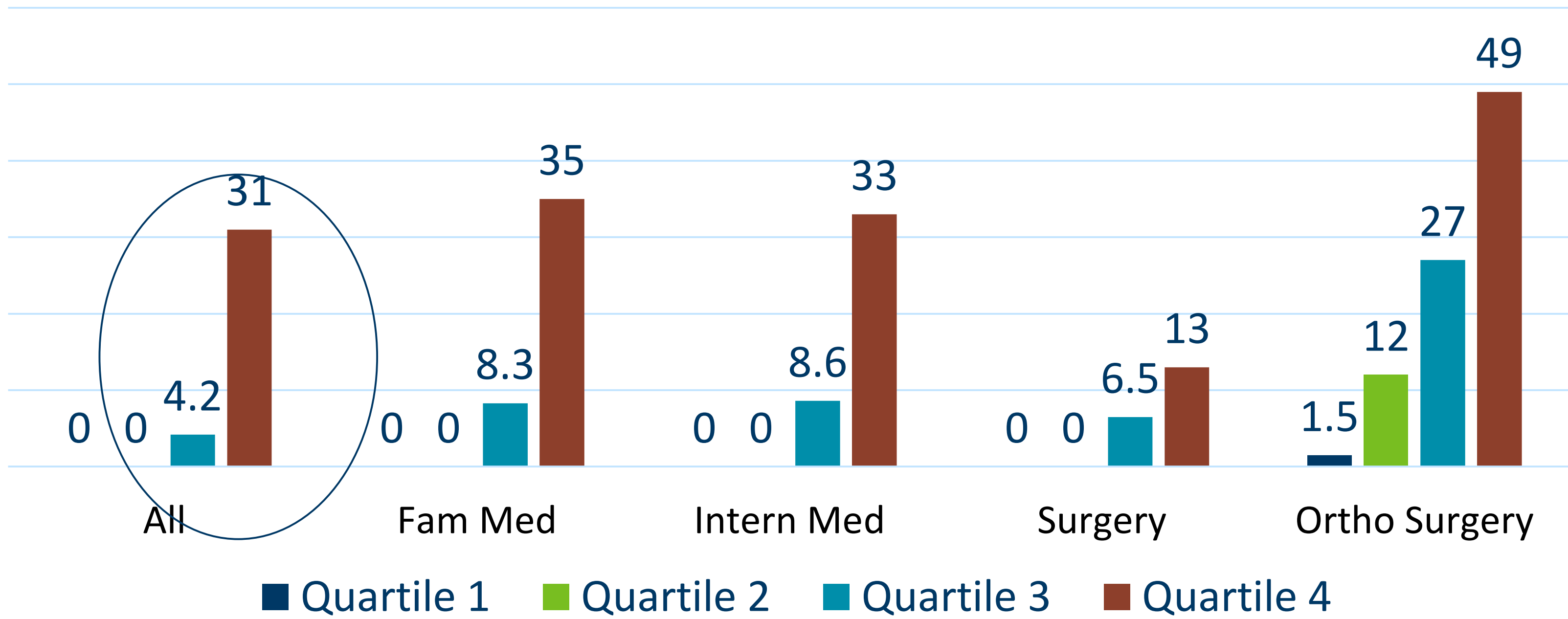
Quality Improvement Measures and Thresholds: Index opioid prescription and initial opioid exposure

Measure	Definition and threshold
Index opioid prescription rate	• Number of index opioid prescriptions/Distinct number of enrollees seen by the provider • Rate of prescribing an index opioid prescription > 8% (non-surgical specialties only)
Rate of prescribing over recommended dose	• Number of index opioid prescriptions exceeding 100 MME or 200 MME (based on specialty type)/Number of index opioid prescriptions prescribed • > 50% of index opioid prescriptions exceed the recommended dose
Percent of prescriptions that exceed 700 cumulative MME	• Number of prescriptions which cross the 700 cumulative MME threshold or exceed 700 cumulative MME/Number of opioid prescriptions written during an initial opioid prescribing episode • >15% of opioid prescriptions meet or exceed 700 cumulative MME

Quality Improvement Thresholds: Chronic Opioid Analgesic Therapy (≥ 60 consecutive days supply)

Measure	Definition / Threshold
Rate of prescribing COAT	• Number of enrollees prescribed COAT/Number of enrollees prescribed any opioid • No quality improvement threshold
Rate of prescribing high-dose COAT	• Number of prescribed COAT > 90 MME/day/Number of enrollees prescribed COAT enrollees • > 10% of enrollees prescribed high-dose COAT
Rate of concomitant prescribing	• Number of enrollees prescribed COAT > 50 MME/day and benzodiazepines/ Number of enrollees prescribed COAT • > 10% of enrollees prescribed concomitant COAT > 50 MME/day and benzodiazepines
Percent of enrollees with multiple prescribers	• Number of enrollees receiving opioids from 3+ prescribers while on COAT/ Number of enrollees prescribed COAT • No quality improvement threshold

Percent of opioid Rxs written in the post-acute interval that cross 700 MME threshold or exceed 700 MME, by specialty



Why this might work

- Alignment
  - Minnesota Medical Association, Minnesota Hospital Association, Academic Health Center, Institute for Clinical Systems Improvement , Health Plans , Stratis (QIO)
- Communication alignment and transparency
  - Normal medical channels
  - Weber Shandwick – “Flip the ‘script”
- Setting the stage for support of culture change
  - No blame
  - Confidential

Overall - Statewide quality improvement program

- Issue that matters to clinicians
- Wide variation
- Measureable outcome
- Surgical process
- Unique lever
- Based on prior model with early elective delivery

Part 3 the core sets – what we report

- Measurement nationally – just a few sets
  - Core sets
  - Plus Health Home set, MIPS, Meaningful use, more
- State Minnesota Community Measurement, State Quality Measurement and Reporting System
  - Measure burden and the new law
- Measures of our own creating – SDoH, opioids, child and teen check up completion

Philosophy

- Baseline oversight measures need to run in the background – HEDIS/ Core set measures
- Save our provider and community engagement for issues that matter to communities and providers
  - Opioids, babies, and dental access
- Save our measure energy for things we will work together to improve

Need more better

- Surveys of health and key components of care
  - PICS, FECC, PROMIS, SF-12, not CAHPS
- Link of public health surveillance to healthcare
- Link of Social Determinants to Health and other outcomes

DEPARTMENT OF HUMAN SERVICES

Thank You!

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Break

Strengthening the Core Sets – Alignment of Measures

Measure Alignment Section

- This section is split into two parts:
  - Alignment of Measures between Medicaid Adult and Child Core Set

    and

  - Alignment of Adult and Child Core Set measures with other Programs

Measure Alignment-between Core Sets

- With 10 total measures, Maternal/Perinatal Care is the most frequently measured topic across the Child and Adult Core Sets
- Relevant measures are present in both sets and need to be reviewed together for a comprehensive assessment of quality
- Despite the relatively large number of measures, some Workgroup members continue to regard maternal/perinatal care as a gap area – specifically, measures that relate to mitigating the risk of poor birth outcomes

Measure Alignment-between Adult and Child Core Sets

- Shared measures with different age groups reported:
  - Chlamydia Screening (#0033)
  - Contraceptive Care- Postpartum Women (#2902)
  - Contraceptive Care- Most and Moderately Effective Methods (#2903)

- Single measure with rates split across the measure sets (#1517):
  - Timeliness of Prenatal Care (Child)
  - Postpartum Care (Adult)

Alignment between the Adult and Child Core Sets

NQF #	Measure Title	Steward
0033	Chlamydia Screening	NCQA
1517	Prenatal Care and Postpartum Care	NCQA
2902	Contraceptive Care- Postpartum Women	US Office of Population Affairs (OPA)
2903	Contraceptive Care- Most and Moderately Effective Methods	OPA

Alignment of Adult and Child Core Sets Across Other Programs

- Examined the following sources for alignment:
  - MLTSS Quality Framework
  - Home Health Quality Initiative
  - Health Home Quality Reporting
    - 2013–2015 Core Set of Health Care Quality Measures for Medicaid Health Home Programs
  - Nursing Home Quality Initiative
  - American Health Insurance Plans (AHIP) Core Sets
  - Certified Community Behavioral Health Clinics (CCBHC) Measures
  - Dual Eligible Measures
  - CMS Measures Inventory Tool (CMIT)

Adult and Child Core Set Measures in the CMS Measures Inventory Tool

- All 26 Child Core Set measures are included in the CMS Measures Inventory Tool
- 32 of the 33 Adult Core Set measures are included in the CMS Measures Inventory Tool
  - #2940: Use of Opioids at High Dosage in Persons Without Cancer - not included.

Child Core Set Measures Aligned Across Other Programs

NQF #	Core Set Measure	Alignment Source
0024	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	Medicare and Medicaid Electronic Health Record Incentive Program for Eligible Professionals (Removed) Merit-Based Incentive Payment System (MIPS) Program (Finalized) Qualified Health Plan (QHP) Quality Rating System (QRS) (Implemented) AHIP Pediatric Core Set CCBHC
0033	Chlamydia Screening in Women (CHL)	Medicare and Medicaid Electronic Health Record Incentive Program for Eligible Professionals (No Status) Merit-Based Incentive Payment System (MIPS) Program (Finalized) Qualified Health Plan (QHP) Quality Rating System (QRS) (Implemented) AHIP Pediatric Core Set

Child Core Set Measures Aligned Across Other Programs, cont.

