NATIONAL QUALITY FORUM

Meeting Summary

Medicaid Innovation Accelerator Project 2016-2017 Technical Expert Panel In-Person Meeting| April 18-19, 2017

The National Quality Forum (NQF) convened the members of the four Technical Expert Panels (TEPs) for a two-day in-person meeting (including break-out sessions) on April 18-19, 2017. The recording for the opening session of the meeting can be accessed using the following link: http://www.qualityforum.org/uploadedFiles/Quality_Forum/Projects/i-m/Medicaid_Innovation_Accelerator_Program/medicaid_iap_recording_02232017.mp3

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

Name	Organization
Andrea Gelzer, MD, MS, FACP– *Technical Expert Panel 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.

Promoting Community Integration through Community-Based Long-Term Services and Supports Technical Expert Panel Members in Attendance

Name	Organization
Barbara McCann, BSW, MA – *Technical Expert Panel Chair*	Interim HealthCare Inc.
Diane McComb, MSEd	Delmarva Foundation
Judit Olah, PhD, MS	UCHealth
Robert Schreiber, MD	Hebrew SeniorLife
Janice Tufte	Engaged Patient

Reducing Substance Use Disorders Technical Expert Panel Members in Attendance

Name	Organization
Sheryl Ryan, MD, FAAP – *Technical Expert Panel 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 McCarthy, PhD	Oregon Health & Science University
Tiffany Wedlake, MD, MPH	Maryland Department of Health and Mental Hygiene

Supporting Physical and Mental Health Integration Technical Expert Panel Members in Attendance

Name	Organization
Maureen Hennessey, PhD, CPCC – *Technical Expert Panel 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	WA State Department of Social and Health Services
James Schuster, MD, MBA	UPMC Insurance Division

Decisions and/or Recommendations

Recommended Innovation Accelerator Program (IAP) Program Area Measures Sets to the Coordinating Committee

During the two-day meeting, the Technical Expert Panels (TEPs) reviewed and recommended measures to the Coordinating Committee (CC) for potential inclusion in each of the four program area measure sets. These programs include Reducing Substance Use Disorders (SUD), Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs (BCN), Promoting Community Integration through Community-Based Long-Term Services and Supports (LTSS), and Supporting Physical and Mental Health Integration (PMH).

The TEPs' review and recommendation of measures occurred over a two-part process:

Prior to the in-person meeting: TEP members reviewed their program area specific measure summary sheets. The summary sheets included measure details and each measure's overall measure score, which included four criteria: feasibility, usability, scientific acceptability, and evidence. The measure summary sheets also included the mean score for all measures in the program area. For each TEP, measures with scores that fell below the mean could not move forward except for those selected by a TEP member. Each member had the opportunity to retain three measures/measure concepts for further discussion during the in-person meeting.

During the in-person meeting: TEP members evaluated the suitability of the remaining measures individually using a decision logic. The decision logic provided a structured approach to evaluate each measure in each program. The criteria include whether the measure addresses the critical issues in the program, the CMS quality objectives, if it offers an opportunity for quality improvement or is an efficient use of resources, is important to stakeholders, and if the measure is ready for implementation. Based on the TEP's vote of each criteria in the algorithm, measures moved forward as recommended. These measures fall into three designations: measure, measure concept, or promising concept. Recommended measures will move forward to the CC for final review. The CC will ultimately recommend four measure sets to CMS.

TEP members suggested a few ways to improve the process, including:

- Changing the measure definition to be more reflective of the measures in use in the Medicaid population. The original definition used in this project was descriptive of an NQF endorsed measure. The TEPs noted many measures used in Medicaid do not meet the rigors of NQF's endorsement criteria and may not have undergone testing; and
- Updating the decision logic to offer an option to eliminate measures/concepts based on the merits of the measure.

