NATIONAL QUALITY FORUM

NQF Medicaid Innovation Accelerator Project

DRAFT REPORT

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Contents

Executive Summary

The National Quality Forum (NQF), under contract with the Center for Medicare and Medicaid Services (CMS), convened a multi-stakeholder Coordinating Committee (CC) and four Technical Expert Panels (TEP) -- one for each Medicaid Innovation Accelerator Program (IAP) program area-- to identify and recommend measures that address key quality issues in each of the four program areas. The IAP is a collaboration between the Center for Medicaid and Children Health Insurance Program (CHIP) Services (CMCS) and the Center for Medicare & Medicaid Innovation (CMMI).[1] A goal of this program is to build state capacity and support ongoing innovation in Medicaid. Through this program, IAP supports states in their ongoing delivery system reform efforts through targeted technical assistance across four main program areas:

- Reducing Substance Use Disorders;
- Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs;
- Promoting Community Integration through Community-Based Long-Term Services and Supports and;
- Supporting Physical and Mental Health Integration.

These measures will serve as a resource for state Medicaid agencies developing measurement strategies for their delivery system reform efforts. Measures recommended in this report are available for use as a measure repository for states to supplement their existing measurement strategies. They are also available for all State Medicaid agencies and stakeholders to adopt regardless of participation in IAP. Additionally, these measure sets include measures and measure concepts that can be collected immediately, support state Medicaid agencies' delivery system reform efforts, and strengthen alignment across payers and settings.

The increase in overall spending and enrollment in Medicaid is the result of the development of Medicaid expansion programs in multiple states through the Affordable Care Act (ACA) and a slow economic recovery following the recession.[2] In FY 2016, Medicaid spending totaled $553 billion, an increase from the $509 billion spent the prior year.[3] [4] These drivers of growth in Medicaid create new impetus to develop measures to evaluate the quality of care across states. State Medicaid programs face numerous challenges in finding and using standardized measures to evaluate quality within states and compare care delivered across providers, states and payers. The decentralized nature of state quality programs has led to a proliferation of measures across states. This has also created a lack of alignment and an increased reporting burden for providers. Benchmarking also can be difficult as similar measures used in states may have different specifications.

Each of these four areas represent high cost and high need priority areas for the Medicaid and CHIP population. There is also overlap between these programs and focusing on the interrelated areas is a comprehensive and cohesive approach to improving healthcare for vulnerable populations. This report provides background for each program area highlighting the issues affecting the recipients of care.

NQF conducted a comprehensive search for measures and measure concepts. With input, from CMS staff, members from the Advisory Group (AG), TEP and CC, staff searched approximately 50 sources. Sources included NQF's repository of measures, CMS Measures Inventory, Healthcare Effectiveness Data

and Information Set (HEDIS), American Society of Addition Medicine (ASAM), etc. Part of the search involved a review of 17 states sources for measures/concepts in use in each state.

First, four TEPs met to review the measures and to analyze and vote on measures for inclusion in each measure set. The TEPs forwarded these measure sets to the CC for final review, discussion and recommendation to CMS. Throughout the discussion and review of these five groups, themes emerged regarding the focus of measures, availability of measures that specifically address the needs of the Medicaid population, and recommendations for future measure development.

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

Medicaid IAP Program Area Abbreviations	
SUD	Reducing Substance Use Disorders
BCN	Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs
CB-LTSS	Promoting Community Integration through Community-Based Long-Term Services and Supports
PMH	Supporting Physical and Mental Health Integration

Introduction and Purpose

Medicaid is the nation's public health insurance program for low-income children, adults, seniors, and people with disabilities. Medicaid serves as the largest provider of health insurance covering 1 in 5 Americans, many of whom are children.[5] State Medicaid programs and the CHIP covered 72.8 million Americans in 2016.[6] [7] In FY 2016, Medicaid spending totaled $553 billion, an increase from the $509 billion spent the prior year.[8] [9]

The increase in overall spending and enrollment in Medicaid is the result of the development of Medicaid expansion programs in multiple states through the Affordable Care Act (ACA) and a slow economic recovery following the recession.[1] These drivers of growth in Medicaid create new impetus to develop measures to evaluate the quality of care across states. This measurement of quality enables providers, health plans, payers (including state Medicaid programs), and consumers to gauge the value of care delivered. State Medicaid programs have faced numerous challenges in finding and using standardized measures to evaluate quality within states and compare care delivered across states. Programs (i.e., waivers, demonstrations and health plans) are often state and population specific and vary in quality improvement and measurement activities. The decentralized nature of state quality programs has led to a proliferation of measures across states. This has also created a lack of alignment and an increased reporting burden for providers. Benchmarking also can be difficult as similar measures used in states may have different specifications.

To support states in their ongoing delivery system reform, CMCS and CMMI launched the Innovation Accelerator Program (IAP). A primary goal of this program is to support states' efforts to select, report, align and standardize quality measures. This program offers targeted technical assistance in four program areas: Reducing Substance Use Disorders (SUD); Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs (BCN); Promoting Community Integration through Community-Based Long-Term Services and Supports (CB-LTSS); and Supporting Physical and Mental Health Integration (PMH).

Under contract with CMS, the NQF convened a multi-stakeholder CC and four TEPs -- one for each IAP program area-- to identify and recommend measures that address key quality issues in each of the four program areas. The measures will serve as a resource for state Medicaid agencies developing measurement strategies for their delivery system reform efforts. Measures recommended in this report serve as a repository for states to supplement their existing measurement strategies. Adoption, implementation and use of these measures is voluntary.

A wide range of stakeholders provided topic specific expertise and board measurement background to guide the creation of each measure set. These four measure sets reflects the CMS quality domains, supports state Medicaid agencies' delivery reform efforts, provides measures that can be collected immediately, and promotes alignment across states, providers and payers. Guided by the measure selection criteria the TEP and CC recommended measures within each measure set for the four IAP program areas. This report details the measure recommendations for each program area.

Methodology

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

The Compendium Composite of Measures contains all measures collected during the environmental scan for measures conducted by NQF staff. Below is a summary of the number of measures and measure concepts from initial collection of measures/concepts to the submission of measures/concepts in each measure set to CMS.

	Measures and Measure Concepts Collected	Measures and Measure Concepts reviewed by the TEP	Measures recommended to the CC by the TEPs	Measure Concepts recommended to the CC by the TEPs	Measures recommended to CMS by the CC	Measure concepts recommended to CMS by the CC
BCN	69	43	14	6	18	1
SUD	114	43	19	6	24	5
PMH	63	44	23	2	30	1
CB-LTSS	66	22	6	7	10	4

Measure-Specific Recommendations

The CC examined all measures based on the measure's opportunity to be of value to state Medicaid agencies in their delivery system reform efforts and to promote alignment across payers and settings. All measures recommended for each program area are included in a table in Appendix E. The measures the CC considered but ultimately decided to exclude from final measure set recommendations are listed in Appendix F. A table of measure recommendations aligned with other programs (i.e., federal, state, etc.) and measure sets are listed in Appendix G.

Reducing Substance Use Disorders Program Area Measure Recommendations

Reducing Substance Use Disorders

Substance abuse, specifically alcohol and substance use issues, are two of the top ten reasons for hospital readmissions among Medicaid beneficiaries.[10] An estimated 12 percent of adult and 6 percent of adolescent Medicaid beneficiaries have a substance abuse issue.[11] Given the prevalence of SUDs and the associated clinical and societal costs for individuals, their families, and the healthcare system at large, the focus on efforts to reduce SUDs is not only necessary, but is also an important step in improving overall population health for Medicaid beneficiaries.

For example, tobacco use, including cigarette smoking, is one of the largest drivers of cost and adverse health outcomes in the Medicaid population.[12] Smoking causes many serious diseases including cancer, heart disease, stroke, chronic obstructive pulmonary disease (COPD), and complications during pregnancy.[13] Consequently, smoking is responsible for more deaths each year than Human Immunodeficiency Virus (HIV), illegal drug use, alcohol use, car accidents, and gun-related incidents combined.[14] Smoking accounts for an estimated 11% of Medicaid costs across all states, ranging from 6% in New Jersey to 18% in Arizona and Washington.[15]

Individuals with opioid use disorders also represent a large and growing portion of the SUD population. Opioid use disorder continues to grow nationally, affecting the Medicaid population at a higher rate with 8.7 per 1,000 beneficiaries diagnosed with an opioid use disorder.[16] Compared to patients on Medicare, private insurance, or the dual eligible beneficiaries, Medicaid-only beneficiaries have the highest combined rate of both illicit and prescription drug use.[17] Opioid misuse is associated with higher rates of emergency department (ED) utilization as well as increased risk of infectious disease transmission, specifically Hepatitis C (HCV) and HIV.[18] Additionally, in 2015, opioid misuse was responsible for more than 33,000 deaths in the United States.[19] Given the relevance of SUDs, NQF continues to address these issues through the Behavioral Health project and portfolio of measures.

Throughout the NQF Medicaid IAP measure selection process, the SUD TEP and the CC identified several themes. One reoccurring discussion throughout the TEP's deliberations was the need for a cascade of SUD measures that started with screening and ended with assessment and intervention and/or treatment. However, the CC, noted that measures that include both screening and intervention in the numerator could cause difficulty in determining potential areas for improvement. The TEP also discussed the need to broaden the existing tobacco measures to include not just tobacco, but drugs and other nicotine products as well.

The CC also noted concern related to measures that focus on Medication Assisted Treatment (MAT), stating that in carve out states, where behavioral health services are separately managed and/or financed, the plan of care may not include information indicating that a person is receiving MAT. The CC was also concerned about potentially incentivizing MAT prescribing without associated therapy. Additional concerns included lack of access to providers able to provide MAT. In some networks, only behavioral health professionals, including psychiatric providers, can provide MAT, preventing other providers (such as internists) from utilizing the treatment option. Additionally, the CC expressed a need for a structural measure to address the availability of MAT as a community resource.

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

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

The CC recommends that CMS consider 24 measures and five concepts for the SUD program area measure set (Table 1). The use of the recommended measures would strengthen the state's measure set by promoting measurement of a variety of high-priority issues, including: screening and brief

intervention, MAT and continuity of care. Below are the descriptions for recommended measures as well as explanation and rationale regarding the CC's support for these measures.