NQF #	Core Set Measure	Alignment Source
0038	Childhood Immunization Status (CIS)	Medicare Physician Quality Reporting System (Implemented) Merit-Based Incentive Payment System (MIPS) Program (Finalized) Physician Feedback/Quality Resource Use Report (Implemented) Physician Value-Based Payment Modifier (Implemented) Qualified Health Plan (QHP) Quality Rating System (QRS) (Implemented) AHIP Pediatric Core Set
0108	Follow-Up Care for Children Prescribed ADHD Medication (ADD)	Medicare and Medicaid Electronic Health Record Incentive Program for Eligible Professionals (No Status) Merit-Based Incentive Payment System (MIPS) Program (Finalized) Qualified Health Plan (QHP) Quality Rating System (QRS) (Implemented) CCBHC

Child Core Set Measures Aligned Across Other Programs, cont.

NQF #	Core Set Measure	Alignment Source
0418	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	CCBHC Health Home Core Set Duals Family of Measures
0471	PC-02 Cesarean Birth	AHIP OB/GYN Core Set

Child Core Set Measures Aligned Across Other Programs, cont.

NQF #	Core Set Measure	Alignment Source
0576	Follow-Up After Hospitalization for Mental Illness (FUH)	Hospital Compare (Implemented) Inpatient Psychiatric Facility Quality Reporting (Implemented) Medicare Physician Quality Reporting System (Implemented) Merit-Based Incentive Payment System (MIPS) Program (Finalized) Physician Feedback/Quality Resource Use Report (Implemented) Physician Value-Based Payment Modifier (Implemented) Qualified Health Plan (QHP) Quality Rating System (QRS) (Implemented) Health Home Core Set
1392	Well-Child Visits in the First 15 Months of Life	Qualified Health Plan (QHP) Quality Rating System (QRS) (Implemented)

Child Core Set Measures Aligned Across Other Programs, cont.

NQF #	Core Set Measure	Alignment Source
1407	Immunizations for Adolescents	Qualified Health Plan (QHP) Quality Rating System (QRS) (Implemented)
1448*	Developmental Screening in the First Three Years of Life	Merit-Based Incentive Payment System (MIPS) Program (Proposed)
1516	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Merit-Based Incentive Payment System (MIPS) Program (Proposed) Qualified Health Plan (QHP) Quality Rating System (QRS) (Implemented) AHIP Pediatric Core Set
1517*	Prenatal & Postpartum Care (PPC)	Qualified Health Plan (QHP) Quality Rating System (QRS) (Implemented)

*Endorsement removed

Child Core Set Measures Aligned Across Other Programs, cont.

NQF #	Core Set Measure	Alignment Source
N/A	Ambulatory Care: Emergency Department (ED) Visits (AMB-CH)	Health Home Core Set
N/A	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.0H – Child Version	MLTSS Quality Framework (one question only)

Adult Core Set Measures Aligned Across other Programs

NQF #	Core Set Measure	Alignment Source
0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	Medicare and Medicaid Electronic Health Record Incentive Program for Eligible Professionals (No Status), Merit-Based Incentive Payment System (MIPS) Program (Finalized), Qualified Health Plan (QHP) Quality Rating System (QRS) (Implemented) Health Home Core Set Duals Family of Measures CCBHC
0018	Controlling High Blood Pressure	Medicare Shared Savings Program (Implemented), Medicare and Medicaid Electronic Health Record Incentive Program for Eligible Professionals (No Status), Merit-Based Incentive Payment System (MIPS) Program (Finalized), Qualified Health Plan (QHP) Quality Rating System (QRS) (Implemented) AHIP Cardiovascular Core Set Health Home Core Set

Adult Core Set Measures Aligned Across Other Programs, cont.

NQF #	Core Set Measure	Alignment Source
0027	Medical Assistance With Smoking and Tobacco Use Cessation (MSC)	Qualified Health Plan (QHP) Quality Rating System (QRS) (Implemented) Duals Family of Measures
0032	Cervical Cancer Screening (CCS)	Medicare and Medicaid Electronic Health Record Incentive Program for Eligible Professionals (No Status), Merit-Based Incentive Payment System (MIPS) Program (Finalized), Qualified Health Plan (QHP) Quality Rating System (QRS) (Implemented) AHIP OB/GYN Core Set Duals Family of Measures AHIP Primary Care Core Set

Adult Core Set Measures Aligned Across Other Programs, cont.

NQF #	Core Set Measure	Alignment Source
0033	Chlamydia Screening in Women (CHL)	Medicare and Medicaid Electronic Health Record Incentive Program for Eligible Professionals (No Status), Merit-Based Incentive Payment System (MIPS) Program (Finalized), Qualified Health Plan (QHP) Quality Rating System (QRS) (Implemented) AHP Pediatric Core Set
0039	Flu Vaccinations for Adults Ages 18 and Older	Qualified Health Plan (QHP) Quality Rating System (QRS) (Implemented)
0057	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing	Qualified Health Plan (QHP) Quality Rating System (QRS) (Implemented)

Adult Core Set Measures Aligned Across Other Programs, cont.

NQF #	Core Set Measure	Alignment Source
0059	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	Medicare and Medicaid Electronic Health Record Incentive Program for Eligible Professionals (Implemented), Merit-Based Incentive Payment System (MIPS) Program (Finalized)
0105	Antidepressant Medication Management (AMM)	Medicare and Medicaid Electronic Health Record Incentive Program for Eligible Professionals (No Status), Merit-Based Incentive Payment System (MIPS) Program (Finalized), Qualified Health Plan (QHP) Quality Rating System (QRS) (Implemented) Duals Family of Measures CCBHC

Adult Core Set Measures Aligned Across Other Programs, cont.

NQF #	Core Set Measure	Alignment Source
0275	Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI 5)	Medicare Shared Savings Program (Removed)
0277	Heart Failure Admission Rate (PQI 8)	Medicare Shared Savings Program (Removed)
0418	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	Health Home Core Set Duals Family of Measures CCBHC
0469	PC-01 Elective Delivery	Hospital Inpatient Quality Reporting (Implemented), Hospital Value-Based Purchasing (Implemented), Medicare and Medicaid Electronic Health Record Incentive Program for Hospitals and Critical Access Hospitals (Implemented) AHIP OB/GYN Core Set

Adult Core Set Measures Aligned Across Other Programs, cont.

NQF #	Core Set Measure	Alignment Source
0476	PC-03 Antenatal Steroids	AHIP OB/GYN Core Set
0576	Follow-Up After Hospitalization for Mental Illness (FUH)	Hospital Compare (Implemented) Inpatient Psychiatric Facility Quality Reporting (Implemented) Medicare Physician Quality Reporting System (Implemented) Merit-Based Incentive Payment System (MIPS) Program (Finalized) Physician Feedback/Quality Resource Use Report (Implemented) Physician Value-Based Payment Modifier (Implemented) Qualified Health Plan (QHP) Quality Rating System (QRS) (Implemented) Health Home Core Set Duals Family of Measures CCBHC

Adult Core Set Measures Aligned Across Other Programs, cont.

NQF #	Core Set Measure	Alignment Source
1517*	Prenatal & Postpartum Care (PPC)	Qualified Health Plan (QHP) Quality Rating System (QRS) (Implemented)
1768	Plan All-Cause Readmissions (PCR)	Hospital Inpatient Quality Reporting (Removed) Qualified Health Plan (QHP) Quality Rating System (QRS) (Implemented) Health Home Core Set CCBHC
1932	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	Duals Family of Measures CCBHC

*Endorsement removed

Adult Core Set Measures Aligned Across Other Programs, cont.

NQF #	Core Set Measure	Alignment Source
2082	HIV viral load suppression	Medicare Physician Quality Reporting System (Implemented), Merit-Based Incentive Payment System (MIPS) Program (Finalized), Physician Feedback/Quality Resource Use Report (Implemented), Physician Value-Based Payment Modifier (Implemented) AHIP HIV/Hep C Core Set
2371	Annual Monitoring for Patients on Persistent Medications	Qualified Health Plan (QHP) Quality Rating System (QRS) (Implemented)

Adult Core Set Measures Aligned Across Other Programs, cont.

NQF #	Core Set Measure	Alignment Source
2372	Breast Cancer Screening	Medicare Shared Savings Program (Implemented) Merit-Based Incentive Payment System (MIPS) Program (Finalized) Qualified Health Plan (QHP) Quality Rating System (QRS) (Implemented) AHIP OB/GYN Core Set AHIP Primary Care Core Set
2605	Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Dependence	Duals Family of Measures CCBHC

Adult Core Set Measures Aligned Across Other Programs, cont.

NQF #	Core Set Measure	Alignment Source
2607	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	Duals Family of Measures CCBHC
n/a	Adult BMI Assessment (ABA)	Medicare Part C Star Rating (Implemented) Health Home Core Set
n/a*	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey, Version 5.0 Adult Version (Medicaid) (CPA-AD)	MLTSS Quality Framework (one question only) Duals Family of Measures

*this NCQA measure is adapted from #0006

Adult Core Set Measures Aligned Across Other Programs, cont.