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

During the in-person meeting, several themes emerged as part of the TEP's discussion. The TEP noted the need for a cascade of SUD measures that started with screening and ended with assessment and intervention. The TEP also discussed the need to broaden the existing tobacco measures to include not just tobacco but drugs, and other nicotine products. The TEP discussed critical gap areas including:

substance abuse measures that focus on pregnant women and the lack of available outcome measures. TEP members noted that available process measures set a low bar.

After deliberations, the TEP recommended the following 19 measures and 6 measure concepts to the CC.

Measures

- NQF #0004 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)
- NQF #2152 Preventive Care and Screening: Unhealthy Alcohol Use
- NQF #3225 (formerly #0028) Preventative Care and Screening: Tobacco Use: Screening and Cessation
- NQF #1654 TOB - 2 Tobacco Use Treatment Provided or Offered and the subset measure TOB-2a Tobacco Use Treatment
- NQF #1656 TOB - 3 Tobacco Use Treatment Provided or Offered at Discharge and the subset measure TOB-3a Tobacco Use Treatment at Discharge
- NQF #2599 Alcohol Screening and Follow-up for People with Serious Mental Illness
- NQF #2597 Substance Use Screening and Intervention Composite
- NQF #2600 Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence
- NQF #1664 Alcohol and other Drug Use Disorder Treatment Provided or Offered at Discharge
- Documentation of Signed Opioid Treatment Agreement
- Evaluation or Interview for Risk of Opioid Misuse
- NQF #1661 Sub-1 Alcohol Use Screening
- NQF #1663 Sub-2 Alcohol Use Brief Intervention Provided or Offered and Sub-2a Alcohol Use Brief Intervention
- 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
- NQF #2950 Use of opioid from multiple providers in persons without cancer
- NQF #2940 Use of opioids at high doses in persons without cancer
- Percent of patients prescribed a medication for opioid use disorders (OUD)
- Percent of patients prescribed a medication for alcohol use disorder
- NQF #2605 Follow-up after discharge from the Emergency Department for mental health or alcohol or other drug dependence*

Measure Concepts

- Primary Care Visit Follow-Up
- Substance Use Disorder Treatment Penetration (AOD)
- Screening for Patients who are Active Injection Drug Users
- Substance use disorders: percentage of patients aged 18 years and older with a diagnosis of current alcohol dependence who were counseled regarding psychosocial AND pharmacologic treatment options for alcohol dependence within the 12 month reporting period

- Substance use disorders: percentage of patients aged 18 years and older with a diagnosis of current substance abuse or dependence who were screened for depression within the 12 month reporting period
- Presence of Screening for Psychiatric Disorder

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

The BCN TEP discussed several themes. They noted that the ambiguity surrounding the definition of the BCN population posed a challenge in identifying best-available quality measures. For instance, members engaged in a recurring discussion about whether to recommend measures that would meet the needs of beneficiaries with current complex care needs and high costs or beneficiaries at risk of developing complex care needs and expending high costs. The TEP expressed a preference for non-proprietary measures as they felt those would have the greatest impact on the population. Additionally, the TEP favored broad measures that encompass multiple conditions over measures with a single condition (e.g. follow-up measures focusing on mental illness versus schizophrenia). Lastly, the TEP members noted that seven measures, currently specified for Medicare and those over age 65, were not appropriate for use in Medicaid. However, they voted to recommend the measures using the review process in place at the meeting. Following the meeting, NQF staff and CMS discussed these measures and agreed that they do not align with the scope of the project and have decided to remove them from consideration.

After deliberations, the BCN TEP recommended the following 14 measures and 6 measure concepts to the CC. The below list of recommended measures and measure concepts excludes the seven measures, which will not advance to the CC.

Measures

- NQF #0105 Antidepressant Medication Management (AMM)
- NQF #0097 Medication Reconciliation Post-Discharge
- NQF #2371 Annual Monitoring for Patients on Persistent Medications (MPM)
- NQF #2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient
- NQF #0576 Follow-Up After Hospitalization for Mental Illness (FUH)
- NQF #0648 Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
- NQF #2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Dependence
- NQF #1598 Total Resource Use Population-based PMPM Index
- NQF #1604 Total Cost of Care Population-based PMPM Index
- Psychiatric Inpatient Readmissions – Medicaid (PCR-P)
- Medication reconciliation post-discharge: percentage of discharges from January 1 to December 1 of the measurement year for members 18 years of age and older for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days).