TABLE 1. MEASURES/CONCEPTS RECOMMENDED FOR INCLUSION IN THE SUD MEASURE SET

0004 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) (National Committee for Quality Assurance (NCQA))	Adult Access to Preventive/Ambulatory Care 20-44, 45-64, 65+ (NCQA)
1654 TOB - 2 Tobacco Use Treatment Provided or Offered and the subset measure TOB-2a Tobacco Use Treatment (The Joint Commission)	Documentation of Signed Opioid Treatment Agreement (American Academy of Neurology)
1656 TOB - 3 Tobacco Use Treatment Provided or Offered at Discharge and the subset measure TOB-3a Tobacco Use Treatment at Discharge (The Joint Commission)	Evaluation or Interview for Risk of Opioid Misuse (American Academy of Neurology)
1661 SUB-1 Alcohol Use Screening (The Joint Commission)	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA) (NCQA)
1663 SUB-2 Alcohol Use Brief Intervention Provided or Offered and SUB-2a Alcohol Use Brief Intervention (The Joint Commission)	Mental Health/substance abuse: mean of patients' overall change on the BASIS 24-survey (Eisen, Susan V., PhD.)
1664 SUB-3 Alcohol and other Drug Use Disorder Treatment Provided or Offered at Discharge (The Joint Commission)	Percent of patients prescribed a medication for alcohol use disorder (ASAM)
2152 Preventive Care and Screening: Unhealthy Alcohol Use (American Medical Association-convened Physician Consortium for Performance Improvement (AMA-PCPI))	Percent of patients prescribed a medication for opioid use disorders (OUD) (ASAM)
2597 Substance Use Screening and Intervention Composite (Composite Measure) (ASAM)	The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user (NCQA)
2599 Alcohol Screening and Follow-up for People with Serious Mental Illness (NCQA)	Annual Hepatitis C Virus (HCV) Screening for Patients who are Active Injection Drug Users (AMA-PCPI): *Measure Concept*
2600 Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence (NCQA)	Presence of Screening for Psychiatric Disorder (ASAM): *Measure Concept*
2605 Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence (NCQA)	Primary Care Visit Follow-Up (ASAM): *Measure Concept*

2940 Use of Opioids at High Dosage in Persons Without Cancer (Pharmacy Quality Alliance (PQA))	Substance use disorders: percentage of patients aged 18 years and older with a diagnosis of current alcohol dependence who were counseled regarding psychosocial AND pharmacologic treatment options for alcohol dependence within the 12 month reporting period (American Psychiatric Association (APA), NCQA, PCPI): Measure Concept
2950 Use of Opioids from Multiple Providers in Persons Without Cancer (PQA)	Substance use disorders: percentage of patients aged 18 years and older with a diagnosis of current substance abuse or dependence who were screened for depression within the 12-month reporting period (APA, NCQA, PCPI): Measure Concept
2951 Use of Opioids at High Dosages from Multiple Providers in Persons without Cancer (PQA)	Substance Use Disorder Treatment Penetration (AOD) (Washington State Department of Social and Health Services): *Measure Concept*
3225 (formerly #0028) Preventative Care and Screening: Tobacco Use: Screening and Cessation Intervention (AMA-PCPI)	

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

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

NQF #1654 TOB - 2 Tobacco Use Treatment Provided or Offered and the subset measure TOB-2a Tobacco Use Treatment (The Joint Commission)

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

EHRs. This measure would therefore not pose a barrier to implementation and data collection. The CC recommended the measure for inclusion in the SUD measure set.

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

NQF #1656 *TOB - 3 Tobacco Use Treatment Provided or Offered at Discharge and the subset measure TOB-3a Tobacco Use Treatment at Discharge* focuses on two rates. The first rate captures hospitalized patients 18 years of age and older to whom tobacco use treatment was provided, or offered and refused, at the time of hospital discharge. The second rate captures the number of patients referred to evidence-based outpatient counseling who received a prescription for FDA-approved cessation medication at discharge. A subset of the first includes only those patients who received tobacco use treatment at discharge. Treatment at discharge includes a referral to outpatient counseling and a prescription for one of the FDA-approved tobacco cessation medications. The TEP noted that this measure strongly overlaps with the previous measure, NQF #1654 *TOB-2 Tobacco Use Treatment Provided or Offered and subset measure TOB-2a Tobacco Use Treatment*, and is a part of a series of tobacco measures stewarded by the Joint Commission. This measure differs by focusing on services delivered at discharge. The CC agreed with the TEP's recommendation and supported inclusion in the final SUD measure set.

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

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

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

NQF #1663 *Sub-2 Alcohol Use Brief Intervention Provided or Offered and Sub-2a Alcohol Use Brief Intervention* focuses on all hospitalized patients 18 years of age and older to whom a brief intervention was provided, or offered and refused, and a second rate, a subset of the first, which includes only those patients who received a brief intervention. This measure is part of a set of four linked measures addressing Substance Use-- two of which the CC also recommended (SUB-1 Alcohol Use Screening; SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge). The TEP agreed that the measure addressed an important quality objective but noted that part 2a of the measure, which focuses on the provision of a brief intervention, is the most useful component. The TEP noted that the numerator, which includes patients who received or refused brief intervention, is confusing and seeks to measure two separate items at once.

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

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

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

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

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

NQF #2597 *Substance Use Screening and Intervention Composite* focuses on the percentage of patients aged 18 years and older who were screened at least once within the last 24 months for tobacco use, unhealthy alcohol use, nonmedical prescription drug use, and illicit drug use AND who received an intervention for all positive screening results. This measure received approval for trial use in 2015. Some members of the expert panel preferred this measure due to its comprehensive approach to screening and brief intervention (SBIRT). However, other members noted the inclusion of both screening and

intervention in one measure confounds these two different issues. In addition, the definition of illegal substances is likely to pose a challenge given variation across states, as marijuana is legal in some states but not others. Since some patients do not consider marijuana to be an illegal substance, they may underreport its use as well. Additionally, the CC noted concerns regarding the construct of the measure, such as multiple rates collected in the numerator. Despite these concerns, the CC supported the measure for inclusion in the final SUD measure set.

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

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

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

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

NQF #2605 Follow-up after discharge from the Emergency Department for mental health or alcohol or other drug dependence (NCQA)

The CC supported NQF #2605 *Follow-up after discharge from the Emergency Department for mental health or alcohol or other drug dependence.* This measure assesses the percentage of discharges for patients 18 and older who visited the emergency department with a primary mental health or alcohol or other drug dependence diagnosis and who had a subsequent follow-up visit any provider. The TEP unanimously agreed that the measure's focus on follow-up care addresses an important quality objective for states. This measure is important to health plans because it ensures follow-up care after an emergency department visit. This CC recommended this measure for inclusion in the BCN and PMH

measure sets supporting alignment across the program areas. This measure is included in the Medicaid Adult Core Set.

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

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

NQF #2950 Use of opioid from multiple providers in persons without cancer (PQA)

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

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

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

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

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

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

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

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

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

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

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

The CC supported the measure *Evaluation or Interview for Risk of Opioid Misuse*. This measure assesses all patients 18 and older prescribed opiates for longer than six weeks duration. Included in this measure are patients evaluated for risk of opioid misuse using a brief validated instrument (e.g. Opioid Risk Tool, SOAAP-R) or patient interview documented, at least once during Opioid Therapy in the medical record. The CC unanimously agreed this measure aligns with the Centers for Disease Control's (CDC) recommendation to use a validated tool for evaluating risk of opioid misuse. However, they expressed concern that the measure applies only to those in treatment for longer than six weeks rather than at day one. Ultimately, the CC recommended the measure for inclusion in the SUD measure set.

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

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

Mental Health/substance abuse: mean of patients' overall change on the BASIS 24-survey (Eisen, Susan V., PhD)

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

Percent of patients prescribed a medication for alcohol use disorder (ASAM)

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

Percent of patients prescribed a medication for opioid use disorders (OUD) (ASAM)

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

The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user (NCQA)

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

age. However, the CC noted that a comprehensive measure would include other nicotine products and/or marijuana as well. The CC recommended the measure for inclusion in the SUD measure set.

Annual Hepatitis C Virus (HCV) Screening for Patients who are Active Injection Drug Users (AMA-PCPI): *Measure Concept*

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

Primary Care Visit Follow-Up (ASAM) *Measure Concept*

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

Presence of Screening for Psychiatric Disorder (ASAM) *Measure Concept*

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

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

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

treatment. The CC agreed with the TEP's recommendation and supported inclusion in the final SUD measure set.

Substance use disorders: percentage of patients aged 18 years and older with a diagnosis of current alcohol dependence who were counseled regarding psychosocial AND pharmacologic treatment options for alcohol dependence within the 12 month reporting period (American Psychiatric Association, NCQA, PCPI): *Measure Concept*

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

Substance use disorders: percentage of patients aged 18 years and older with a diagnosis of current substance abuse or dependence who were screened for depression within the 12 month reporting period (American Psychiatric Association, CQA, PCPI): *Measure Concept*

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

Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs Program Area Measure Recommendations

Medicaid beneficiaries with complex care needs utilize high levels of costly but preventable services.[20] This sub-population within Medicaid is an extremely heterogeneous group with varying medical, behavioral, and psychosocial needs. While patients with complex care needs may be a relatively small portion of the Medicaid population, they account for a significant amount of Medicaid expenditures. In Medicaid, five percent of beneficiaries account for 54 percent of total Medicaid expenditures and one percent of beneficiaries account for 25 percent of total Medicaid expenditures.[21] Within this one percent of Medicaid beneficiaries, eighty-three percent have at least three chronic conditions and more than sixty percent have five or more chronic conditions.[22]

Beneficiaries with complex care needs have approximately four times as many hospital stays per year as compared with other patients.[23] Congestive heart failure, COPD, and diabetes-related complications account for three of the top reasons for hospitalizations among high-need individuals.[24]

To address these high need individuals, programs across the country currently implement innovative models and systems of care such as Accountable Care Organizations (ACOs) and health homes with the

goals of improving the health and containing the health care costs of Medicaid beneficiaries with complex needs.[25] Nevertheless, there are difficulties when addressing the health needs of this population. For instance, variations in design, focus, and setting among care management interventions make comparisons challenging. As a result, the literature has not identified specific best practices for wide implementation.[26] Additionally, there is a lot of churn, manifested as an individual's transition between different types of coverage, among individuals characterized as high utilizers of healthcare. The majority of individuals experience brief periods of increased utilization and then return to lower rates of utilization. Changes in status are likely due to multiple factors including the natural history of illness, the impact of care, and mortality [27]

Further, available measures that comprehensively address complex care issues are often limited or focused on condition-specific needs. Additionally, the costs associated with complex care patients underscore the need to improve their care delivery, coordination and connection to various support services. Many institutions, including NQF, addressed this issue conceptually. NQF developed a multiple chronic conditions measurement framework in 2012. [28]

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

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

TABLE 2. MEASURES/CONCEPTS RECOMMENDED FOR INCLUSION IN THE BCN MEASURE SET

0097 Medication Reconciliation Post-Discharge (NCQA)	2605 Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence (NCQA)

0105 Antidepressant Medication Management (AMM) (NCQA)	Adult Access to Preventive/Ambulatory Care 20-44, 45-64, 65+ (NCQA)
0576 Follow-Up After Hospitalization for Mental Illness (FUH) (NCQA)	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA) (NCQA)
0709 Proportion of patients with a chronic condition that have a potentially avoidable complication during a calendar year (Altarum Institute)	Medication reconciliation post-discharge: percentage of discharges from January 1 to December 1 of the measurement year for members 18 years of age and older for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days) (NCQA)
1598 Total Resource Use Population-based PMPM Index (HealthPartners)	Potentially Preventable Emergency Room Visits (3M)
1604 Total Cost of Care Population-based PMPM Index (HealthPartners)	Potentially Preventable Readmissions (3M)
1768 Plan All-Cause Readmissions (PCR) (NCQA)	Prevention Quality Indicators #90 (PQI #90) Agency for Healthcare Research and Quality (AHRQ)
2371 Annual Monitoring for Patients on Persistent Medications (MPM) (NCQA)	Psychiatric Inpatient Readmissions – Medicaid (PCR-P) (Washington State Department of Social and Health Services)
2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient (Brigham and Women's Hospital)	Potentially Preventable Emergency Room Visits (for persons with BH diagnosis) (3M): *Measure Concept*
2483 Gains in Patient Activation (PAM) Scores at 12 Months (Insignia Health)	

NQF #0097 Medication Reconciliation Post-Discharge (NCQA)

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

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

NQF #0105 *Antidepressant Medication Management (AMM)* assesses the percentage of adult patients with a diagnosis of major depression, newly treated with antidepressant medication and, who remained on an antidepressant medication treatment. TEP members expressed concern about a single diagnosis in the measure specifications as well as the phrasing, "newly treated with an antidepressant medication," due to difficulties capturing those "newly treated" in the BCN population. Ultimately, TEP members noted that the measure is included in the HEDIS measure set and is widely reported by states, therefore

measure reporting feasibility is not an issue. NQF #0105 is included in the 2017 Medicaid Adult Core Set. The CC also recommended this measure for the PMH measure set. The CC recommended this measure for inclusion in the BCN measure set.

