NATIONAL QUALITY FORUM

NQF Medicaid Innovation Accelerator Project 2016-2017

Coordinating Committee Post In-Person Web Meeting

June 20, 2017

Welcome and Review of Meeting Objective

Coordinating Committee

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	Jennifer Moore, PhD, RN, Institute for Medicaid Innovation

Coordinating Committee Members

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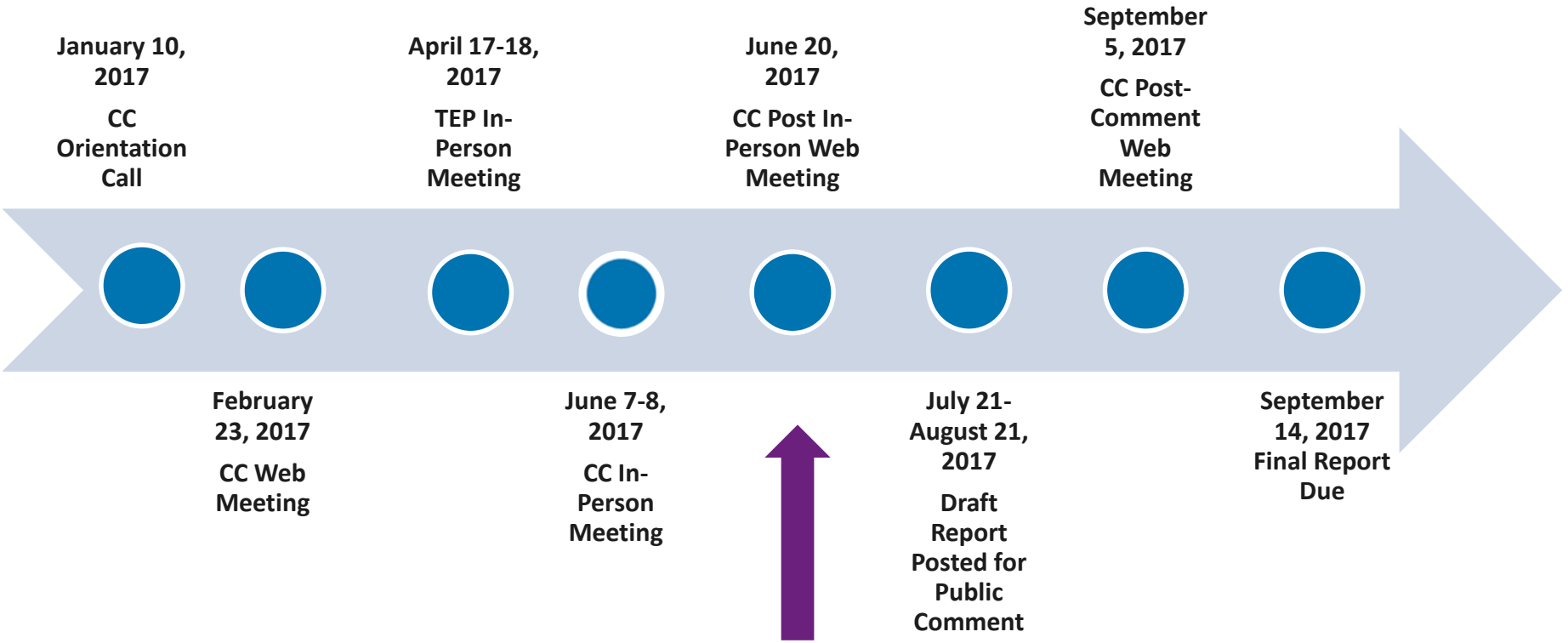
- Barbara McCann, BSW, MA, Interim HealthCare Inc.
- Sarita Mohanty, MD, MPH, MBA, Kaiser Permanente
- MaryBeth Musumeci, JD, Kaiser Family Foundation
- Michael Phelan, MD, JD, FACEP, RDMS, CQM, Cleveland Clinic
- Cheryl Powell, MPP, Truven Health Analytics
- Sheryl Ryan, MD, FAAP, Yale School of Medicine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

Meeting Objective

- Make final measure set recommendations for strengthening states' Medicaid delivery system reform efforts in the four program areas of CMS's Medicaid IAP.

Timeline and Deliverables



Final Review of All Measure Sets

Measures & Measure Concepts

- **Performance measure -** Is a fully developed metric that includes detailed specifications and may have undergone scientific testing. Clear specifications of measures allows for replicability across states, health plans, etc.