NQF #	Core Set Measure	Alignment Source
n/a	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Medicare Physician Quality Reporting System (Considered), Medicare Shared Savings Program (Considered), Physician Compare (Considered), Physician Feedback/Quality Resource Use Report (Considered), Physician Value-Based Payment Modifier (Considered)

Discussion

- How can alignment across Medicaid Core Sets and other federal programs be maximized?

- What are some key success markers/characteristics of successful measure alignment across federal programs?

Discussion Questions

- What are some practical challenges for alignment across the sets and other programs?
- What are some opportunities for change?
- What are states' most notable successes related to quality measurement? How are they using the measures?
- What are some alignment issues that states can address in the near future?
- How can HHS/CMS address and facilitate alignment at the state level?

Issues of Shared Importance—

Adult and Child Continuum of Care: Looking at Behavioral Health Measures Across the Core Sets

Behavioral Healthcare is a Measurement Priority

- Behavioral healthcare is frequently measured across the Child and Adult Core Sets
  - » 14 measures across both set
- Shared measures with different age groups reported:
  - » Screening for depression and Follow-up Plan (#0418/0418e)
  - » Follow-up After Hospitalization for Mental Illness (#0576)
- Despite the relatively large number of behavioral measures, some workgroup members continue to regard this as a gap area

Measure Review for Potential Addition to the Core Set

- Workgroup annual recommendations are guided by the Measure Selection Criteria, feedback from state implementation and Medicaid population specific gap areas
- A Medicaid-specific algorithm and preliminary analysis was used as a standardized way to organize discussion on potential measure recommendations.
- A Medicaid Workgroup member recommended depression measures for strengthening the core sets

Tools Used to Guide Measure Review

MAP's Measure Selection Criteria (MSC)

1	NQF- endorsed measures are required for program measure sets, unless no relevant endorsed measures are available to achieve a critical program objective
2	Program measure set adequately addresses each of the National Quality Strategy's three aims
3	Program measure set is responsive to specific program goals and requirements
4	Program measure set includes an appropriate mix of measure types
5	Program measure set enables measurement of person- and family-centered care and services
6	Program measure set includes considerations for healthcare disparities and cultural competency
7	Program measure set promotes parsimony and alignment

Tools Used to Guide Measure Review

MAP's Preliminary Analysis Algorithm

Measure Voting Process

- The Workgroup must reach a decision about every measure discussed
  - Each decision should be accompanied by one or more statements that explain why each decision was reached
- Tallying the votes:
  - Quorum—66% of Workgroup required to be present for voting
  - >60% of votes denote the result of voting

Medicaid Decision Categories

SUPPORT

- Addresses a previously identified measure gap
- Ready for immediate use
- Promotes alignment across programs and settings

CONDITIONAL SUPPORT

- Pending endorsement from NQF
- Pending CMS confirmation of feasibility

DO NOT SUPPORT

- Measure and/or measure focus inappropriate or a poor fit for the Core Sets
- Duplication of efforts
- Resource constraints
- State Medicaid agencies will need to tweak and/or vary the level of analysis to increase measure adoption and implementation

2018 Workgroup Recommendations for Strengthening the Child/Adult Core Sets

NQF #	Measure Name	Measure Steward	Program Alignment
0710	Depression Remission at Twelve Months	MN Community Measurement	Medicare Shared Savings Program (Implemented), Medicare and Medicaid Electronic Health Record Incentive Program for Eligible Professionals (Implemented), Merit-Based Incentive Payment System (MIPS) Program (Finalized)
0711	Depression Remission at Six Months	MN Community Measurement	Medicare Physician Quality Reporting System (Implemented), Merit-Based Incentive Payment System (MIPS) Program (Finalized), Physician Feedback/Quality Resource Use Report (Finalized), Physician Value-Based Payment Modifier (Finalized)

2018 Workgroup Recommendations for Strengthening the Child/Adult Core Sets

NQF #	Measure Name	Measure Steward	Program Alignment
0712	Depression Utilization of the PHQ-9 Tool	MN Community Measurement	Medicare and Medicaid Electronic Health Record Incentive Program for Eligible Professionals (No Status), Merit-Based Incentive Payment System (MIPS) Program (Finalized)
1884	Depression Response at Six Months- Progress Towards Remission	MN Community Measurement	N/A
1885	Depression Response at Twelve Months- Progress Towards Remission	MN Community Measurement	N/A

NQF #0710e – Depression Remission at Twelve Months

Measure Steward: MN Community Measurement

QPS Link: http://www.qualityforum.org/QPS/0710e

Discussion Guide Link:
http://public.qualityforum.org/MAP/Medicaid%20Adult%20and%20Child/MAP_Medicaid_Adult_Discussion_Guide.html#1BEHA

NQF #0711 – Depression Remission at Six Months

Measure Steward: MN Community Measurement

QPS Link: http://www.qualityforum.org/QPS/0711

Discussion Guide Link:
http://public.qualityforum.org/MAP/Medicaid%20Adult%20and%20Child/MAP_Medicaid_Adult_Discussion_Guide.html#2BEHA

NQF #0712e – Depression Utilization of the PHQ-9 Tool

Measure Steward: MN Community Measurement

QPS Link: http://www.qualityforum.org/QPS/0712e

Discussion Guide Link:
http://public.qualityforum.org/MAP/Medicaid%20Adult%20and%20Child/MAP_Medicaid_Adult_Discussion_Guide.html#3BEHA

NQF# 1885 – Depression Response at Twelve Months- Progress Towards Remission

Measure Steward: MN Community Measurement

QPS Link: http://www.qualityforum.org/QPS/1885

Discussion Guide Link:
http://public.qualityforum.org/MAP/Medicaid%20Adult%20and%20Child/MAP_Medicaid_Adult_Discussion_Guide.html#5BEHA

NQF# 1884 – Depression Response at Six Months- Progress Towards Remission

Measure Steward: MN Community Measurement

QPS Link: http://www.qualityforum.org/QPS/1884

Discussion Guide Link:
http://public.qualityforum.org/MAP/Medicaid%20Adult%20and%20Child/MAP_Medicaid_Adult_Discussion_Guide.html#4BEHA

Opportunity for Public Comment

Child Workgroup Votes to Recommend Each Measure for Inclusion

- Vote to support inclusion of:
  - #0710: Depression Remission at Twelve Months
  - #0711: Depression Remission at Six Months
  - #0712: Depression Utilization of the PHQ-9 Tool
  - #1885: Depression Response at Twelve Months- Progress Towards Remission
  - #1884: Depression Response at Six Months- Progress Towards Remission

* Denotes measures recommended by TF members

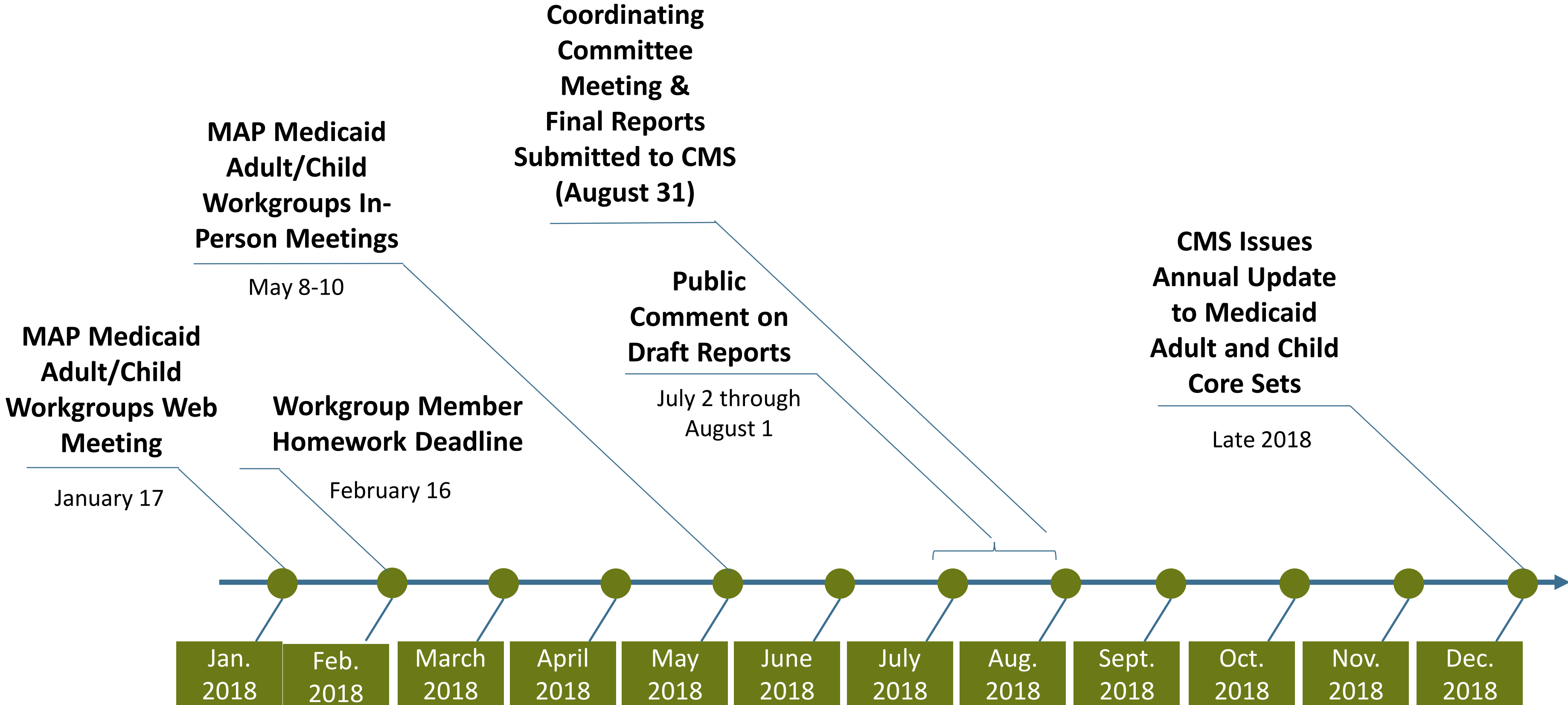
Ranking Measures (Child Core Set) with Support for Addition

- Workgroup members will prioritize measures selected for use (day one and two). Priority will indicate the order in which MAP recommends CMS add the measures to the set.