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

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

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

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

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

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

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

NQF #1768 *Plan All-Cause Readmissions (PCR)* assesses the number of adult patients' acute inpatient stays during the measurement year followed by any unplanned acute readmission within 30 days and the predicted probability of an acute readmission. One CC member voiced a concern that this measure may not capture multiple hospitalizations if it measures readmissions at the hospital level instead of the

plan level. NQF #1768 is included in the 2017 Medicaid Adult Core Set. The CC supported this measure's inclusion in the recommended BCN measure set.

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

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

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

NQF #2456 *Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient* assesses the actual quality of the medication reconciliation process through the identification of errors at admission and discharge due to problems with the medication reconciliation process. The CC recommended this measure because it establishes the 'gold standard' of medication reconciliation due to the measure's ability to identify who is responsible and delineating which action should be taken. Additionally, the measure could incentivize emergency departments to use continuity of care documents (CCD). The CC acknowledged potential challenges in extracting data.

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

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

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

NQF #2605: This measures assesses the percentage of discharges for adults, with an emergency department visit, with a primary diagnosis of mental health, or alcohol, or other drug dependence during the measurement year; and had a follow-up visit with a provider with a corresponding primary diagnosis of mental health, or alcohol, or other drug dependence within 7 and 30-days of discharge. NQF

#2605 is similar to *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)* and NQF #0576 *Follow-Up After Hospitalization for Mental Illness (FUH)*. The CC recommended NQF #2605 as the stronger measure because it encompasses both mental health and substance use. This measure uses claims data, thereby increasing implementation feasibility. The CC recommended this measure for inclusion in the BCN measure set. NQF #2605 is included in the 2017 Medicaid Adult Core Set. The CC also recommended this measure for the SUD and PMH measure sets.

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

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

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

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

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

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

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

TEP members were familiar with the suite of 3M measures because they are widely used across states, but due to proprietary restrictions, TEP members were unable to evaluate the detailed specifications. Publically available 3M materials indicate that potentially preventable emergency room visits and readmissions are designated as such when clinical action or inaction occurs leading to an avoidable emergency visit or readmission[29,30]. The TEP also noted the measures are in use in many Medicaid pay-for-value programs. The CC recommended all three potentially preventable measures for inclusion in the BCN measure set.

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

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

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

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

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

Community-Based Long-Term Services and Supports empower millions of Americans to live meaningful lives in the community of their choice. CB-LTSS services include daily self-care activities (e.g., walking, bathing, and dressing), medication management, food preparation, transportation, employment, and other activities that support community living provided by paid and unpaid individuals and caregivers. Individuals who use community-based CB-LTSS require these services due to disability, mental illness, and/or multiple chronic conditions. Medicaid is the primary payer for institutional and community-based CB-LTSS.[31] Approximately 4.8 million Medicaid beneficiaries received CB-LTSS in 2011.[32] Specifically, people with CB-LTSS needs account for about one third of all Medicaid expenditures.[33] Total federal and state CB-LTSS spending was $152 billion in FY2014 including $80.6 billion for home and community-based services (HCBS). [34] In the future, these expenditures may grow in concert with demand, with growth specifically occurring within HCBS. [35]

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

A few themes emerged as the CC discussed the lack of available measures for consideration and use. The CC discussed the diversity within CB-LTSS population. This population represents a variety of conditions and healthcare needs. Among those who use CB-LTSS services are elderly and non-elderly individuals who have intellectual and developmental disabilities, behavioral health diagnoses, physical disabilities, spinal cord or traumatic brain injury (TBI), and/or disabling chronic conditions. In addition to these conditions, other social factors, such as a beneficiary's age, living arrangement, disability status, gender, socioeconomic status, etc., can affect the type of long-term care needed as well as the appropriate duration of care.[36] Each of these populations would benefit from measures that account for their individual characteristics and significant differences. Furthermore, medical measures are often adapted for people in the CB-LTSS community. While these measures address the medical component of health, they do not address issues such as quality of life, community integration and rebalancing. Given the state of measurement for CB-LTSS, the CC recognized the challenge of developing measures that meet the needs of such a diverse population without established standards of practice and/or language.

The CC recommended 10 measures and 4 concepts for the CB-LTSS program area measure set (Table 3). The CC considered both parsimony and alignment when recommending measures. The inclusion of the recommended measures would strengthen the measure set by promoting measurement of a variety of high-priority issues, including quality of services, access to care, and medication reconciliation. Further explanation and rationale regarding the CC's support for these measures follow.

TABLE 3. MEASURES/CONCEPTS RECOMMENDED FOR INCLUSION IN THE CB-LTSS MEASURE SET

0097 Medication Reconciliation Post-Discharge (NCQA)	Adult Access to Preventive/Ambulatory Care 20-44, 45-64, 65+ (NCQA)
0101 Falls: Screening for Fall Risk (NCQA)	Home- and Community- Based Long Term Services and Supports Use Measure Definition (HCBS) (Washington State Department of Social and Health Services)
0326 Advance Care Plan (NCQA)	Percentage of Short-Stay Residents who were Successfully Discharged to the Community (CMS)
0419 Documentation of Current Medications in the Medical Record (CMS)	Individualized Plan of Care Completed: *Measure Concept*
0647 Transition Record with Specified Elements Received by Discharged Patients (Discharges from an	National Core Indicators (Human Services Research Institute (HSRI) and The National Association of States United for Aging and Disabilities): *Measure Concept*

Inpatient Facility to Home/Self Care or Any Other Site of Care) (PCPI)	
2483 Gains in Patient Activation (PAM) Scores at 12 Months (Insignia Health)	National Core Indicators – Aging and Disability (Human Services Research Institute (HSRI) and The National Association of States United for Aging and Disabilities): *Measure Concept*
2967 CAHPS® Home and Community Based Services (HCBS) Measures (CMS)	Number and percent of waiver participants who had assessments completed by the MCO that included physical, behavioral, and functional components to determine the member's needs *Measure Concept*

NQF #0097 Measure of Medication Reconciliation (NCQA)

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

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

The CC noted that the change in function and balance at age 65 and over could be significant regardless of psychosocial barriers. Falls can make a difference between admission to a nursing home and staying in the community. NQF #0101 is a process measure that assesses fall prevention in older adults. This measure has three rates: 1.) screening for future fall risk; 2.) falls risk assessment; and 3.) plan of care for falls. The CC recommended this measure for the CB-LTSS measure set.

NQF #0326 Advance Care Plan (NCQA)

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

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

This is one of two medication reconciliation measures supported for inclusion in the CB-LTSS measure set. This measure assesses the percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. The denominator of this measure includes eligible outpatient individuals already in the community. The CC agreed that this measure includes a broader approach to

medication reconciliation and reflects the state of practice in home health. This measure is also included in the Family of Measures for Dual Eligible Beneficiaries. The CC recommended this measure for inclusion in CB-LTSS as well as the PMH measure set.

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) (PCPI)

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

To note, the Consensus Standards Approval Committee (CSAC) in July 2017 voted to remove endorsement from NQF #0647 due to a lack of current performance data and testing during measure development used data from one site's EHR only. Ultimately, the CC voted to recommend this measure for the measure set.

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

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

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

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

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

The CC supported the inclusion of this measure, and noted the importance of this measure as a proxy for whether people can get to necessary care. This measure is used to assess the percentage of

members 20 years and older who had an ambulatory or preventive care visit. From the CB-LTSS perspective, this measure could be a proxy for whether people have transportation and capacity to reach care or available services. The CC recommended this measure for the BCN, SUD and PMH measure sets. Inclusion of the measure in multiple sets support the concept of measurement alignment.

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

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

Percentage of Short-Stay Residents who were Successfully Discharged to the Community (CMS)

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

Individualized Plan of Care Completed – *Measure Concept*

The CB-LTSS TEP acknowledged the Individualized Plan of Care Completed (IPC) as a good measure concept with the potential for implementation, post measure development with detailed specifications. This measure concept assesses those with high-risk score who have an Individual Plan of Care (IPC). The CC noted that the specifications of the concept lack clarity. Therefore, it was difficult to determine if the IPC is synonymous with a person-centered plan. The CC recommended the need for measure specification clarification along with the enumeration of a definition for IPC. The TEP and CC agreed that the CB-LTSS populations benefit by care plans that are person-centered and person-driven and/or caregiver-driven based on the preferences, goals and values of the individual. This measure applies to all populations in Medicaid. Ultimately, the CC supported the measure concept for inclusion in the measure set.

National Core Indicators (NCI) (The National Association of States United for Aging and Disabilities) – *Measure Concept*

The NCI survey provides states with information about the experiences of adults with intellectual and developmental disabilities receiving publicly funded services and supports. Currently, the survey is used in 46 states plus the District of Columbia (47 total). The Administration for Community Living has provided grant funding to the stewards of the NCI and NCI-AD measures. The funding supports the stewards' pursuit of NQF endorsement for at least 20 PRO-PMs from the NCI ACS and NCI-AD ACS over

the next three years. The CC supported inclusion of this measure concept because it focuses on elements important to quality of life. The NCI and NCI-AD address all individuals with disabilities.