- **Measure concept (includes promising measure concepts) -** An idea for a measure that includes a description of the measure, including a planned target (numerator) and population (denominator)

Final Review– All Measure Sets

- Balanced measure sets representing diversity measure types: access, structure, process, outcome, patient-reported outcome (PRO), etc.
- Measure sets that address most, if not all, of the critical issues in the program area
- Measure concepts that add significantly to the measure sets and are near the end of the development process
- Measures that can be easily implemented by all states

High-Level Themes Observed During the CC In-Person Meeting

- Lack of measures addressing:
  - *Pediatric populations*
  - *Women's health*
- Measure variation (changes to measure specifications)
  - *Reasons measures may be varied: implementation challenges, patient demographics, resource limitations, data infrastructure, etc.*
- Preference for fully developed measures vs. measure concepts
- Necessity for measures that work in both Fee for Services and Managed Care states

Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs (BCN)

BCN Measure Set

CC Recommended 19 Measures/Concepts

- CMS Domains
  - *Access = 1*
  - *Care coordination = 3*
  - *Clinical care = 4*
  - *Patient & caregiver experience = 1*
  - *Population health & prevention = 2*
  - *Safety= 8*
  - *Total = 19 measures*
- Measure Type
  - *Composite = 1*
  - *Outcome = 6*
  - *Patient Reported Outcome = 1*
  - *Process = 8*
  - *Resource Use = 2*
  - *No information = 1*
- Data Source
  - *Claims = 11*
  - *Administrative = 0*
  - *EHR Hybrid = 0*
  - *EHR (Only) = 4*
  - *Laboratory = 1*
  - *Paper Records = 3*
  - *PRO-PM = 1*
  - *Pharmacy = 0*
  - *Registry = 0*
  - *Survey = 0*
  - *Other = 2*

BCN Measure Set

- 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 #0648 Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

BCN Measure Set (cont.)

- 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)

BCN Measure Set (cont.)

- Potentially Preventable Emergency Room Visits (for persons with BH diagnosis)*
- Potentially Preventable Emergency Room Visits
- Potentially Preventable Readmissions
- Prevention Quality Indicators #90 (PQI #90)
- Psychiatric Inpatient Readmissions – Medicaid (PCR-P)

BCN – Examples of Themes Raised During Measure Deliberations

- Lack of measures that address the multiple needs of the population
  - *Measures related to pediatric high-cost complex patients*
  - *Measures that address the ongoing access to primary and preventive care for high-need populations*
  - *Measures that address the entire care continuum/whole person*
  - *Importance of patient activation measures to improve quality of care*

Final Review Discussion

- Are there additional themes for the BCN program area?
- Does the measure set:
  - *Include diversity of access, structure, process, outcome, patient-reported outcome (PRO), etc. measures*
  - *Address most, if not all, of the critical issues in the program area*
- Are there high-level recommendations for future iterations of the measure sets in the BCN program area?

Reducing Substance Use Disorders (SUD)

SUD Measure Set

CC Recommended 27 Measures/Concepts

- CMS Domains
  - *Access = 4*
  - *Care coordination = 2*
  - *Clinical care = 20*
  - *Patient and caregiver experience = 0*
  - *Population health and prevention = 0*
  - *Safety= 1*
- Measure Type
  - *Process = 25*
  - *Outcome = 2*
- Data Source
  - *Claims = 11*
  - *Administrative = 3*
  - *EHR Hybrid = 0*
  - *EHR (Only) = 11*
  - *Laboratory = 0*
  - *Paper Records = 8*
  - *PRO-PM = 12*
  - *Pharmacy = 12*
  - *Registry = 6*
  - *Survey = 12*
  - *Other = 11*

SUD Measure Set

- Documentation of Signed Opioid Treatment Agreement
- Evaluation or Interview for Risk of Opioid Misuse
- 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

SUD Measure Set (cont.)

- 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
- Percent of patients prescribed a medication for alcohol use disorder*

***Measure Concept**

SUD Measure Set (cont.)

- Percent of patients prescribed a medication for opioid use disorders (OUD)*
- Presence of Screening for Psychiatric Disorder*
- Primary Care Visit Follow-Up*
- Annual Hepatitis C Virus (HCV) Screening for Patients who are Active Injection Drug Users
- Substance Use Disorder Treatment Penetration (AOD) *
- 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

SUD Measure Set (cont.)

- 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
- Mental Health/substance abuse: mean of patients' overall change on the BASIS 24-survey
- NQF #2951: Use of Opioids at High Dosages from Multiple Providers in Persons with Cancer

Measures for Inclusion in Program Areas

- Adult Access to Preventive/Ambulatory Care 20-44, 45-64, 65+
- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)

SUD - Examples of Themes Raised During Measure Deliberations

- Some measures include both screening and intervention in the numerator which could cause difficulty in distinguishing when improvement is needed

- Concerns about measures that focus on Medication Assisted Treatment (MAT)
  - *In carve out states a plan may not know someone is receiving MAT*
  - *MAT measures can incentivize prescribing without concomitant therapy*

- Lack of HIV screening measures for individuals in the SUD population

Final Review Discussion

- Are there additional themes for the SUD program area?
- Does the measure set:
  - *Include diversity of access, structure, process, outcome, patient-reported outcome (PRO), etc. measures*
  - *Address most, if not all, of the critical issues in the program area*
- Are there high-level recommendations for future iterations of the measure sets in the SUD program area?