- Recommended measures
  - TBD

Next Steps

2018 Timeline



Project Contact Info

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  - Adult Workgroup: mapmedicaidadult@qualityforum.org
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- **NQF Phone:** 202-783-1300
- **Project page:** http://www.qualityforum.org/MAP_Medicaid_Adult_and_Child_Workgroups.aspx
- **SharePoint sites**
  - *Adult Workgroup:* http://staff.qualityforum.org/Projects/MAP%20Medicaid%20Adult%20Workgroup/SitePages/Home.aspx
  - *Child Workgroup:* http://share.qualityforum.org/Projects/MAP%20Medicaid%20Child%20Workgroup/SitePages/Home.aspx

Lunch

Adult Workgroup Votes to Recommend Each Measure for Inclusion

- Vote to support inclusion of:
  - #0710: Depression Remission at Twelve Months
  - #0711: Depression Remission at Six Months
  - #0712: Depression Utilization of the PHQ-9 Tool
  - #1885: Depression Response at Twelve Months- Progress Towards Remission
  - #1884: Depression Response at Six Months- Progress Towards Remission

* Denotes measures recommended by TF members

Adult Core Set: Prior Recommendations and Updated 2018 Measure Set

Medicaid Adult Population

- In FY 2016, Medicaid covered:[1]
  - 27 million adults
  - 9 million blind and disabled
  - 6 million aged
- In 2015, Medicaid covered roughly 21 percent of adults with mental illness, 26 percent of adults with serious mental illness, and 17 percent of adults with substance use disorder.
- 5 percent of Medicaid beneficiaries with complex care needs account for 54 percent of total Medicaid expenditures.[3]

[1.] Congressional Budget Office. Detail of Spending and Enrollment for Medicaid for CBO's January 2017 Baseline. Available at: https://www.cbo.gov/sites/default/files/recurringdata/51301-2017-01-medicaid.pdf. Accessed February 2017. [2.] Kaiser Family Foundation. Medicaid's Role in Financing Behavioral Health Services for Low-Income Individuals. Available at: https://www.kff.org/medicaid/issue-brief/medicaids-role-in-financing-behavioral-health-services-for-low-income-individuals/. Accessed December 2017. [3.] Medicaid.gov. Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs. Available at: https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/beneficiaries-with-complex-needs/beneficiaries-with-complex-needs.html. Accessed December 2017.

MAP's 2017 Recommendations to Address High Priority Gaps

- Behavioral health (integration and coordination with primary and acute care settings and outcomes)
- Assessing and addressing social determinants of health*
- Maternal/Reproductive health
  - Inter-conception care to address risk factors
  - Access to obstetric care in the rural community
  - Postpartum complications
- Long-term supports and services
- New chronic opiate use (45 days)

*** Denotes newly identified gap area**

2017 Adult Task Force Measure-Specific Recommendations

- In 2017, MAP supported 28 of 30 measures in the 2017 Adult Core Set for continued use
- MAP recommended the removal of
  - **NQF #0476 PC-03 Antenatal Steroids**
    - MAP recommends removal from the Adult Core Set to reduce duplication and burden at the state level and increase bandwidth for reporting other measures
  - **NQF #1517 Postpartum Care Rate***
    - MAP emphasized the importance of promoting actionable measures that directly address outcomes; NQF #1517 focuses on visit counts.

***Conditional support to remove**

2017 Adult Task Force Measure-Specific Recommendations, cont.

MAP recommended four measures for phased addition:

Rank	NQF #	Measure Title	Recommendation
1*	1800	Asthma Medication Ratio	Support
2	2967	CAHPS @ Home and Community-Based Services Experience Measures	Conditional Support
2*	N/A	Concurrent Use of Opioids and Benzodiazepines	Conditional Support
3*	2903	Contraceptive Care: Most & Moderately Effective Methods	Support

* Adopted in 2018 Core Set

CMS—Adult Core Set Update for 2018 Reporting

Issued November 14, 2017

- Based on MAP's recommendations, CMCS updated the 2018 Adult Core Set:
  - Added three measures:
    - » NQF #1800: Asthma Medication Ratio
    - » Concurrent Use of Opioids and Benzodiazepines
    - » NQF #2903: Contraceptive Care – Most & Moderately Effective Methods
- No measures were retired

CMCS Informational Bulletin. 2017 Updates to the child and Adult Core Health Care Quality Measurement Sets. Available: https://www.medicaid.gov/federal-policy-guidance/downloads/cib120516.pdf. Accessed February 2017.

Medicaid Adult Core Set Measures for FFY 2018 Use

Primary Care Access and Preventive Care

NQF #	Measure Name	Measure Steward
0032	Cervical Cancer Screening (CCS-AD)	NCQA
0033	Chlamydia Screening in Women Ages 21–24 (CHL-AD)	NCQA
0039	Flu Vaccinations for Adults Ages 18 to 64 (FVA-AD)	NCQA
0418	Screening for Clinical Depression and Follow-Up Plan (CDF-AD)	CMS
2372	Breast Cancer Screening (BCS-AD)	NCQA
N/A	Adult Body Mass Index Assessment (ABA-AD)	NCQA

Maternal and Perinatal Health

NQF #	Measure Name	Measure Steward
0469/ 2829	PC-01: Elective Delivery (PC01-AD)	TJC
0476	PC-03: Antenatal Steroids (PC03-AD)	TJC
2902	Contraceptive Care – Postpartum Women Ages 15–44 (CCP-AD)*	OPA
2903	Contraceptive Care: Most & Moderately Effective Methods	OPA
N/A	Postpartum Care Rate (PPC-AD)	NCQA

CMS = Centers for Medicare & Medicaid Services; NCQA: National Committee for Quality Assurance; NQF: National Quality Forum; TJC = The Joint Commission; OPA = U.S. Office of Population Affairs

† Newly Added Measure

Medicaid Adult Core Set Measures for FFY 2018 Use, cont.

Care of Acute and Chronic Conditions

NQF #	Measure Name	Measure Steward
0018	Controlling High Blood Pressure (CBP-AD)	NCQA
0057	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing (HA1C-AD)	NCQA
0059	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC-AD)	NCQA
0272	PQI 01: Diabetes Short-Term Complications Admission Rate (PQI01-AD)	AHRQ
0275	PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05-AD)	AHRQ
0277	PQI 08: Heart Failure Admission Rate (PQI08-AD)	AHRQ
0283	PQI 15: Asthma in Younger Adults Admission Rate (PQI15-AD)	AHRQ
1800	Asthma Medication Ratio	NCQA

† Newly Added Measure

NCQA: National Committee for Quality Assurance; AHRQ: Agency for Healthcare Research & Quality

Medicaid Adult Core Set Measures for FFY 2018 Use, cont.

Care of Acute and Chronic Conditions

NQF #	Measure Name	Measure Steward
1768	Plan All-Cause Readmissions (PCR-AD)	NCQA
2082	HIV Viral Load Suppression (HVL-AD)	HRSA
2371	Annual Monitoring for Patients on Persistent Medications (MPM-AD)	NCQA

Experience of Care

NQF #	Measure Name	Measure Steward
0006	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.0H, Adult Version (Medicaid) (CPA-AD)	AHRQ

NCQA: National Committee for Quality Assurance; AHRQ: Agency for Healthcare Research & Quality; HRSA = Health Resources and Services Administration

Medicaid Adult Core Set Measures for FFY 2018 Use, cont.