National Core Indicators – Aging and Disability (NCI-AD) (The National Association of States United for Aging and Disabilities) – *Measure Concept*

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

Number and percent of waiver participants who had assessments completed by the MCO that included physical, behavioral, and functional components to determine the member's needs *Measure Concept*

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

Supporting Physical and Mental Health Integration Program Area

In 2015, 20 percent of Medicaid enrollees lived with a diagnosed mental health condition or substance use disorder. According to a 215 Government Accountability Office publication, these beneficiaries accounted for a disproportionate share of Medicaid expenditures,[37] where over half of the Medicaid-only enrollees in the top five percent of expenditures had a mental health condition, and one-fifth had a substance use disorder. Individuals with mood disorders or schizophrenia and other psychotic disorders represented the top two most common diagnoses for re-hospitalizations among Medicaid beneficiaries.[38]

Currently, there are numerous barriers to the integration of physical and mental health services throughout the health care system. For instance, states often limit the number of reimbursable visits to one type of care per day, i.e. either a mental health or physical health visit, which makes it difficult for providers to provide comprehensive care within a specific visit.[39]

Further, workforce shortages create an immense problem; an estimated 91 million people live in geographic areas lacking sufficient mental health professionals.[40] In addition to workforce shortages, many electronic health records (EHR) systems are limited in their ability to document relevant

behavioral health and physical health information as well as the ability to support communication and coordination of care among integrated teams.[41]

Consequently, individuals with serious mental illness (SMI) die approximately 25 years earlier compared to those without SMI.[42] With the co-occurrence of both physical and mental health conditions and the negative effect on overall health and well-being, integration of care across physical and mental health conditions is imperative for improving overall health of Medicaid beneficiaries, and for reducing the cost of their care.

There are many efforts to improve the integration of physical and mental health services. For example, NQF's Behavioral Health Standing Committee identified measures that encompass multiple settings to better assist in achieving integrated behavioral health and physical health- a major gap- that would improve the Committee's portfolio and move the health care community towards a more integrated practice.[43]

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

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

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

The CC recommends that CMS consider 30 measures and one concept for the PMH program area measure set (Table 4). The use of the recommended measures would strengthen the measure set by

promoting measurement of a variety of high-priority issues including coordination of treatment among providers, screening for physical and mental health conditions, and care follow-up. Further explanation and rationale regarding the CC's support for these measures follow.

TABLE 4. MEASURES/CONCEPTS RECOMMENDED FOR INCLUSION IN THE PMH MEASURE SET

0097 Medication Reconciliation Post-Discharge (NCQA)	2602 Controlling High Blood Pressure for People with Serious Mental Illness (NCQA)
0105 Antidepressant Medication Management (AMM) (NCQA)	2603 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Testing (NCQA)
0418 Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan (CMS)	2604 Diabetes Care for People with Serious Mental Illness: Medical Attention for Nephropathy (NCQA)
0419 Documentation of Current Medications in the Medical Record (CMS)	2605 Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence (NCQA)
0576 Follow-Up After Hospitalization for Mental Illness (FUH) (NCQA)	2607 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (NCQA)
0710 Depression Remission at Twelve Months (Minnesota Community Measurement)	2609 Diabetes Care for People with Serious Mental Illness: Eye Exam (NCQA)
1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia (CMS)	Adult Access to Preventive/Ambulatory Care 20-44, 45-64, 65+ (NCQA)
1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder (CMS)	Behavioral Health Risk Assessment (for Pregnant Women) (BHRA) (AMA-PCPI)
1922 HBIPS-1 Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths Completed (The Joint Commission)	Combined BH-PH Inpatient 30-Day Readmission Rate for Individuals With SMI Eligible Population, Denominator and Numerator Specifications (IPRO)
1927 Cardiovascular Health Screening for People With Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications (NCQA)	Depression Remission or Response for Adolescents and Adults (NCQA)
1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) (NCQA)	Follow-Up After Emergency Department Visit for Mental Illness (NCQA)
1933 Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC) (NCQA)	Mental Health Service Penetration (Washington State DSHS)
1934 Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD) (NCQA)	Mental health utilization: number and percentage of members receiving the following mental health services during the measurement year: any service, inpatient, intensive outpatient or partial hospitalization, and outpatient or ED (NCQA)

1937 Follow-Up After Hospitalization for Schizophrenia (7- and 30-day) (NCQA)	Post-Partum Follow-up and Care Coordination (AHRQ)
2599 Alcohol Screening and Follow-up for People with Serious Mental Illness (NCQA)	PACT Utilization for Individuals with Schizophrenia (APA): *Measure Concept*
2600 Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence (NCQA)	

NQF #0097 Medication Reconciliation Post-Discharge (NCQA)

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

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

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

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

NQF #0418 assesses the percentage of patients aged 12 years and older, screened for clinical depression and who receive a follow-up plan. Several TEP members expressed concern about reporting the measure as it is very labor intensive and involves chart review. However, the CC recommended the measure because it focuses on the key issue of care coordination and is important to stakeholders. NQF #0418 is part of the Medicaid Adult Core Set. In addition, NQF's MAP Medicaid Child Taskforce supported this measure for inclusion in the 2018 Child Core Set. The recommendation of the measure to the PMH set promotes alignment across programs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

NQF #1937 measures the percentage of discharges for individuals between 18 – 64 years of age hospitalized for treatment of schizophrenia and had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner after discharge. The measure

reports two rates: first, the percentage of individuals who received follow-up within 30 days of discharge and second, and the percentage of individuals who received follow-up within seven days of discharge. The CC recommended the measure because it addresses an important element of physical and mental health integration – follow-up post discharge. However, members expressed concern that the measure only includes mental health practitioners and does not include wraparound services such as ACT.

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

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

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

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

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

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

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

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

the measure through claims data and that it is important to stakeholders. The CC recommended the measure.

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

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

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

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

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

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

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

NQF #2609 captures the percentage of patients 18-75 years of age with SMI and type 1 and type 2 diabetes who had an eye exam during the measurement year. The TEP noted that ACOs and health plans currently report the measure. It agreed that the measure directly addresses care integration especially

for behavioral health providers who were not a part of the EHR meaningful use incentives. The CC affirmed the TEP's recommendation.

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

This measure assesses the percentage of people 20 years and older who had an ambulatory or preventive care visit during the measurement year or the two years prior to the measurement year. The CC voted to include the measure in the PMH set because it measures access to ambulatory services, an important aspect of care management for individuals with co-occurring physical and mental health conditions. The CC included the measure in the SUD, CB-LTSS, and BCN measure sets. The inclusion of a measure in multiple sets promotes alignment across the IAP program areas.

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

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

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

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

Depression Remission or Response for Adolescents and Adults (NCQA)

The measure captures the percentage of people aged 12 or older with a diagnosis of major depressive disorder or dysthymia and an elevated Patient Health Questionnaire (PHQ-9) score, who had evidence of response or remission within 5–7 months after the initial elevated score. Given that the measure is a first year HEDIS measure, the TEP expressed concern that it may not be an efficient use of resources since it is not sure of the efficiency of the measure in capturing appropriate individuals. However, the CC recommended this outcome measure because it extends beyond screening for depression and highlights the individual's response to treatment. Additionally, the measure relies on patient reported data, which is different from the clinical data source reflected in most of the measures in this set.

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

The measure assesses the percentage of ED visits for members aged 6 years and older with a primary diagnosis of mental illness, who had an outpatient visit, an intensive outpatient encounter or a partial hospitalization for mental illness. The TEP noted that the measure does not include certain wraparound clinical services for individuals with co-occurring SMI and physical health conditions such as assertive community treatment (ACT), mobile crisis services, or Lifeline – a suicide crisis line. However, the CC recommended the measure because it includes follow-up care provided by both behavioral health and non-behavioral health clinicians, which specifically addresses the integration of mental and physical health.

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

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

Mental health utilization: number and percentage of members receiving the following mental health services during the measurement year: any service, inpatient, intensive outpatient or partial hospitalization, and outpatient or ED (NCQA)

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

Post-Partum Follow-up and Care Coordination (AHRQ)

This measures assesses the percentage of patients, regardless of age, who gave birth during a 12-month period and who were seen for post-partum care within 8 weeks of giving birth, and who received a breast feeding evaluation and education, post-partum depression screening, post-partum glucose screening for gestational diabetes patients, and family and contraceptive planning. The CC noted that the measure includes both physical health screening in addition to depression screening in a population at risk for depression. This is especially important because only few measures within the PMH measure set address maternal health. One concern the CC had is that, in some states, Medicaid coverage ends prior to the measurement timeframe. Ultimately, the CC recommended the measure.

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

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

Conclusion

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

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

Appendix A: Technical Expert Panel and Coordinating Committee Rosters

Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs Technical Expert Panel

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

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

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

David Moskowitz, MD, MAS
Alameda Health System

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

Reducing Substance Use Disorders Technical Expert Panel

Sheryl Ryan, MD, FAAP, TEP Chair
Yale School of Medicine

Christina Andrews, PhD
University of South Carolina

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

Dennis McCarty, PhD
Oregon Health & Science University

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

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

Barbara McCann, BSW, MA, TEP Chair
Interim HealthCare Inc.

Diane McComb, MSEd
Delmarva Foundation

Judit Olah, PhD, MS

UCHealth

Robert Schreiber, MD
Hebrew SeniorLife

Janice Tufte
Engaged Patient

Supporting Physical and Mental Health Integration Program Area Measure Recommendations Technical Expert Panel

Maureen Hennessey, PhD, CPCC, TEP Chair
Precision Advisors

Angela Kimball
National Alliance on Mental Illness (NAMI)

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

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

James Schuster, MD, MBA
UPMC Insurance Division

Coordinating Committee

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

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

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

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

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

Allison Hamblin, MSPH

Center for Health Care Strategies, Inc.

Maureen Hennessey, PhD, CPCC
Precision Advisors

David Kelley, MD, MPA
Pennsylvania Department of Human Services

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

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

Barbara McCann, BSW, MA
Interim HealthCare Inc.