Supporting Physical and Mental Health Integration (PMH)

PMH Measure Set

CC Recommended 30 Measures/Concepts

- CMS Domains
  - *Access = 2*
  - *Care coordination = 18*
  - *Clinical care = 8*
  - *Patient and caregiver experience = 0*
  - *Population health and prevention = 0*
  - *Safety= 2*
- Measure Type
  - *Process = 20*
  - *Outcome = 4*
  - *No information = 6*
- Data Source
  - *Claims = 22*
  - *Administrative = 2*
  - *EHR Hybrid = 0*
  - *EHR (Only) = 13*
  - *Laboratory = 6*
  - *Paper Records = 12*
  - *PRO-PM = 0*
  - *Pharmacy = 10*
  - *Registry = 1*
  - *Survey = 0*
  - *Other = 7*

PMH Measure Set

- 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)

PMH Measure Set (cont.)

- 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)

PMH Measure Set (cont.)

- 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

PMH Measure Set (cont.)

- 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
- PACT Utilization for Individuals with Schizophrenia*
- Post-Partum Follow-up and Care Coordination

Measure for Inclusion in Program Areas

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

PMH- Examples of Themes Raised During Measure Deliberations

- Lack of measures that address social determinants of health (SDOH) within the population
- Importance of screening for behavioral health conditions for pre-natal and post-natal women
- Challenge retrieving data from states that carve out services
- Medicaid behavioral health has benefits exclusive to Medicaid programs

Final Review Discussion

- Are there additional themes for the PMH program area?
- Does the measure set:
  - *Include diversity of access, structure, process, outcome, patient-reported outcome (PRO), etc. measures*
  - *Address most, if not all, of the critical issues in the program area*
- Are there high-level recommendations for future iterations of the measure sets in the PMH program area?

Promoting Community Integration through Community-Based Long-Term Services and Supports (LTSS)

LTSS Measure Set

CC Recommended 10 Measures/ 4 Concepts

- CMS Domains
  - *Access = 1*
  - *Care coordination = 4*
  - *Clinical care = 2*
  - *Patient and caregiver experience = 5*
  - *Population health and prevention = 1*
  - *Safety= 1*
- Measure Type
  - *Process = 6*
  - *Patient Reported Outcome = 4*
  - *No information = 4*
- Data Source
  - *Claims = 8*
  - *Administrative = 0*
  - *EHR Hybrid = 2*
  - *EHR (Only) = 3*
  - *Laboratory = 0*
  - *Paper Records = 3*
  - *PRO-PM = 3*
  - *Pharmacy = 0*
  - *Registry = 1*
  - *Survey = 2*
  - *Other = 2*

LTSS Measure Set

- Adult Access to Preventive/Ambulatory Care 20-44, 45-64, 65+
- NQF #0326: Advance Care Plan
- 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
- Home- and Community-Based Long Term Services and Supports Use Measure Definition (HCBS)
- Individualized Plan of Care Completed*
- National Core Indicators – Aging and Disability*
- National Core Indicators*

LTSS Measure Set (cont.)

- 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*
- 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)
- NQF #0648: Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

*** Measure Concept**

LTSS Measure Set (cont.)

- NQF #0097: Measure of Medication Reconciliation
- Percentage of short-Stay Residents who were Successfully Discharged to the Community
- NQF #0419 Documentation of Current Medications in the Medical Record

LTSS – Examples of Themes Raised During Measure Deliberations

- LTSS population is very diverse, ranging from children to the frail elderly
- Lack of measures in the LTSS field.
- Measures that are available are too medically focused
- LTSS lack standards of practice which make it challenging to develop measures

Final Review Discussion

- Are there additional themes for the LTSS program area?
- Does the measure set:
  - *Include diversity of access, structure, process, outcome, patient-reported outcome (PRO), etc. measures*
  - *Address most, if not all, of the critical issues in the program area*
- Are there high-level recommendations for future iterations of the measure sets in the LTSS program area?

Opportunity for Public Comment

Next Steps

Next Steps

June 23, 2017

- Complete Post In-Person Meeting Survey: https://www.surveymonkey.com/r/MedicaidIAP

July 21-August 21, 2017

- Draft Report Posted for Public Comment

September 14, 2017

- Final Report Due

Contact Information

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- Project Webpage: http://www.qualityforum.org/Medicaid_Innovation_Accelerator_Project_2016-2017.aspx

Closing Remarks

Adjourn