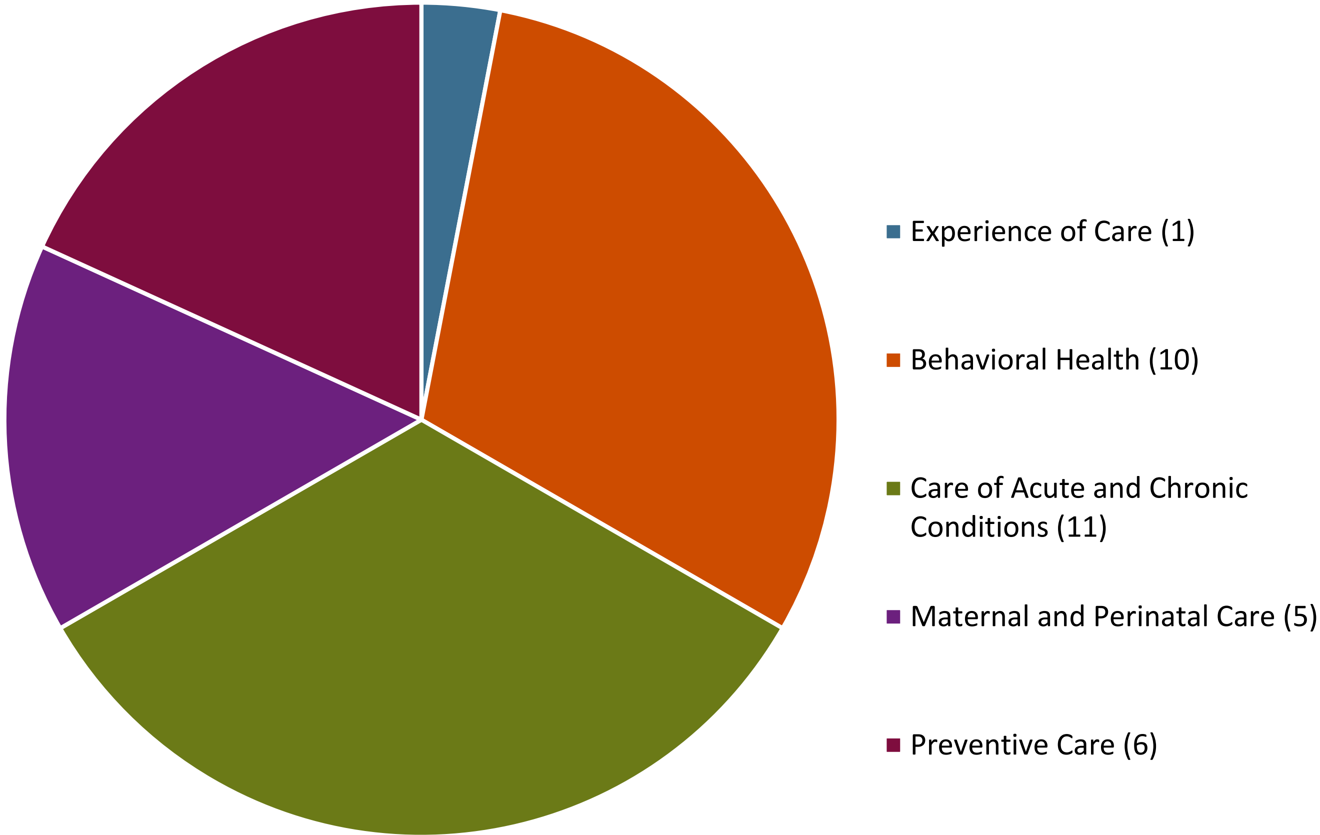
Behavioral Health Care

NQF #	Measure Name	Measure Steward
0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD)	NCQA
0027	Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD)	NCQA
0105	Antidepressant Medication Management (AMM-AD)	NCQA
0576	Follow-Up After Hospitalization for Mental Illness: Age 21 and Older (FUH-AD)	NCQA
1879	Adherence to Antipsychotics for Individuals with Schizophrenia (SAA-AD)	CMS
1932	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)	NCQA
2605	Follow-Up After Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence (FUA-AD)*	NCQA
2607	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)*	NCQA
N/A	Use of Opioids at High Dosage (OHD-AD)	PQA
N/A	Concurrent Use of Opioids and Benzodiazepines	PQA

NCQA: National Committee for Quality Assurance; CMS = Centers for Medicare & Medicaid Services;
PQA: Pharmacy Quality Alliance

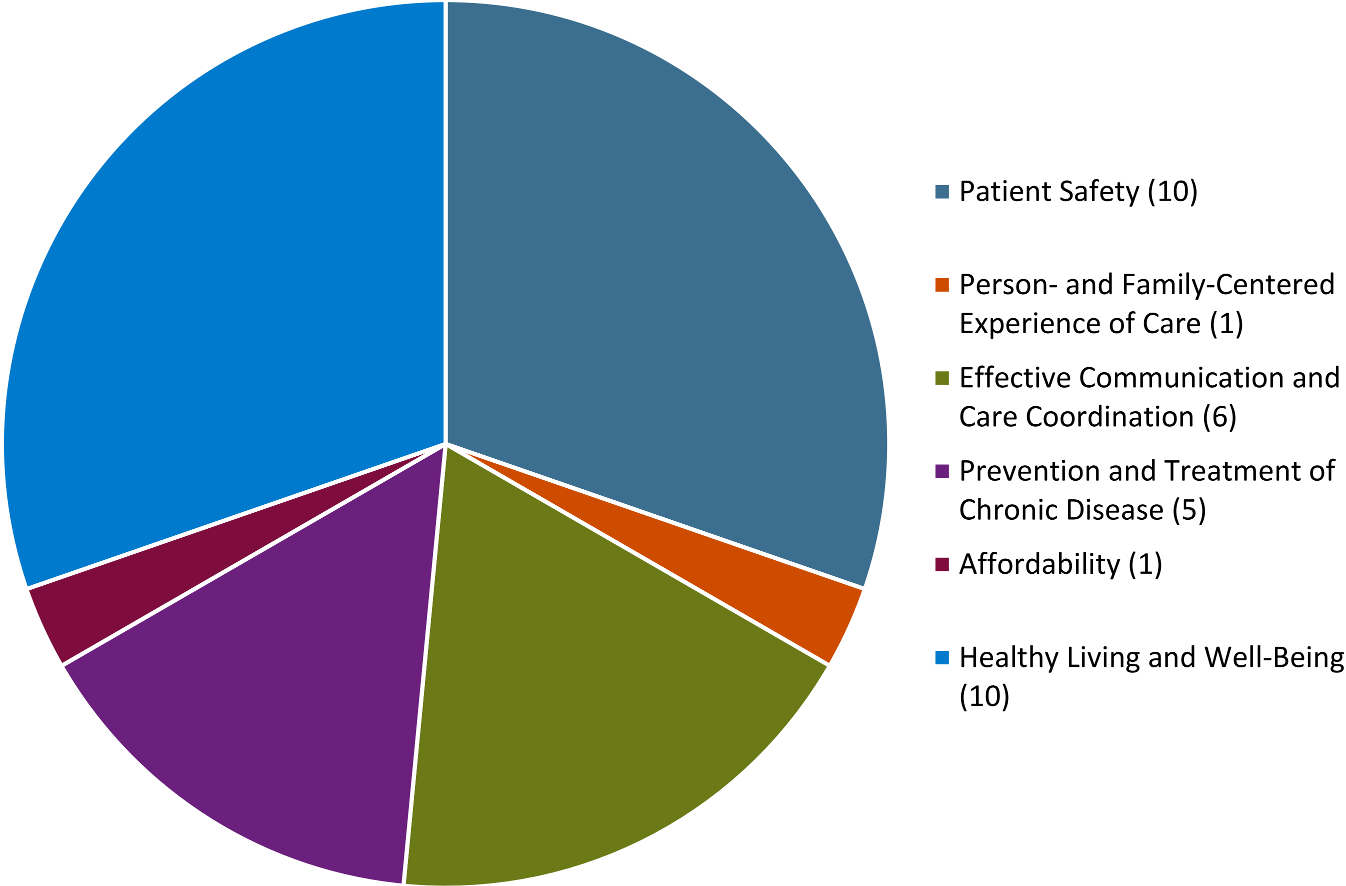
† Newly Added Measure

Medicaid Adult Core Set Properties: Clinical Area



Data aggregated from 2018 Adult Core Set

Medicaid Adult Core Set Properties: NQS Priorities



Data obtained from NQF's Quality Positioning System

Medicaid Adult Core Set Properties: Measure Characteristics

Medicaid Adult Core Set Characteristics		# of Measures (n = 33)
NQF Endorsement Status	Endorsed	29
	Not Endorsed	4
Measure Type	Structure	0
	Process	22
	Outcome	10
	Patient Experience of Care	1