Sarita Mohanty, MD, MPH, MBA
Kaiser Permanente

MaryBeth Musumeci, JD
Kaiser Family Foundation

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

Cheryl Powell, MPP
Truven Health Analytics

Sheryl Ryan, MD, FAAP
Yale School of Medicine

Jeff Schiff, MD, MBA
Minnesota Department of Human Services

John Shaw, MEng
Next Wave

Alvia Siddiqi, MD, FAAFP
Advocate Physician Partners

Susan Wallace, MSW, LSW
LeadingAge Ohio

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

Christine Hawkins, RN, MBA, MSML
Centene Corporation (unable to attend meeting)

Appendix B: Measure Search Process and Measure Sources

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

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

MEASURE SOURCES

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

States
Arkansas
California
Colorado
Georgia
Kansas

Kentucky
Maryland
Massachusetts
Minnesota
Missouri
New York
Ohio
Oregon
Pennsylvania
Vermont
Washington
Wyoming

Selected Sources
Agency for Healthcare Research and Quality (AHRQ) National Quality Measures Clearinghouse
American Society of Addiction Medicine
Center for Medicare & Medicaid Innovation (CMMI) Behavioral Health Integration Projects
Center for Quality Assessment and Improvement in Mental Health (CQAIMH)
CMS Consensus Core Set: Accountable Care Organization (ACO) and Patient-Centered Medical Home (PCMH) / Primary Care Measures
CMS Measures Inventory
CMS Quality Measure Development Plan: Supporting the Transition to the Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMs)
Dr. Robert Bree Collaborative – Behavioral Health Integration Report and Recommendations
Healthcare Effectiveness Data and Information Set (HEDIS)
IMPACT Act Measures
Implementing Coverage and Payment Initiatives: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2016 and 2017
Kaiser Family Foundation
Kennedy Center Report on a Core Set Of Outcome Measures For Behavior Health

Marketplace Quality Measures
National Institute on Alcohol Abuse and Alcoholism (NIAA)
National Institute on Drug Abuse (NIDA)
Outcomes measures for early intervention with schizophrenia projects (RAISE)
Pediatric Integrated Survey (PICS)
Pharmacy Quality Alliance
Population-Level Quality Measures for Behavioral Screening and Intervention
Robert Wood Johnson Foundation (RWJF) – Buying Value
State-by-State Analysis of Medicaid MCO Requirements for Providers Alternative Payment Reimbursement
Substance Abuse and Mental Health Services Administration (SAMHSA) publication on National Behavioral Health Quality Framework
The National Academies Press – Vital Signs
Trends in Emergency Department Visits Involving Mental and Substance Use Disorders, 2006-2013

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

Medicaid Beneficiaries with Complex Care Needs and High Costs Program Area Search Terms	
No specific conditions-all cause measures	Transitions across care settings
Self-management	Mental illness and two or more chronic conditions
Coordination of care, continuity of care	Super-utilizers
Underuse of primary care all cause follow-up	Relationship between care/case manager, physician, and beneficiary
Outpatient, home health and other post-acute care preventive services	Self-management of chronic diseases
Potentially avoidable hospital and ED utilization	All cause readmissions and follow-up
Hospitalization and ED use	Outpatient preventive services for multiple conditions

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

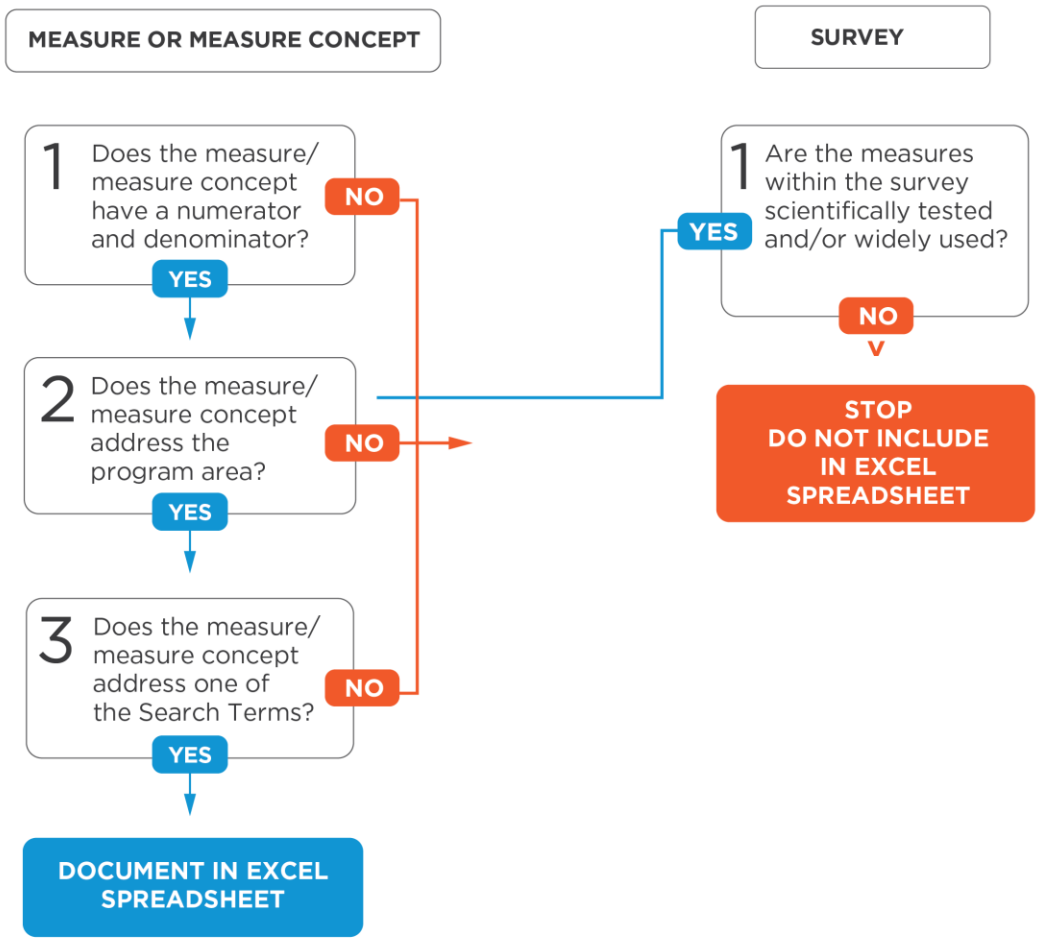
Reducing Substance Use Disorders Program Area Search Terms	
Early intervention	Continuity of care after detox
Screening and brief intervention	Prevention activities for opioid prescribing practices
Attainment of timely and appropriate healthcare	Screening for: level of substance use, intoxication/withdrawal,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

Promoting Community Integration through Community-Based Long-Term Services and Supports Program Area Search Terms	
Person-centered system and planning	Self-direction of services
Sufficient, accessible, and appropriate services	Rebalancing or transitioning from institution to community
Care coordination and service coordination for LTSS	Meaningful activity in the community

Community Inclusion	Quality of life
Beneficiary measure of care coordination	Medication reconciliation
HCBS EOC survey	Patient and caregiver experience
LTSS workforce	Access
Patient centeredness	Person and family-centered care

The Decision Logic for inclusion of measures in the four IAP program area measure sets is below.

Measure Search Inclusion Criteria Decision Logic



PROCESS FOR DEVELOPING MEASURE SETS

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

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

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

- Feasibility is the extent to which the specifications, including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement. The ranking has been included below:

    - High (3): Administrative/Claims
    - Medium (2): Paper Record/Medical record/EHR/ Registry data
    - Low (1): Patient Reported Outcome – Performance Measure
    - Unsure (0)

- Usability is the extent to which potential audiences (e.g. state Medicaid agencies, health plans, consumers, purchasers, providers, policymakers) are using or could use performance results for both accountability and quality improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

    - High (3): Use in federal program or use in multiple states for accountability/quality improvement
    - Medium (2): Use by state/local/health plan for accountability/quality improvement or planned use in state Medicaid programs
    - Low (1): No indication of use in field or any programs
    - Unsure (0)

- Scientific Acceptability, which refers to a measure's reliability and validity, is the extent to which a measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented.

    - High (3): Currently NQF endorsed OR evidence of reliability/validity testing in the Medicaid population
    - Medium (2): Any evidence of reliability/validity testing OR testing in Medicaid project is underway
    - Low (1): No evidence of testing
    - Unsure (0)

- Evidence is the extent to which the specific measure focus is evidence-based and important to making significant gains in healthcare quality where there is variation in or overall less-than-optimal performance.

    - Yes (1): There is evidence of data or information resulting from studies and analyses of the data elements and/or scores for a measure as specified, unpublished, published, or NQF endorsed without exception to evidence
    - No (0): Evidence is not available
    - Unsure (0)

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

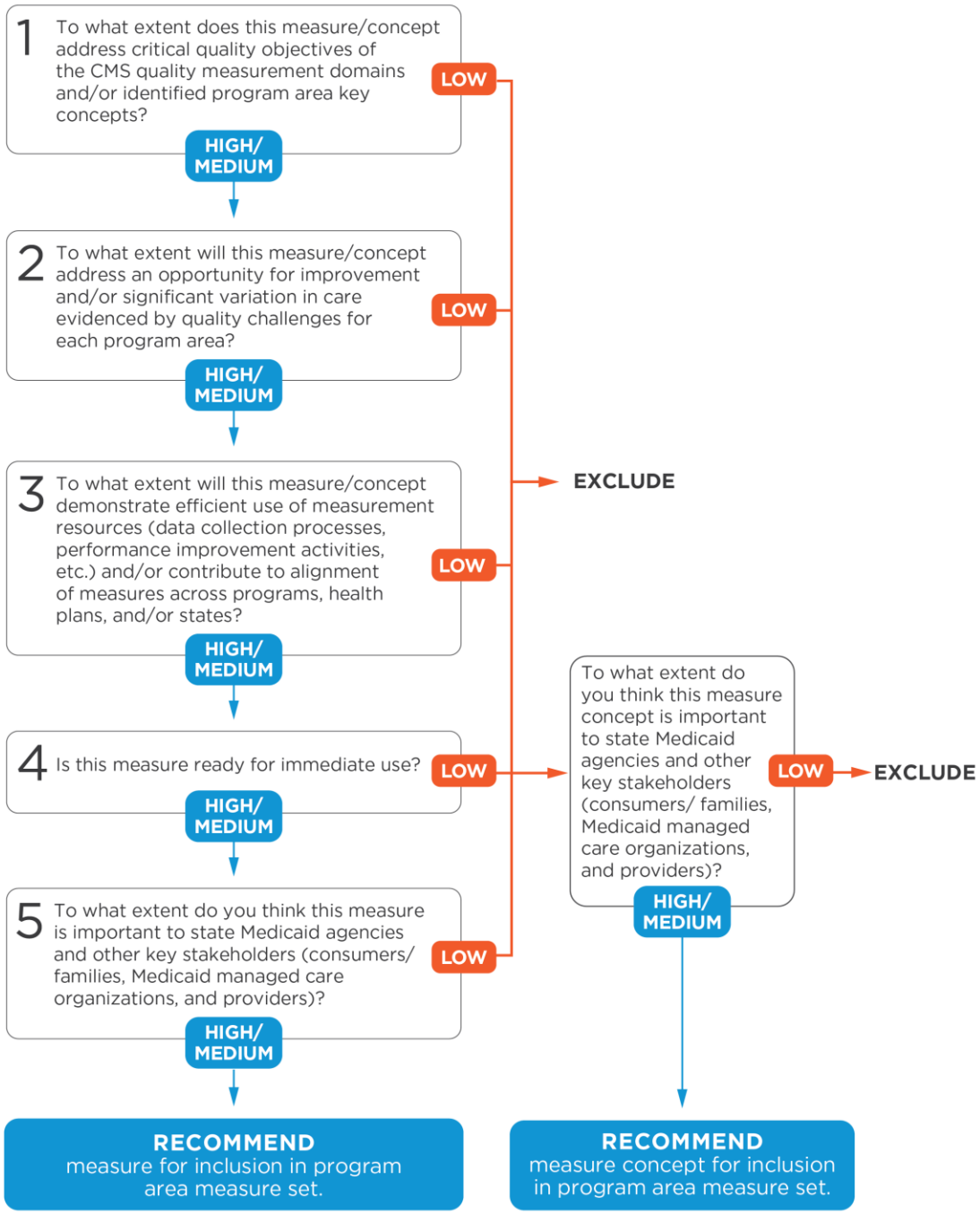
Overall Measure Score Composite	
Criteria	**Weight**
Feasibility	30%
Usability	30%
Scientific Acceptability	25%
Evidence	15%

