NATIONAL QUALITY FORUM

Meeting Summary

Medicaid Innovation Accelerator Project 2016-2017 Coordinating Committee In-Person Meeting| June 7-8, 2017

The National Quality Forum (NQF) convened the members of the Coordinating Committee (CC) for a two-day in-person meeting on June 7-8, 2017. The recording of the meeting can be accessed using the following link: http://www.qualityforum.org/ProjectMaterials.aspx?projectID=83348

Coordinating Committee Members in Attendance

William Golden, MD, Co-Chair, Arkansas Medicaid and University of Arkansas	Sarita Mohanty, MD, MPH, MBA, Kaiser Permanente
Jennifer Moore, PhD, RN, Co-Chair Institute for Medicaid Innovation	MaryBeth Musumeci, JD, Kaiser Family Foundation
Karen Amstutz, MD, MBA, Magellan Health	Michael Phelan, MD, JD, FACEP, RDMS, CQM, Cleveland Clinic
Sandra Finestone AA, BA, MA, PsyD, Association of Cancer Patient Educators	Cheryl Powell, MPP, Truven Health Analytics
Andrea Gelzer, MD, MS, FACP AmeriHealth Caritas Family of Companies	Sheryl Ryan, MD, FAAP, Yale School of Medicine
Allison Hamblin, MSPH, Center for Health Care Strategies, Inc.	Jeff Schiff, MD, MBA, Dept. of Human Services Minnesota
Maureen Hennessey, PhD, CPCC, Precision Advisors	John Shaw, MEng, Next Wave
David Kelley, MD, MPA, Pennsylvania Dept. of Human Services	Alvia Siddiqi, MD, FAAFP, Advocate Physician Partners
Deborah Kilstein, RN, MBA, JD, Association for Community Affiliated Plans	Susan Wallace, MSW, LSW, LeadingAge Ohio
SreyRam Kuy, MD, MHS, FACS, Louisiana Dept. of Health	Judy Zerzan, MD, MPH, Colorado Dept. of Health Care Policy and Financing
Barbara McCann, BSW, MA, Interim HealthCare Inc.	

Decisions and/or Recommendations

Recommended Innovation Accelerator Program (IAP) Program Area Measures Sets to the Coordinating Committee in-person meeting

During a two-day in-person meeting on June 7-8, 2017, the CC convened to review measure recommendations made by the project's four Technical Expert Panels (TEPs). Using a standardized measure selection process, measures that passed at greater than the 60% threshold will be recommended to CMS for inclusion in each IAP program areas. They are Reducing Substance Use Disorders (SUD), Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs (BCN), Promoting Community Integration through Community-Based Long-Term Services and Supports (LTSS), and Supporting Physical and Mental Health Integration (PMH).

The process for this review included: reconsideration of measures not recommended by the TEP but selected for further review by a CC member, late-submission measures and measures referred by one TEP to another program area. Additionally, members of the CC had the opportunity to pull a measure for further discussion if they felt the measure was unsuitable for the final measure set. At each stage of this process, voting took place to add measures to each of the sets or to remove measures deemed unsuitable. There are three potential measures for inclusion in the SUD and PMH program areas that the CC will vote on after the in-person meeting. The CC also reviewed each program area measure sets in their entirety through a process of a brief overview of each measure in the bloc of recommended measures.

Following the meeting, NQF staff reviewed the classification of all measures and measure concepts recommended by the CC and updated designations to reflect the revised definition of a measure. These designations are in the measure set recommendations below. Also after discussion with CMS staff, NQF staff removed NQF #0648 *Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)* from the BCN and LTSS program area sets. With the removal of this measure from the Medicaid Adult Core Set, it no longer met one the project goals to promote alignment across programs.

Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs (BCN) Technical Expert Panel Measure Set Recommendations

An overarching theme that arose during the meeting was the lack of measures that address the multiple needs of the populations. Examples include the dearth of measures that address the ongoing access to primary and preventive care for high-need populations and measures related to pediatric high-cost complex patients.