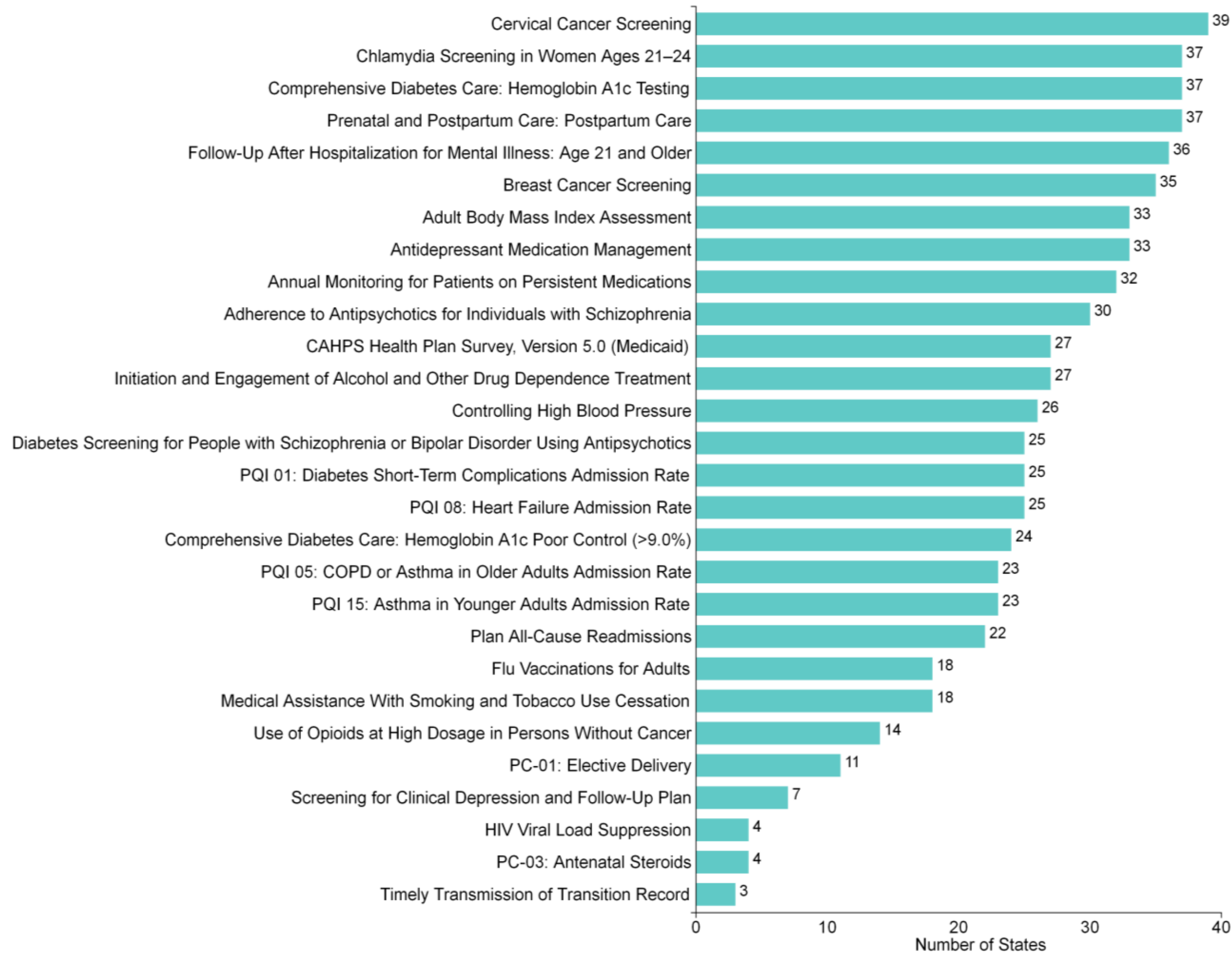
Questions

Staff Review of FFY 2016 State Reporting of Adult Core Set

Overview of Medicaid Adult Core Set FFY 2016 Reporting

- 41 states voluntarily reported at least one Adult Core Set measure
- States reported a median of 17 measures
- Most frequently reported measures assess women's access to primary and preventive care, diabetes care, prenatal and postpartum care, and behavioral health care
- FFY 2016 is the first year reporting two new measures:
  - NQF#2940 Use of Opioids at High Dosage in Persons Without Cancer
  - NQF# 1932 Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

Number of States Reporting the Adult Core Set Measures, FFY 2016

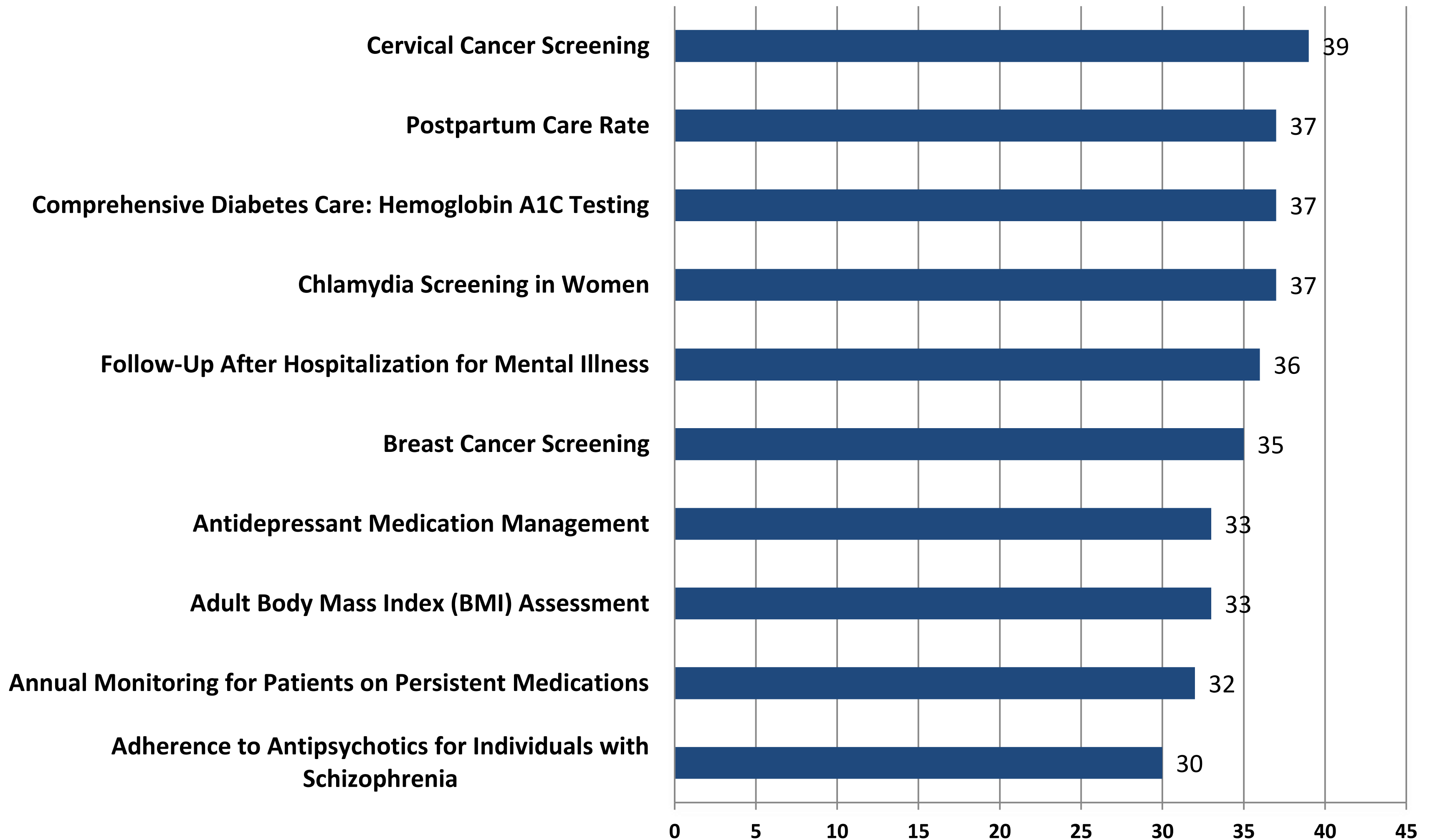


41

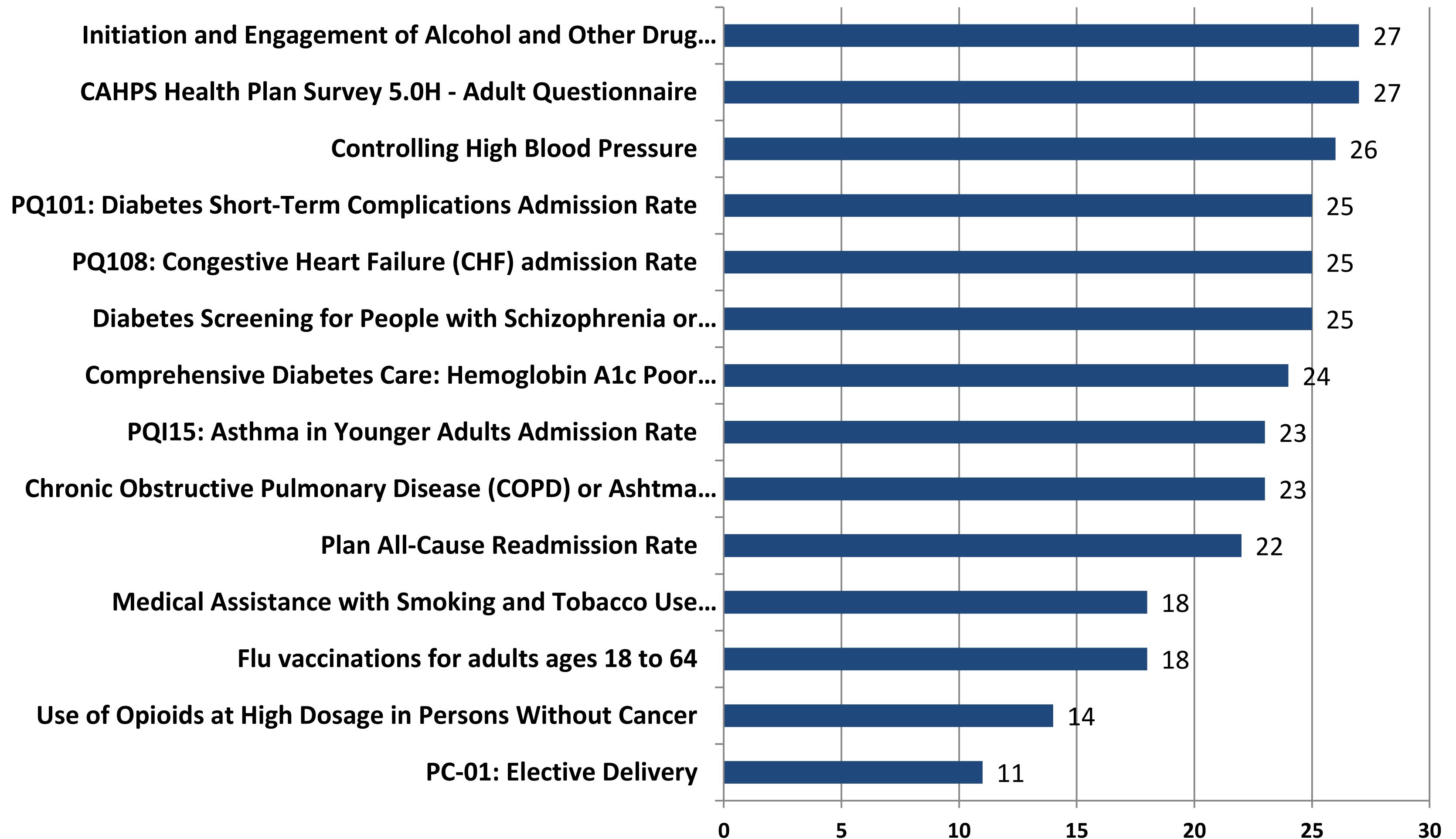
states voluntarily reported at least one Adult Core Set measure for FFY 2016