Appendix C: Technical Expert Panel Measure Selection Process

Goal

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

Technical Expert Panel Measure Selection Criteria Decision Logic



Appendix D: Coordinating Committee Measure Selection Process

Goals

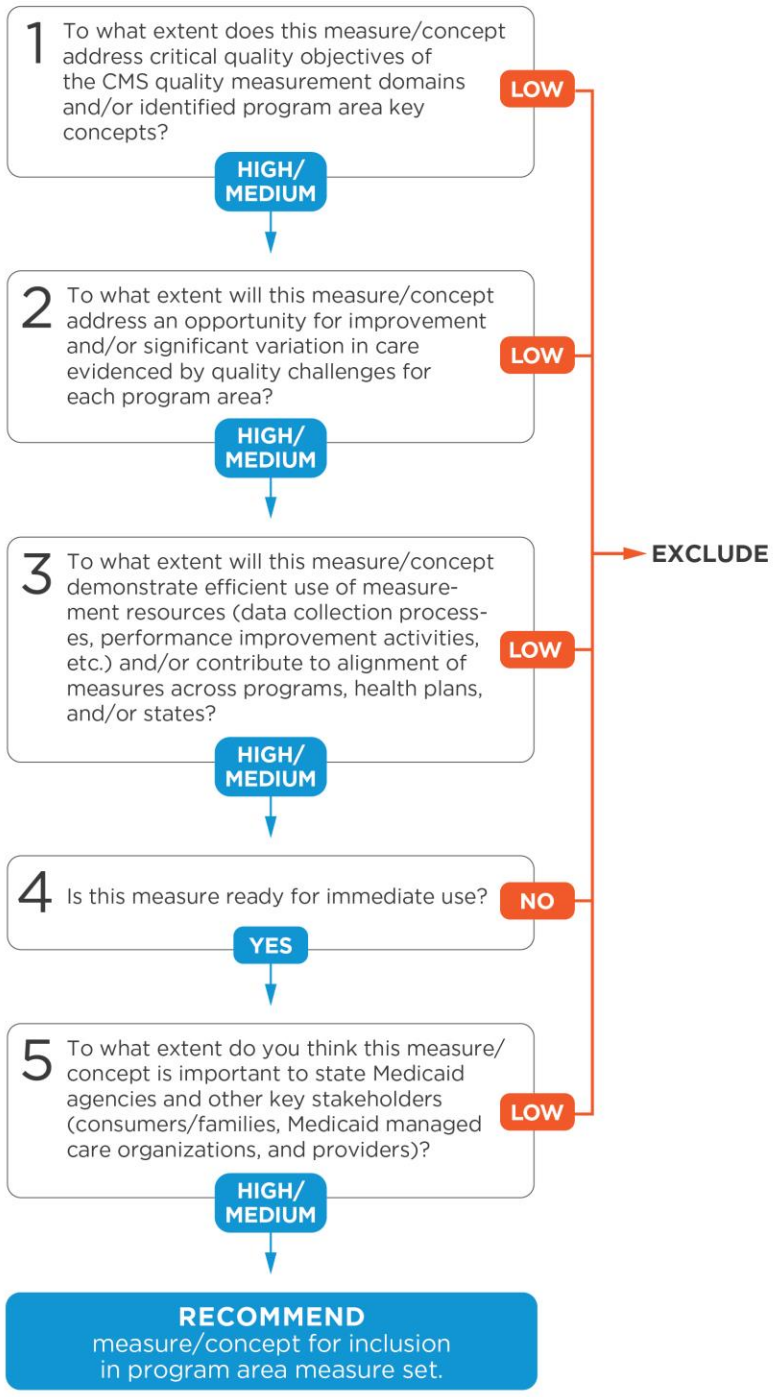
To submit the "best-available" Medicaid-relevant measures and/or concepts that can be used to support the Centers for Medicare & Medicaid Services' (CMS) Medicaid innovation Accelerator Program (IAP) and states' Medicaid delivery reform efforts. The CC evaluated additional measures and approved measures and concepts recommended by the TEPs. Measures and measure concepts approved by the CC were recommended for each measure set in the IAP program areas to CMS.

Objectives

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

The CC used the Measure Selection Criteria Decision Logic below to reach consensus on the measures and measure concepts recommended for each of the four IAP program areas.

Coordinating Committee Measure Selection Criteria Decision Logic



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

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

Measure Title	BCN	SUD	PMH	CB - LTSS	Medicaid Adult and/or Child Core Set
NQF #0004 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)		X			Medicaid Adult Core Set
NQF #0097 Medication Reconciliation Post-Discharge	X		X	X	
NQF #0101 Falls: Screening for Fall Risk				X	
NQF #0105 Antidepressant Medication Management (AMM)	X		X		Medicaid Adult Core Set
NQF #0326 Advance Care Plan				X	
NQF #0418 Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan			X		Medicaid Adult Core Set; Recommended for inclusion in the 2018 Medicaid Child Core Set
NQF #0419 Documentation of Current Medications in the Medical Record			X	X	
NQF #0576 Follow-Up After Hospitalization for Mental Illness (FUH)	X		X		Medicaid Adult and Child Core Sets
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)				X	
NQF #0709 Proportion of Patients with a Chronic Condition That Have a Potentially Avoidable Complication During a Calendar Year	X				
NQF #0710 Depression Remission at Twelve Months			X		
NQF #1598 Total Resource Use Population-based PMPM Index	X				
NQF #1604 Total Cost of Care Population-based PMPM Index	X				
NQF #1654 TOB - 2 Tobacco Use Treatment Provided or Offered and the subset measure TOB-2a Tobacco Use Treatment		X			
NQF #1656 TOB - 3 Tobacco Use Treatment Provided or Offered at Discharge and the subset measure TOB-3a Tobacco Use Treatment at Discharge		X			
NQF #1661 Sub-1 Alcohol Use Screening		X			

NQF #1663 Sub-2 Alcohol Use Brief Intervention Provided or Offered and Sub-2a Alcohol Use Brief Intervention		X			
NQF #1664 SUB-3 Alcohol and other Drug Use Disorder Treatment Provided or Offered at Discharge		X			
NQF #1768 Plan All-Cause Readmissions (PCR)	X				Medicaid Adult Core Set
NQF #1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia			X		
NQF #1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder			X		
NQF #1922 HBIPS-1 Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths Completed			X		
NQF #1927 Cardiovascular Health Screening for People with Schizophrenia or Bipolar Disorder Who are Prescribed Antipsychotic Medications			X		
NQF #1932 Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)			X		Medicaid Adult Core Set
NQF #1933 Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)			X		
NQF #1934 Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)			X		
NQF #1937 Follow-Up After Hospitalization for Schizophrenia (7- and 30-day)			X		
NQF #2152 Preventive Care and Screening: Unhealthy Alcohol Use		X			
NQF #2371 Annual Monitoring for Patients on Persistent Medications (MPM)	X				Medicaid Adult Core Set
NQF #2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient	X				
NQF #2483 Gains in Patient Activation (PAM) Scores at 12 Months	X			X	
NQF #2597 Substance Use Screening and Intervention Composite		X			
NQF #2599 Alcohol Screening and Follow-up for People with Serious Mental Illness		X	X		
NQF #2600 Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence		X	X		
NQF #2602 Controlling High Blood Pressure for People with Serious Mental Illness			X		
NQF #2603 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Testing			X		
NQF #2604 Diabetes Care for People with Serious Mental Illness: Medical Attention for Nephropathy			X		
NQF #2605 Follow-up after discharge from the Emergency Department for mental health or alcohol or other drug dependence	X	X	X		Medicaid Adult Core Set
NQF #2607 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)			X		Medicaid Adult Core Set

NQF #2609 Diabetes Care for People with Serious Mental Illness: Eye Exam			X		
NQF #2940 Use of Opioids at High Dosages in Persons without Cancer		X			Medicaid Adult Core Set
NQF #2950 Use of opioid from multiple providers in persons without cancer		X			
NQF #2951: Use of Opioids at High Dosages from Multiple Providers in Persons without Cancer		X			
NQF #2967 CAHPS® Home and Community Based Services (HCBS) Measures				X	Recommended for inclusion in the 2018 Medicaid Adult Core Set
NQF #3225 (formerly #0028) Preventative Care and Screening: Tobacco Use: Screening and Cessation		X			
Adult Access to Preventive/Ambulatory Care 20-44, 45-64, 65+	X	X	X	X	
Annual Hepatitis C Virus (HCV) Screening for Patients who are Active Injection Drug Users		X			
Behavioral Health Risk Assessment (for Pregnant Women) (BHRA)			X		Medicaid Child Core Set
Combined BH-PH Inpatient 30-Day Readmission Rate for Individuals with SMI			X		
Depression Remission or Response for Adolescents and Adults			X		
Documentation of Signed Opioid Treatment Agreement		X			
Evaluation or Interview for Risk of Opioid Misuse		X			
Follow-Up after Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)	X	X			
Follow-Up After Emergency Department Visit for Mental Illness			X		
Home- and Community Based Long Term Services and Supports Use Measure Definition (HCBS)				X	
Individualized Plan of Care Completed				X	
Medication reconciliation post-discharge: percentage of discharges from January 1 to December 1 of the measurement year for members 18 years of age and older for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days)	X				
Mental Health Service Penetration			X		
Mental health utilization: number and percentage of members receiving the following mental health services during the measurement year: any service, inpatient, intensive outpatient or partial hospitalization, and outpatient or ED			X		
Mental Health/substance abuse: mean of patients' overall change on the BASIS 24-survey		X			
National Core Indicators (NCI)				X	
National Core Indicators – Aging and Disability (NCI-AD)				X	
Number and percent of waiver participants who had assessments completed by the MCO that included physical,				X	

behavioral, and functional components to determine the member's needs					
PACT Utilization for Individuals with Schizophrenia			X		
Percent of patients prescribed a medication for alcohol use disorder		X			
Percent of patients prescribed a medication for opioid use disorders (OUD)		X			
Percentage of Short-Stay Residents who were Successfully Discharged to the Community				X	
Post-Partum Follow-up and Care Coordination			X		
Potentially Preventable Emergency Room Visits	X				
Potentially Preventable Emergency Room Visits (for persons with BH diagnosis)	X				
Potentially Preventable Readmissions	X				
Presence of Screening for Psychiatric Disorder		X			
Prevention Quality Indicators #90 (PQI #90)	X				
Primary Care Visit Follow-Up		X			
Psychiatric Inpatient Readmissions – Medicaid (PCR-P)	X				
Substance use disorders: percentage of patients aged 18 years and older with a diagnosis of current alcohol dependence who were counseled regarding psychosocial AND pharmacologic treatment options for alcohol dependence within the 12 month reporting period		X			
Substance use disorders: percentage of patients aged 18 years and older with a diagnosis of current substance abuse or dependence who were screened for depression within the 12 month reporting period		X			
Substance Use Disorder Treatment Penetration (AOD)		X			
The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user		X			