The final recommended BCN Measure Set include the following 18 measures and one measure concept:

Measures

- Adult Access to Preventive/Ambulatory Care 20-44, 45-64, 65+
- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)
- Medication reconciliation post-discharge: percentage of discharges from January 1 to December 1 of the measurement year for members 18 years of age and older for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days)
- NQF #0097 Medication Reconciliation Post-Discharge
- NQF #0105 Antidepressant Medication Management (AMM)
- NQF #0576 Follow-Up After Hospitalization for Mental Illness (FUH)
- NQF #0709 Proportion of patients with a chronic condition that have a potentially avoidable complication during a calendar year.
- NQF #1598 Total Resource Use Population-based PMPM Index
- NQF #1604 Total Cost of Care Population-based PMPM Index
- NQF #2371 Annual Monitoring for Patients on Persistent Medications (MPM)
- NQF #2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient
- NQF #2483 Gains in Patient Activation (PAM) Scores at 12 Months
- NQF #2605 Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence

- NQF# 1768 Plan All-Cause Readmissions (PCR)
- Potentially Preventable Emergency Room Visits
- Potentially Preventable Readmissions
- Prevention Quality Indicators #90 (PQI #90)
- Psychiatric Inpatient Readmissions – Medicaid (PCR-P)

Measure Concept

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

Reducing Substance Use Disorders (SUD) Technical Expert Panel Measure Set Recommendations

During the meeting, several issues emerged regarding the available selection of SUD measures. The CC noted that some measures include both screening and intervention in the numerator, which could cause difficulty in distinguishing when improvement took place. Some members of the CC also raised concerns over measures that focus on medication assisted treatment (MAT). The CC noted that in carve out states a plan may not know someone is receiving MAT and that MAT measures can incentivize prescribing without concomitant therapy. Additionally, the CC discussed the lack of HIV screening measures for individuals in the SUD population.

The recommended SUD Measure Set include the following 22 measures and 5 measure concepts. This set is subject to change following the results of the post in-person meeting voting:

Measures

- Documentation of Signed Opioid Treatment Agreement
- Evaluation or Interview for Risk of Opioid Misuse
- Mental Health/substance abuse: mean of patients' overall change on the BASIS 24-survey
- NQF #0004 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)
- NQF #1664 SUB-3 Alcohol and other Drug Use Disorder Treatment Provided or Offered at Discharge
- NQF #2152 Preventive Care and Screening: Unhealthy Alcohol Use
- NQF #2597 Substance Use Screening and Intervention Composite (Composite Measure)
- NQF #2599 Alcohol Screening and Follow-up for People with Serious Mental Illness
- NQF #2600 Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence
- NQF #2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Dependence
- NQF #2951: Use of Opioids at High Dosages from Multiple Providers in Persons with Cancer
- NQF# 2940 Use of Opioids at High Dosage in Persons Without Cancer
- NQF# 2950 Use of Opioids from Multiple Providers in Persons Without Cancer
- NQF#1661 SUB-1 Alcohol Use Screening
- NQF#1663 SUB-2 Alcohol Use Brief Intervention Provided or Offered and SUB-2a Alcohol Use Brief Intervention
- NQF: #1654 TOB - 2 Tobacco Use Treatment Provided or Offered and the subset measure TOB-2a Tobacco Use Treatment

- NQF: #1656 TOB - 3 Tobacco Use Treatment Provided or Offered at Discharge and the subset measure TOB-3a Tobacco Use Treatment at Discharge
- NQF: #3225 (formerly #0028) Preventative Care and Screening: Tobacco Use: Screening and Cessation Intervention
- Annual Hepatitis C Virus (HCV) Screening for Patients who are Active Injection Drug Users
- Substance use disorders: percentage of patients aged 18 years and older with a diagnosis of current alcohol dependence who were counseled regarding psychosocial AND pharmacologic treatment options for alcohol dependence within the 12 month reporting period.
- Substance use disorders: percentage of patients aged 18 years and older with a diagnosis of current substance abuse or dependence who were screened for depression within the 12-month reporting period.
- The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user

Measure Concepts

- Percent of patients prescribed a medication for alcohol use disorder
- Percent of patients prescribed a medication for opioid use disorders (OUD)
- Presence of Screening for Psychiatric Disorder
- Primary Care Visit Follow-Up
- Substance Use Disorder Treatment Penetration (AOD)

Supporting Physical and Mental Health Integration (PMH) Technical Expert Panel Measure Set Recommendations

During their deliberations, the CC noted the challenge of measuring the integration of physical and mental health services. The CC attributed this in part to the challenges of retrieving data in states that carve out behavioral health services. An additional measurement barrier identified is the exclusive Medicaid behavioral health benefits; a consequence of which is measures must be specific to both the population and benefit package.