Sources: Mathematica analysis of MACPro reports for the FFY 2016 reporting cycle
Notes: The term “states” includes the 50 states and the District of Columbia

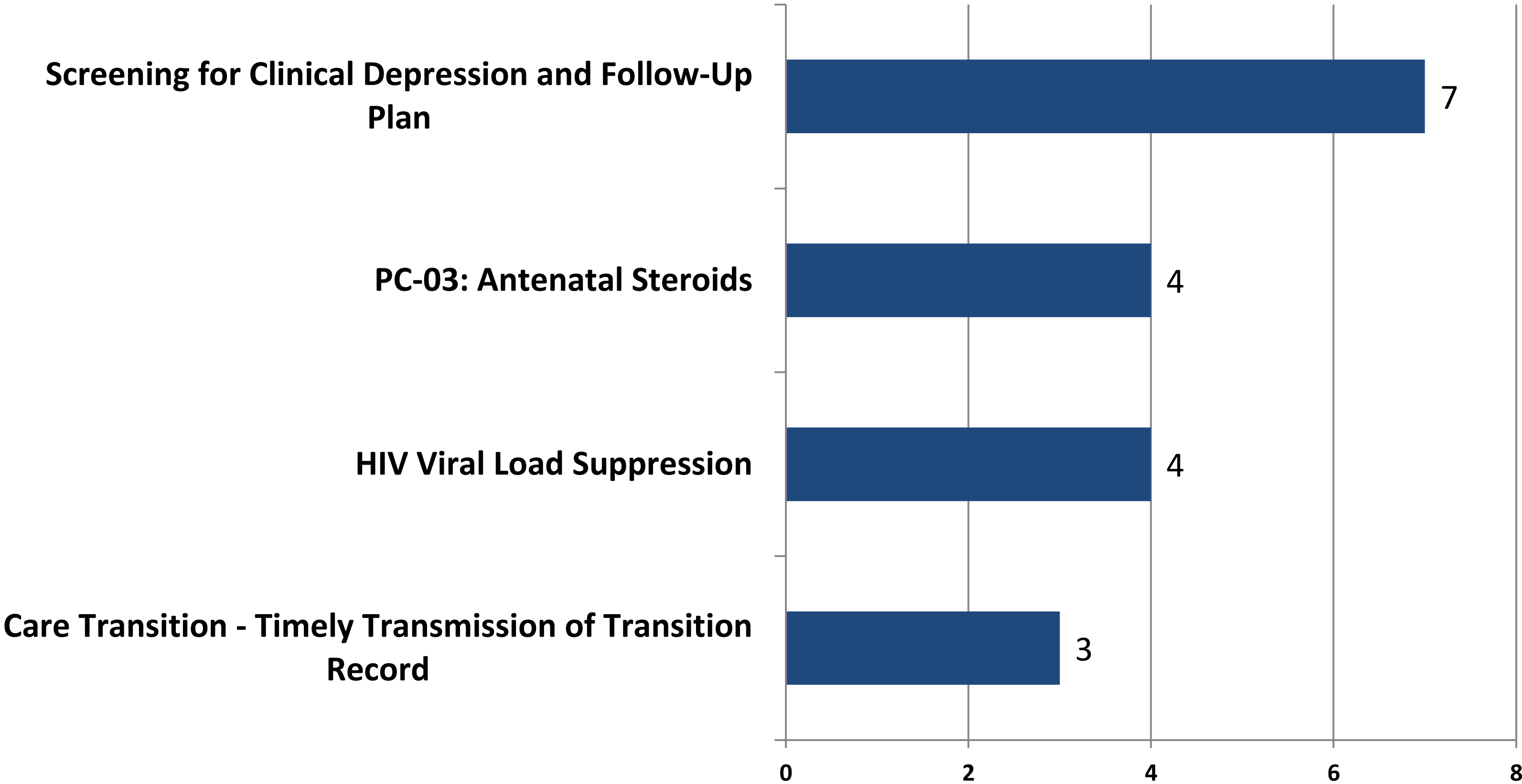
Measures with High Levels of Reporting (10)



Measures Reported More Frequently in 2016 (14)



Measures with Low Levels of Reporting (4)



NQF #0418: Screening for Clinical Depression and Follow-Up Plan (CMS)

Description	Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.
Numerator	See details in multiple formats - Patients screened for depression on the date of the encounter using an age appropriate standardized tool AND if positive, a follow-up plan is documented on the date of the positive screen
Denominator	See details in multiple formats - All patients aged 12 years and older
Exclusions	See details in multiple formats - A patient is not eligible if one or more of the following conditions are documented: Patient refuses to participate; Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status; Situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools. For example: certain court appointed cases or cases of delirium; Patient has an active diagnosis of Depression; Patient has a diagnosed Bipolar Disorder
Data Source	Claims (Only), Registry
Type	Process

NQF #0476: PC-03 Antenatal Steroids (The Joint Commission)

Description	This measure assesses patients at risk of preterm delivery at >=24 and <32 weeks gestation receiving antenatal steroids prior to delivering preterm newborns. This measure is a part of a set of five nationally implemented measures that address perinatal care. (PC-01: Elective Delivery, PC-02: Cesarean Birth, PC-04: Health Care-Associated Bloodstream Infections in Newborns, PC-05: Exclusive Breast Milk Feeding).
Numerator	Patients with antenatal steroid therapy initiated prior to delivering preterm newborns.
Denominator	Patients delivering live preterm newborns with >=24 and <34 weeks gestation completed with ICD-10-PCS Principal or Other Procedure Codes for delivery as defined in Appendix A, Table 11.01.1 available at: http://manual.jointcommission.org/releases/TJC2016A/
Exclusions	• Less than 8 years of age • Greater than or equal to 65 years of age • Length of Stay >120 days • Documented Reason for Not Initiating Antenatal Steroids • ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes for fetal demise as defined in Appendix A, Table 11.09.1 available at: http://manual.jointcommission.org • Gestational Age < 24 or >= 34 weeks or UTD
Data Source	Electronic Health Records, Other, Paper Medical Records
Type	Process

NQF #2082: HIV Viral Load Suppression (HRSA)

Description	Percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year. A medical visit is any visit in an outpatient/ambulatory care setting with a nurse practitioner, physician, and/or a physician assistant who provides comprehensive HIV care.
Numerator	Number of patients in the denominator with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.
Denominator	Number of patients, regardless of age, with a diagnosis of HIV with at least one medical visit in the measurement year.
Exclusions	None
Data Source	Electronic Health Data, Paper Medical Records
Type	Outcome

NQF #0648: Care Transition – Transition Record Transmitted to Health Care Professional (PCPI)

No longer part of Core Set

Description	Percentage of patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge.
Numerator	Patients for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge.
Denominator	All patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self care or any other site of care.
Exclusions	Patients who died Patients who left against medical advice (AMA) or discontinued care
Data Source	Electronic Health Data, Paper Medical Records
Type	Process

Measure Review

- States appear to collect, report and use a majority of the measures. Therefore, they do not warrant detailed discussion.

- Focus on measures with the least amount of state reporting.
  - How might participation in reporting these measures be increased?
  - What can we learn about the measures that are (or are not) a good fit for this program based on the handful that relatively few states report?

Based on information do any members of the Workgroup wish to propose any low reported measures for removal?