Appendix F: Additional Measures Considered

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

Measure Number	Measure Title	Measure Steward	Program Area
1888	Workforce development measure derived from workforce development domain of the C-CAT	American Medical Association	Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs
			Supporting Physical and Mental Health Integration

Measure Number	Measure Title	Measure Steward	Program Area
			Promoting Community Integration through Community-Based Long-Term Services and Supports Program Area Measure Recommendations
N/A	Clinical Risk Score	N/A	Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs
			Supporting Physical and Mental Health Integration
N/A	Referral To Community Based Health Resources	N/A	Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs
			Supporting Physical and Mental Health Integration
			Promoting Community Integration through Community-Based Long-Term Services and Supports Program Area Measure Recommendations
N/A	Adherence to Antipsychotics for Individuals with Schizophrenia	N/A	Supporting Physical and Mental Health Integration
0105	Antidepressant Medication Management (AMM)	NCQA	Supporting Physical and Mental Health Integration
N/A	Follow-up after all-cause emergency department visit	NCQA	Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs
N/A	Potentially avoidable emergency department utilization	NYU Wagner	Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs
0648	Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	AMA-PCPI	Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs
			Promoting Community Integration through Community-Based Long-Term Services and Supports Program Area Measure Recommendations

Appendix G: Measures and Alignment with Other Programs and Measure Sets

Coordinating Committee Measure Set Recommendations for the Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs Program Area

NQF Endorsement Status, Measure Title, Measure Steward	Alignment
0097 Endorsed Medication Reconciliation Post-Discharge Measure Steward: National Committee for Quality Assurance (NCQA)	**Alignment**: MAP Dual Eligible Beneficiaries Family of Measures; Merit-Based Incentive Payment System (MIPS); Reported in Colorado
0105 Endorsed Antidepressant Medication Management (AMM) Measure Steward: NCQA	**Alignment**: 2016 Medicaid Adult Core Set; MAP Dual Eligible Beneficiaries Family of Measures; Reported in the following states: • Alabama • Arkansas • California • Colorado • Connecticut • Delaware • Dist. of Columbia • Georgia • Illinois • Iowa • Kentucky • Louisiana • Massachusetts • Michigan • Minnesota • Mississippi • Missouri • New Hampshire • New Mexico • New York • North Carolina • Ohio • Oklahoma • Pennsylvania • Rhode Island

	• Tennessee • Texas • Vermont • Virginia • Washington
0576 Endorsed Follow-Up After Hospitalization for Mental Illness (FUH) Measure Steward: NCQA	**Alignment**: Medicaid Adult and Child Core Sets (2017); MAP Dual Eligibles Family of Measures (Last Modified 2015); Reported in Oregon's coordinated care organizations (CCOs); MIPS; Inpatient Psychiatric Facility Quality Reporting Program (IPFQR); Reported in the following states: • Alabama • Arkansas • California • Colorado • Connecticut • Delaware • Dist. of Columbia • Georgia • Illinois • Iowa • Kentucky • Louisiana • Massachusetts • Minnesota • Mississippi • Missouri • New Hampshire • New Mexico • New York • Ohio • Oklahoma • Oregon • Pennsylvania • Rhode Island • South Carolina • Tennessee • Texas • Vermont • Virginia • Washington • West Virginia
0709 Endorsed	**Alignment**: MAP Dual Eligible Beneficiaries Family of Measures

Proportion of patients with a chronic condition that have a potentially avoidable complication during a calendar year Measure Steward: Altarum Institute	
1598 Endorsed Total Resource Use Population-based PMPM Index Measure Steward: HealthPartners	**Alignment**: N/A
1604 Endorsed Total Cost of Care Population-based PMPM Index Measure Steward: HealthPartners	**Alignment**: N/A
1768 Endorsed Plan All-Cause Readmissions (PCR) Measure Steward: NCQA	**Alignment**: Medicaid Adult Core Set (2017); MAP Dual Eligibles Family of Measures (2016); Reported in the following states: • Alabama • Arizona • Arkansas • California • Colorado • Connecticut • Delaware • Georgia • Iowa • Louisiana • Michigan • Minnesota • Missouri • New Mexico • New York • North Carolina • Ohio • Oklahoma • Oregon • Rhode Island • South Carolina • Tennessee • Vermont • Washington
2371 Endorsed Annual Monitoring for Patients on Persistent Medications (MPM) Measure Steward: NCQA	**Alignment**: 2017 Medicaid Adult Core Set; Reported in the following states: • Arkansas • California • Colorado • Connecticut

	• Delaware • Dist. of Columbia • Georgia • Illinois • Iowa • Kentucky • Louisiana • Maryland • Massachusetts • Michigan • Minnesota • Mississippi • Missouri • Montana • New Hampshire • New Jersey • New Mexico • New York • North Carolina • Oklahoma • Pennsylvania • Rhode Island • South Carolina • Tennessee • Texas • Vermont • Washington • West Virginia
2456 Endorsed Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient Measure Steward: Brigham and Women's Hospital	**Alignment**: MAP Dual Eligible Beneficiaries Family of Measures
2483 Endorsed Gains in Patient Activation (PAM) Scores at 12 Months Measure Steward: Insignia Health	**Alignment**: Reported in Colorado's Rocky Mountain Regional Care Collaborative Organization
2605 Endorsed Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence Measure Steward: NCQA	**Alignment**: MAP Dual Eligibles Family of Measures (2016); Reported in Vermont
Not NQF-endorsed Adult Access to Preventive/Ambulatory Care 20-44, 45-64, 65+ Measure Steward: NCQA	**Alignment**: N/A

Not NQF-endorsed Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA) Measure Steward: NCQA	**Alignment**: HEDIS; Reported in New York
Not NQF-endorsed Medication reconciliation post-discharge: percentage of discharges from January 1 to December 1 of the measurement year for members 18 years of age and older for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days) Measure Steward: NCQA	**Alignment**: N/A
Not NQF-endorsed Potentially Preventable Emergency Room Visits Measure Steward: 3M	**Alignment:** Reported in New York
Not NQF-endorsed Potentially Preventable Readmissions Measure Steward: 3M	**Alignment:** Reported in New York
Not NQF-endorsed Prevention Quality Indicators #90 (PQI #90) Measure Steward: N/A	**Alignment**: California DHCS in 1115 waiver; Reported in New York
Not NQF-endorsed Psychiatric Inpatient Readmissions – Medicaid (PCR-P) Measure Steward: Washington State Department of Social and Health Services	**Alignment**: Reported in Washington State Common Measure Set
Not NQF-endorsed Potentially Preventable Emergency Room Visits (for persons with BH diagnosis)* Measure Steward: 3M	**Alignment:** Reported in New York

**Measure Concept*

Coordinating Committee Measure Set Recommendations for the Supporting Physical and Mental Health Integration Program Area

NQF Endorsement Status, Measure Title, Measure Steward	Alignment
0097 Endorsed Medication Reconciliation Post-Discharge Measure Steward: National Committee for Quality Assurance (NCQA)	**Alignment**: MAP Dual Eligible Beneficiaries Family of Measures; Merit-

	Based Incentive Payment System (MIPS); Reported in Colorado
0105 Endorsed Antidepressant Medication Management (AMM) Measure Steward: NCQA	**Alignment**: 2016 Medicaid Adult Core Set; MAP Dual Eligible Beneficiaries Family of Measures; Reported in the following states: • Alabama • Arkansas • California • Colorado • Connecticut • Delaware • Dist. of Columbia • Georgia • Illinois • Iowa • Kentucky • Louisiana • Massachusetts • Michigan • Minnesota • Mississippi • Missouri • New Hampshire • New Mexico • New York • North Carolina • Ohio • Oklahoma • Pennsylvania • Rhode Island • Tennessee • Texas • Vermont • Virginia • Washington
0418 Endorsed Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan Measure Steward: Centers for Medicare & Medicaid Services (CMS)	**Alignment**: Medicaid; Medicare Physician Quality Reporting System (PQRS); Medicare Shared Savings Program (MSSP); Physician Compare; Physician Feedback/Quality and Resource Use Reports (QRUR); Physician

	Value-Based Payment Modifier (VBM); Reported in the following states: • Oregon CCO • CA 1115 waiver – PRIME • Georgia • Colorado • Rhode Island • Alabama • Delaware
0419 Endorsed Documentation of Current Medications in the Medical Record Measure Steward: CMS	**Alignment**: PQRS; MSSP; QRUR; VBM
0576 Endorsed Follow-Up After Hospitalization for Mental Illness (FUH) Measure Steward: NCQA	**Alignment**: Medicaid Adult and Child Core Sets (2017); MAP Dual Eligibles Family of Measures (2016); Reported in Oregon's coordinated care organizations (CCOs); MIPS; Inpatient Psychiatric Facility Quality Reporting Program (IPFQR); Reported in the following states: • Alabama • Arkansas • California • Colorado • Connecticut • Delaware • Dist. of Columbia • Georgia • Illinois • Iowa • Kentucky • Louisiana • Massachusetts • Minnesota • Mississippi • Missouri • New Hampshire • New Mexico • New York • Ohio • Oklahoma • Oregon • Pennsylvania • Rhode Island • South Carolina • Tennessee • Texas

	• Vermont • Virginia • Washington • West Virginia
0710 Endorsed Depression Remission at Twelve Months Measure Steward: Minnesota Community Measurement	**Alignment**: PQRS, MSSP, QRUR, VBM, CA 1115 waiver – PRIME
1879 Endorsed Adherence to Antipsychotic Medications for Individuals with Schizophrenia Measure Steward: CMS	**Alignment**: PQRS; QRUR; VBM; PA DHS Integrated Care Pay for Performance Program; Reported in the following states: • Alabama • Arkansas • California • Colorado • Connecticut • Delaware • Dist. of Columbia • Georgia • Illinois • Iowa • Kentucky • Louisiana • Massachusetts • Missouri • New Mexico • New York • North Carolina • Pennsylvania • Rhode Island • South Carolina • Tennessee • Texas • Vermont • Washington • West Virginia
1880 Endorsed Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder Measure Steward: CMS	**Alignment**: NYS Medicaid Value Based Payment
1922 Endorsed HBIPS-1 Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths Completed Measure Steward: The Joint Commission	**Alignment**: N/A