- NQF #0709 Proportion of patients with a chronic condition that have a potentially avoidable complication during a calendar year
- Prevention Quality Indicators #90 (PQI #90)
- NQF #1768 Plan All-Cause Readmissions (PCR)

Measure Concepts

- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)
- Follow-up after all-cause emergency department visit
- Potentially avoidable emergency department utilization
- Potentially Preventable Emergency Room Visits
- Potentially Preventable Readmissions
- Potentially Preventable Emergency Room Visits (for persons with BH diagnosis)

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

Members of the LTSS TEP discussed two main themes. First, there is a critical need for the standardization of language across providers, e.g. the meaning of individual care plan has a different meaning for different LTSS providers. Second, the TEP also noted that the LTSS community encompasses at least five major populations. Measure development is critical to fit the needs of each population, as there currently are few available measures. Current measures do not adequately address the needs of all of the populations and in many cases, medical measures are being adapted for use in the LTSS community.

Overall, the TEP recommended the following six measures, five promising concepts and two measure concepts to the CC.

Measure

- NQF #0647: Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
- NQF #0648: Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
- NQF #0101: Falls: Screening for Fall Risk
- NQF #0326: Advance Care Plan
- NQF #2967: CAHPS® Home and Community Based Services (HCBS) Measures
- NQF #2483: Gains in Patient Activation (PAM) Scores at 12 Months

Promising Concepts

- Adult Access to Preventative/Ambulatory Care 20-44, 45-64, 65+
- Home- and Community Based Long Term Services and Supports Use Measure Definition (HCBS)
- National Core Indicators – Aging and Disability
- National Core Indicators

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

Measure Concepts

- Individualized Plan of Care Completed
- Referral to Community Based Health Resources

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

The PMH TEP noted that several themes arose during their deliberation. One major theme is the need to stratify by conditions, which allows providers to identify those individuals who had a behavioral health diagnosis as either primary or secondary. This identification would allow states or providers to access the integration of care. Additionally, the TEP raised concerns that some measures lacked the specificity needed to address the population. The TEP also discussed issues related to the ease of measure collection, specifically related to electronic health records and paper records.

Overall, the TEP recommended the following 23 measures, one promising concept, and one measure concept to the CC.

Measures

- Mental Health Service Penetration
- Mental health utilization: number and percentage of members receiving the following mental health services during the measurement year: any service, inpatient, intensive outpatient or partial hospitalization, and outpatient or ED.
- NQF #2599 Alcohol Screening and Follow-up for People with Serious Mental Illness
- NQF #1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia
- NQF #1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder
- NQF #0105 Antidepressant Medication Management (AMM)
- Depression Remission or Response for Adolescents and Adults
- NQF #0418 Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan
- NQF #1927 Cardiovascular Health Screening for People With Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications
- NQF #1933 Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)
- NQF #2609 Diabetes Care for People with Serious Mental Illness: Eye Exam
- NQF #2607 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
- NQF #2603 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Testing
- NQF #2604 Diabetes Care for People with Serious Mental Illness: Medical Attention for Nephropathy

- NQF #1934 Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)
- NQF #1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)
- NQF #2605 Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence
- NQF #0576 Follow-Up After Hospitalization for Mental Illness (FUH)
- NQF #1937 Follow-Up After Hospitalization for Schizophrenia (7- and 30-day)
- NQF #0097 Medication Reconciliation Post-Discharge
- NQF #2600 Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence
- Follow-Up After Emergency Department Visit for Mental Illness
- NQF #0419 Documentation of Current Medications in the Medical Record

Promising Concepts

- Combined BH-PH Inpatient 30-Day Readmission Rate for Individuals With SMI

Measure Concepts

- PACT Utilization for Individuals with Schizophrenia