Potential Reasons for Removal from Core Set

- Consistently high levels of performance (e.g., >95%), indicating little room for additional improvement
- Multiple years of very low numbers of states reporting, indicating low feasibility or low priority of the topic
- Change in clinical evidence has made the measure obsolete
- Measure does not provide actionable information for state Medicaid program and/or its network of plans/providers
- Superior measure on the same topic has become available

Measure by Measure Review of the Adult Core Set

2017 TF Measure Removal Recommendations Not Accepted by CMS

NQF #	Measure Name	Measure Steward	Program Alignment
0476	PC-03 Antenatal Steroids	The Joint Commission	Medicaid (Implemented)
1517	Prenatal Care and Postpartum Care	National Committee for Quality Assurance	CMS Inventory

**The 2015 and 2016 Adult Task Force recommended all measures for continued use.*

Workgroup Recommendations for Removal from the Adult Core Set

NQF#	Measure Name	Measure Steward	Program Alignment
0275	PQI 05:COPD/Asthma in Older Adults Admission Rate	AHRQ	Medicaid (Implemented), Medicare Shared Savings Program (Removed)
0277	PQI 08: Heart Failure Admission Rate	AHRQ	Medicaid (Implemented), Medicare Shared Savings Program (Removed)

NQF #0275 - PQI 05:COPD/Asthma in Older Adults Admission Rate

Measure Steward: Agency for Healthcare Research & Quality

QPS Link: http://www.qualityforum.org/QPS/0275

Discussion Guide Link: http://public.qualityforum.org/MAP/Medicaid%20Adult%20and%20Child/MAP_Medicaid_Adult_Discussion_Guide.html#24PRO

NQF #0277 – PQI 08: Heart Failure Admission Rate

Measure Steward: Agency for Healthcare Research & Quality

QPS Link: http://www.qualityforum.org/QPS/0277

Discussion Guide Link: http://public.qualityforum.org/MAP/Medicaid%20Adult%20and%20Child/MAP_Medicaid_Adult_Discussion_Guide.html#25PRO

Opportunity for Public Comment

Measure Voting Process

- The Workgroup must reach a decision about every measure discussed
  - Each decision should be accompanied by one or more statements that explain why each decision was reached
- Tallying the votes:
  - Quorum—66% of Workgroup required to be present for voting
  - >60% of votes denote the result of voting

Medicaid Decision Categories

SUPPORT

- Addresses a previously identified measure gap
- Ready for immediate use
- Promotes alignment across programs and settings

CONDITIONAL SUPPORT

- Pending endorsement from NQF
- Pending CMS confirmation of feasibility

DO NOT SUPPORT

- Measure and/or measure focus inappropriate or a poor fit for the Core Sets
- Duplication of efforts
- Resource constraints
- State Medicaid agencies will need to tweak and/or vary the level of analysis to increase measure adoption and implementation

Workgroup Votes to Recommend Each Measure for Removal

- Vote to support (or conditionally support) removal of:
  - #0275 PQI 05:COPD/Asthma in Older Adults Admission Rate
  - #0277 PQI 08: Heart Failure Admission Rate

* Denotes measures recommended by TF members

Measure by Measure Review: Potential Gap-Filling Measures for Addition to the Adult Core Set

2015, 2016 & 2017 TF Measure Addition Recommendations Not Accepted by CMS

NQF #	Measure Name	Measure Steward	Program Alignment
2967	CAHPS @ Home and Community-Based Services Experience Measures	Centers for Medicare and Medicaid Services	N/A
2152	Preventive Care and Screening: Unhealthy Alcohol Use	Physician Consortium for Performance Improvement	Medicare Physician Quality Reporting System (Implemented), Merit-Based Incentive Payment System (MIPS) Program (Finalized), Physician Feedback/Quality Resource Use Report (Finalized), Physician Value-Based Payment Modifier (Finalized)
0541	Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category	Pharmacy Quality Alliance	Medicare Part D Star Rating (Implemented)
1799	Medication Management for People with Asthma	National Committee for Quality Assurance	Medicaid (Implemented), Merit-Based Incentive Payment System (MIPS) Program (Finalized), Qualified Health Plan (QHP) Quality Rating System (QRS) (Implemented)

2015, 2016 & 2017 TF Measure Addition Recommendations Not Accepted by CMS

NQF #	Measure Name	Measure Steward	Program Alignment
2602	Controlling High Blood Pressure for People with Serious Mental Illness	National Committee for Quality Assurance	N/A
1927	Cardiovascular Health Screening for People With Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications	National Committee for Quality Assurance	N/A
2950	Use of Opioids from Multiple Providers in Persons Without Cancer	Pharmacy Quality Alliance	N/A
2951	Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer	Pharmacy Quality Alliance	N/A

2018 Workgroup Recommendations for Strengthening the Adult Core Set

NQF #	Measure Name	Measure Steward	Program Alignment
0028	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	PCPI	Medicare Shared Savings Program (Implemented), Medicare and Medicaid Electronic Health Record Incentive Program for Eligible Professionals (No Status), Merit-Based Incentive Payment System (MIPS) Program (Finalized)
0104	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	PCPI	Medicare and Medicaid Electronic Health Record Incentive Program for Eligible Professionals (No Status), Merit-Based Incentive Payment System (MIPS) Program (Finalized)

2018 Workgroup Recommendations for Strengthening the Adult Core Set

NQF #	Measure Name	Measure Steward	Program Alignment
2152	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	PCPI	Medicare Physician Quality Reporting System (Implemented), Merit-Based Incentive Payment System (MIPS) Program (Finalized), Physician Feedback/Quality Resource Use Report (Finalized), Physician Value-Based Payment Modifier (Finalized)
0726	Patient Experience of Psychiatric Care as Measured by the Inpatient Consumer Survey (ICS)	National Association of State Mental Health Program Directors Research Institute (NASMHPD)	N/A

2018 Workgroup Recommendations for Strengthening the Adult Core Set

NQF #	Measure Name	Measure Steward	Program Alignment
1927	Cardiovascular Health Screening for People With Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications	NCQA	N/A
1934	Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)	NCQA	N/A
2600	Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence	NCQA	N/A
3175	Continuity of Pharmacotherapy for Opioid Use Disorder	RAND Corporation	N/A
2950	Use of Opioids from Multiple Providers in Persons Without Cancer	PQA	N/A

NQF #0028 – Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Measure Steward: PCPI Foundation

QPS Link: http://www.qualityforum.org/QPS/0028

Discussion Guide Link: http://public.qualityforum.org/MAP/Medicaid%20Adult%20and%20Child/MAP_Medicaid_Adult_Discussion_Guide.html#8BEHA

NQF #0104e – Adult Major Depressive Disorder (MDD): Suicide Risk Assessment

Measure Steward: PCPI

QPS Link: http://www.qualityforum.org/QPS/0104e

Discussion Guide Link:
http://public.qualityforum.org/MAP/Medicaid%20Adult%20and%20Child/MAP_Medicaid_Adult_Discussion_Guide.html#7BEHA

NQF # 2152 – Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

Measure Steward: PCPI

QPS Link: http://www.qualityforum.org/QPS/2152

Discussion Guide Link:
http://public.qualityforum.org/MAP/Medicaid%20Adult%20and%20Child/MAP_Medicaid_Adult_Discussion_Guide.html#10BEHA

NQF #0726 – Patient Experience of Psychiatric Care as Measured by the Inpatient Consumer Survey (ICS)

Measure Steward: National Association of State Mental Health Program Directors Research Institute

QPS Link: http://www.qualityforum.org/QPS/0726

Discussion Guide Link: http://public.qualityforum.org/MAP/Medicaid%20Adult%20and%20Child/MAP_Medicaid_Adult_Discussion_Guide.html#16PAT

NQF #1927 – Cardiovascular Health Screening for People With Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications

Measure Steward: NCQA

QPS Link: http://www.qualityforum.org/QPS/1927

Discussion Guide Link:
http://public.qualityforum.org/MAP/Medicaid%20Adult%20and%20Child/MAP_Medicaid_Adult_Discussion_Guide.html#9BEHA

NQF #1934 – Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)

Measure Steward: NCQA

QPS Link: http://www.qualityforum.org/QPS/1934

Discussion Guide Link:
http://public.qualityforum.org/MAP/Medicaid%20Adult%20and%20Child/MAP_Medicaid_Adult_Discussion_Guide.html#6BEHA

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

Measure Steward: NCQA

QPS Link: http://www.qualityforum.org/QPS/2600

Discussion Guide Link:
http://public.qualityforum.org/MAP/Medicaid%20Adult%20and%20Child/MAP_Medicaid_Adult_Discussion_Guide.html#20TREA

NQF #3175 – Continuity of Pharmacotherapy for Opioid Use Disorder

Measure Steward: RAND Corporation

QPS Link: http://www.qualityforum.org/QPS/3175

Discussion Guide Link:
http://public.qualityforum.org/MAP/Medicaid%20Adult%20and%20Child/MAP_Medicaid_Adult_Discussion_Guide.html#17NEW

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

Measure Steward: Pharmacy Quality Alliance

QPS Link: http://www.qualityforum.org/QPS/2950

Discussion Guide Link:
http://public.qualityforum.org/MAP/Medicaid%20Adult%20and%20Child/MAP_Medicaid_Adult_Discussion_Guide.html#18NEW

Opportunity for Public Comment

Adult Workgroup Votes to Recommend Each Measure for Inclusion

- Vote to support inclusion of:
  - #0028: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
  - #0104: Adult Major Depressive Disorder (MDD): Suicide Risk Assessment
  - #2152: Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling
  - #1927: Cardiovascular Health Screening for People With Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications
  - #1934: Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)
  - #2600: Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence
  - #3175: Continuity of Pharmacotherapy for Opioid Use Disorder
  - #2950: Use of Opioids from Multiple Providers in Persons Without Cancer
  - #0726: Patient Experience of Psychiatric Care as measured by ICS

Adjourn for the Day