1927 Endorsed Cardiovascular Health Screening for People With Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications Measure Steward: NCQA	**Alignment**: Reported in Arkansas Medicaid
1932 Endorsed Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) Measure Steward: NCQA	**Alignment**: Medicaid
1933 Endorsed Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC) Measure Steward: NCQA	**Alignment**: Reported in Arkansas Medicaid
1934 Endorsed Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD) Measure Steward: NCQA	**Alignment**: Reported in Arkansas Medicaid
1937 Endorsed Follow-Up After Hospitalization for Schizophrenia (7- and 30-day) Measure Steward: NCQA	**Alignment**: N/A
2599 Endorsed Alcohol Screening and Follow-up for People with Serious Mental Illness Measure Steward: NCQA	**Alignment**: N/A
2600 Endorsed Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence Measure Steward: NCQA	**Alignment**: N/A
2602 Endorsed Controlling High Blood Pressure for People with Serious Mental Illness Measure Steward: NCQA	**Alignment**: N/A
2603 Endorsed Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Testing Measure Steward: NCQA	**Alignment**: N/A
2604 Endorsed	**Alignment**: N/A

Diabetes Care for People with Serious Mental Illness: Medical Attention for Nephropathy Measure Steward: NCQA	
2605 Endorsed Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence Measure Steward: NCQA	**Alignment**: MAP Dual Eligibles (2016); Reported in Vermont
2607 Endorsed Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) Measure Steward: NCQA	**Alignment**: N/A
2609 Endorsed Diabetes Care for People with Serious Mental Illness: Eye Exam Measure Steward: NCQA	**Alignment**: N/A
Not NQF-endorsed Adult Access to Preventive/Ambulatory Care 20-44, 45-64, 65+ Measure Steward: NCQA	**Alignment**: N/A
Not NQF-endorsed Behavioral Health Risk Assessment (for Pregnant Women) (BHRA) Measure Steward: American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)	**Alignment**: Georgia Department of Community Health
Not NQF-endorsed Combined BH-PH Inpatient 30-Day Readmission Rate for Individuals With SMI Eligible Population, Denominator and Numerator Specifications Measure Steward: IPRO	**Alignment**: Reported in Pennsylvania Medicaid
Not NQF-endorsed Depression Remission or Response for Adolescents and Adults Measure Steward: NCQA	**Alignment**: N/A
Not NQF-endorsed Follow-Up After Emergency Department Visit for Mental Illness Measure Steward: NCQA	**Alignment**: CA Whole Person Care Pilot
Not NQF-endorsed Mental Health Service Penetration	**Alignment**: Washington State Medicaid Demo

Measure Steward: Washington State DSHS	
Not NQF-endorsed Mental health utilization: number and percentage of members receiving the following mental health services during the measurement year: any service, inpatient, intensive outpatient or partial hospitalization, and outpatient or ED Measure Steward: NCQA	**Alignment**: N/A
Not NQF-endorsed Post-Partum Follow-up and Care Coordination Measure Steward: AHRQ	**Alignment**: PQRS
Not NQF-endorsed PACT Utilization for Individuals with Schizophrenia* Measure Steward: American Psychiatric Association	**Alignment**: N/A

**Measure Concept*

Coordinating Committee Measure Set Recommendations for the Reducing Substance Use Disorders Program Area

NQF Endorsement Status, Measure Title, Measure Steward	Alignment
0004 Endorsed Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) Measure Steward: NCQA	**Alignment**: PQRS; QRUR; VBM; QRS; Medicaid Adult Core Set; Reported in the following states; • California • Colorado • Connecticut • Delaware • Dist. of Columbia • Georgia • Illinois • Iowa • Kentucky • Louisiana • Maryland • Massachusetts • Minnesota • Mississippi • Missouri • New Hampshire • New York • North Carolina • Ohio • Oregon • Pennsylvania

	• Rhode Island • South Carolina • Tennessee • Texas • Vermont • Washington
1654 Endorsed TOB - 2 Tobacco Use Treatment Provided or Offered and the subset measure TOB-2a Tobacco Use Treatment Measure Steward: The Joint Commission	**Alignment**: Hospital Compare; IPFQR
1656 Endorsed TOB - 3 Tobacco Use Treatment Provided or Offered at Discharge and the subset measure TOB-3a Tobacco Use Treatment at Discharge Measure Steward: The Joint Commission	**Alignment**: Hospital Compare; IPFQR
1661 Endorsed SUB-1 Alcohol Use Screening Measure Steward: The Joint Commission	**Alignment**: N/A
1663 Endorsed SUB-2 Alcohol Use Brief Intervention Provided or Offered and SUB-2a Alcohol Use Brief Intervention Measure Steward: The Joint Commission	**Alignment**: N/A
1664 Endorsed SUB-3 Alcohol and other Drug Use Disorder Treatment Provided or Offered at Discharge Measure Steward: The Joint Commission	**Alignment**: N/A
2152 Endorsed Preventive Care and Screening: Unhealthy Alcohol Use Measure Steward: AMA-convened Physician Consortium for Performance Improvement	**Alignment**: PQRS; QRUR; VBM
2597 Endorsed Substance Use Screening and Intervention Composite (Composite Measure) Measure Steward: ASAM	**Alignment**: N/A
2599 Endorsed Alcohol Screening and Follow-up for People with Serious Mental Illness Measure Steward: NCQA	**Alignment**: N/A

2600 Endorsed Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence Measure Steward: NCQA	**Alignment**: N/A
2605 Endorsed Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence Measure Steward: NCQA	**Alignment**: MAP Dual Eligibles Family of Measures (2016); Reported in Vermont
2940 Endorsed Use of Opioids at High Dosage in Persons Without Cancer Measure Steward: PQA	**Alignment**: CMS Medicare Part D Drug Benefit
2950 Endorsed Use of Opioids from Multiple Providers in Persons Without Cancer Measure Steward: PQA	**Alignment**: CMS Medicare Part D Drug Benefit
2951 Endorsed Use of Opioids at High Dosages from Multiple Providers in Persons with Cancer Measure Steward: PQA	**Alignment**: CMS Medicare Part D Drug Benefit
3225 (formerly #0028) Endorsed Preventative Care and Screening: Tobacco Use: Screening and Cessation Intervention Measure Steward: AMA-convened Physician Consortium for Performance Improvement	**Alignment**: PQRS, MSSP, Million Hearts, Physician Compare, QRUR, VBM
Not NQF-endorsed Adult Access to Preventive/Ambulatory Care 20-44, 45-64, 65+ Measure Steward: NCQA	**Alignment**: N/A
Not NQF-endorsed Documentation of Signed Opioid Treatment Agreement Measure Steward: American Academy of Neurology	**Alignment**: Medicare
Not NQF-endorsed Evaluation or Interview for Risk of Opioid Misuse Measure Steward: American Academy of Neurology	**Alignment**: Medicare
Not NQF-endorsed	**Alignment**: HEDIS; Reported in New York

Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA) Measure Steward: NCQA	
Not NQF-endorsed Mental Health/substance abuse: mean of patients' overall change on the BASIS 24-survey Measure Steward: Eisen, Susan V., PhD.	**Alignment**: N/A
Not NQF-endorsed Percent of patients prescribed a medication for alcohol use disorder Measure Steward: ASAM	**Alignment**: N/A
Not NQF-endorsed Percent of patients prescribed a medication for opioid use disorders (OUD) Measure Steward: ASAM	**Alignment**: N/A
Not NQF-endorsed The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user Measure Steward: NCQA	**Alignment**: Medicare
Not NQF-endorsed Annual Hepatitis C Virus (HCV) Screening for Patients who are Active Injection Drug Users* Measure Steward:	**Alignment**: Medicare
Not NQF-endorsed Presence of Screening for Psychiatric Disorder* Measure Steward: ASAM	**Alignment**: N/A
Not NQF-endorsed Primary Care Visit Follow-Up* Measure Steward: ASAM	**Alignment**: N/A
Not NQF-endorsed Substance use disorders: percentage of patients aged 18 years and older with a diagnosis of current alcohol dependence who were counseled regarding psychosocial AND pharmacologic treatment options for alcohol dependence within the 12 month reporting period*	**Alignment**: N/A

Measure Steward: American Psychiatric Association, NCQA, Physician Consortium for Performance Improvement	
Not NQF-endorsed Substance use disorders: percentage of patients aged 18 years and older with a diagnosis of current substance abuse or dependence who were screened for depression within the 12-month reporting period* Measure Steward: American Psychiatric Association, NCQA, Physician Consortium for Performance Improvement	**Alignment**: N/A
Not NQF-endorsed Substance Use Disorder Treatment Penetration (AOD)* Measure Steward: Washington State Department of Social and Health Services	**Alignment**: Reported in Washington State

**Measure Concept*

Coordinating Committee Measure Set Recommendations for the Promoting Community Integration through Community-Based Long-Term Services and Supports Program Area

NQF Endorsement Status, Measure Title, Measure Steward	Alignment
0097 Endorsed Medication Reconciliation Post-Discharge Measure Steward: National Committee for Quality Assurance (NCQA)	**Alignment**: MAP Dual Eligible Beneficiaries Family of Measures; Merit-Based Incentive Payment System (MIPS); Reported in Colorado
0101 Endorsed Falls: Screening for Fall Risk Measure Steward: NCQA	**Alignment**: PQRS; MSSP; QRUR; VBM
0326 Endorsed Advance Care Plan Measure Steward: NCQA	**Alignment**: MIPS; PQRS
0419 Endorsed Documentation of Current Medications in the Medical Record Measure Steward: CMS	**Alignment**: PQRS; MSSP; QRUR; VBM
0647 Endorsed Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) Measure Steward: PCPI	**Alignment**: IPFQR

2483 Endorsed Gains in Patient Activation (PAM) Scores at 12 Months Measure Steward: Insignia Health	**Alignment**: Reported in Colorado's Rocky Mountain Regional Care Collaborative Organization
2967 Endorsed CAHPS® Home and Community Based Services (HCBS) Measures Measure Steward: CMS	**Alignment**: N/A
Not NQF-endorsed Adult Access to Preventive/Ambulatory Care 20-44, 45-64, 65+ Measure Steward: NCQA	**Alignment**: N/A
Not NQF-endorsed Home- and Community- Based Long Term Services and Supports Use Measure Definition (HCBS) Measure Steward: Washington State Department of Social and Health Services	**Alignment**: Reported in Washington Medicaid
Not NQF-endorsed Percentage of short-Stay Residents who were Successfully Discharged to the Community Measure Steward: N/A	**Alignment**: Five-Star Quality Rating System
Not NQF-endorsed Individualized Plan of Care Completed* Measure Steward: N/A	**Alignment**: N/A
Not NQF-endorsed National Core Indicators* Measure Steward: Human Services Research Institute (HSRI) and The National Association of States United for Aging and Disabilities	**Alignment**: NY State Managed Long Term Care Measures
Not NQF-endorsed National Core Indicators – Aging and Disability* Measure Steward: Human Services Research Institute (HSRI) and The National Association of States United for Aging and Disabilities	**Alignment**: N/A
Not NQF-endorsed Number and percent of waiver participants who had assessments completed by the MCO that included physical, behavioral, and functional components to determine the member's needs* Measure Steward: N/A	**Alignment**: KanCare; additional states' Managed Care

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