The recommended PMH Measure Set include the following 29 measures and one measure concept. This set is subject to change following the results of the post in-person meeting voting:

Measures

- Behavioral Health Risk Assessment (for Pregnant Women) (BHRA)
- Combined BH-PH Inpatient 30-Day Readmission Rate for Individuals With SMI Eligible Population, Denominator and Numerator Specifications
- Depression Remission or Response for Adolescents and Adults
- Follow-Up After Emergency Department Visit for Mental Illness
- Mental Health Service Penetration
- Mental health utilization: number and percentage of members receiving the following mental health services during the measurement year: any service, inpatient, intensive outpatient or partial hospitalization, and outpatient or ED
- NQF #0097 Medication Reconciliation Post-Discharge

- NQF #0105 Antidepressant Medication Management (AMM)
- NQF #0418 Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan
- NQF #0419 Documentation of Current Medications in the Medical Record
- NQF #0576 Follow-Up After Hospitalization for Mental Illness (FUH)
- NQF #0710 Depression Remission at Twelve Months
- NQF #1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia
- NQF #1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder
- NQF #1922 HBIPS-1 Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths Completed
- NQF #1927 Cardiovascular Health Screening for People With Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications
- NQF #1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)
- NQF #1933 Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)
- NQF #1934 Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)
- NQF #1937 Follow-Up After Hospitalization for Schizophrenia (7- and 30-day)
- NQF #2599 Alcohol Screening and Follow-up for People with Serious Mental Illness
- NQF #2600 Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence
- NQF #2602 Controlling High Blood Pressure for People with Serious Mental Illness
- NQF #2603 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Testing
- NQF #2604 Diabetes Care for People with Serious Mental Illness: Medical Attention for Nephropathy
- NQF #2605 Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence
- NQF #2607 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
- NQF #2609 Diabetes Care for People with Serious Mental Illness: Eye Exam
- Post-Partum Follow-up and Care Coordination

Measure Concept

- PACT Utilization for Individuals with Schizophrenia

Community Integration—Community-Based Long-term Services and Supports (LTSS) Technical Expert Panel Measure Set Recommendations

The CC identified several themes of the LTSS measure set. First, the CC noted that the LTSS population is very diverse and ranges from children to the frail elderly. The CC also noted the lack of measures that currently exist in the LTSS field. Of those measures that are available, the CC noted that these measures are often medically focused. The CC also discussed the lack of standards of practice and language, which make developing measures to address the population a challenge.

The final recommended LTSS Measure Set include the following 10 measures and four concepts.

Measure

- Adult Access to Preventative/Ambulatory Care 20-44, 45-64, 65+
- Home- and Community Based Long Term Services and Supports Use Measure Definition (HCBS)
- NQF #0097: Measure of Medication Reconciliation
- NQF #0326: Advance Care Plan
- NQF #0419 Documentation of Current Medications in the Medical Record
- NQF #2967: CAHPS® Home and Community Based Services (HCBS) Measures
- NQF #0101: Falls: Screening for Fall Risk
- NQF #2483: Gains in Patient Activation (PAM) Scores at 12 Months
- Percentage of short-Stay Residents who were Successfully Discharged to the Community
- NQF #0647: Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

Measure Concepts

- Individualized Plan of Care Completed
- National Core Indicators – Aging and Disability
- National Core Indicators
- Number and percent of waiver participants who had assessments completed by the MCO that included physical, behavioral, and functional components to determine the member's needs

Next Steps

The CC continued its work at the June 20, 2017 post in-person web meeting. During the meeting, the CC took a comprehensive look at the measure sets and made recommendations for future iterations. After the web meeting, the CC voted on the inclusion of three possible measures for the SUD and PMH program area. The final SUD and PMH program area measure set recommendations will be in the web meeting summary. This summary is scheduled for submission to CMS by June 29, 2017.