NQF Medicaid Innovation Accelerator Project 2016-2017

Coordinating Committee In-Person Meeting – Day 1

June 7-8, 2017

Welcome

Introduction of Coordinating Committee (CC) Members and Disclosures of Interest

Coordinating Committee

Coordinating Committee Chairs	William Golden, MD, Arkansas Medicaid and University of Arkansas
	Jennifer Moore, PhD, RN, Institute for Medicaid Innovation

Coordinating Committee Members

- Karen Amstutz, MD, MBA, Magellan Health
- Andrea Gelzer, MD, MS, FACP, AmeriHealth Caritas Family of Companies
- Allison Hamblin, MSPH, Center for Health Care Strategies, Inc.
- Christine Hawkins, RN, MBA, MSML, Centene Corporation
- Maureen Hennessey, PhD, CPCC, Precision Advisors
- David Kelley, MD, MPA, Pennsylvania Dept. of Human Services
- Deborah Kilstein, RN, MBA, JD, Association for Community Affiliated Plans
- SreyRam Kuy, MD, MHS, FACS, Louisiana Dept. 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, Dept. of Human Services Minnesota
- John Shaw, MEng, Next Wave
- Alvia Siddiqi, MD, FAAFP, Advocate Physician Partners
- Susan Wallace, MSW, LSW, LeadingAge Ohio
- Judy Zerzan, MD, MPH, Colorado Dept. of Health Care Policy and Financing

Meeting Objectives and Agenda

Meeting Objectives

- Review measures/concepts recommended by the four Technical Expert Panels (TEP) relevant to the four program areas covered in the CMS Medicaid Innovation Accelerator Program (IAP):
  - *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)*
  - *Supporting Physical and Mental Health Integration (PMH)*

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

Coordinating Committee's role

- Using the decision logic the CC will review:
  - » Late submission measures that were not reviewed by the TEPs
  - » Measures that the TEP members recommended for consideration by a different program area.
  - » Measures not recommended by the TEP but identified in the pre-work for further reconsideration
- Review the related measures tables in each program area
  - » Identify measures which may not be the best in class for possible removal
- Review measures recommended by the TEP that CC members motion to remove
- Vote en bloc to recommend all remaining measures to CMS's IAP
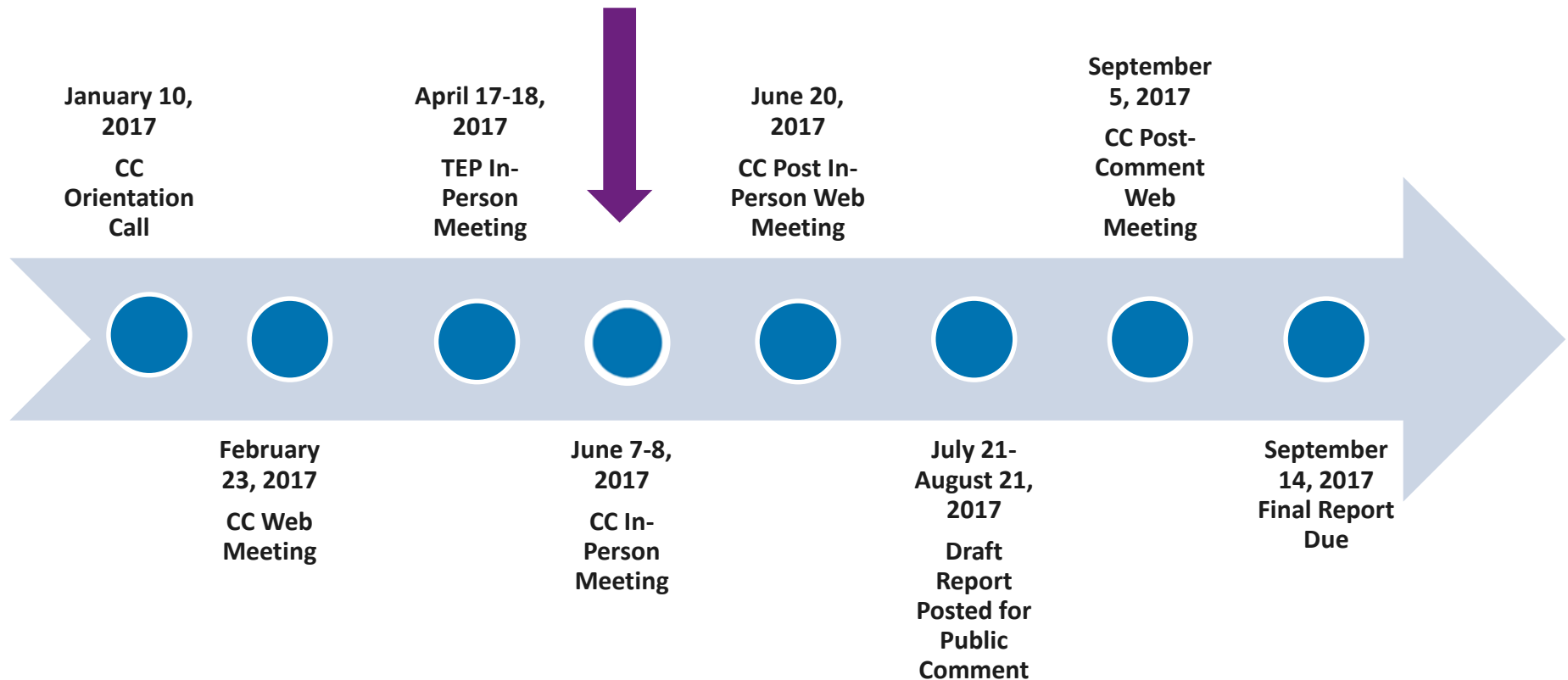
Coordinating Committee's role

- Today's process involves
  - *Multiple steps, discussions, votes, and decisions*

- Recommend measure/concepts for immediate use in the
  - *Four measure sets: BCN, PMH, SUD and LTSS*

Day 1 Agenda

- Welcome
- Introductions and Disclosure of Interest
- CMS Opening Remarks
- Overview of Project Goals and Key Points from Staff Literature Review
- Overview Measure Selection Process
- Review Medicaid IAP Program Area Measures- BCN
- Review Medicaid IAP Program Area Measures- SUD
- Adjourn for the Day

Timeline and Deliverables

January 10, 2017

CC Orientation Call

April 17-18, 2017

TEP In-Person Meeting

June 20, 2017

CC Post In-Person Web Meeting

September 5, 2017

CC Post-Comment Web Meeting

February 23, 2017

CC Web Meeting

June 7-8, 2017

CC In-Person Meeting

July 21-August 21, 2017

Draft Report Posted for Public Comment

September 14, 2017
Final Report Due

Medicaid Innovation Accelerator Program

Karen LLanos

Director, Medicaid IAP Center for Medicaid and CHIP Services, CMS

NQF Coordinating Committee Meeting

June 7, 2017

Background: Medicaid IAP

- Four year commitment by CMS to build state capacity and support ongoing innovation in Medicaid through technical assistance

- Support states' and HHS delivery system reform efforts
  - *The end goal for IAP to increase the number of states moving towards delivery system reform across program priorities*

- Not a grant program; targeted technical assistance and tools for states

Medicaid Delivery System Reform

PROGRAM AREAS

Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs

Promoting Community Integration Through Long-Term Services and Supports

Supporting Physical and Mental Health Integration

Reducing Substance Use Disorders

Functional Areas
- Data Analytics
- Quality Measurement
- Performance Improvement
- Value-Based Payment and Financial Simulations

IAP Program Areas

- Reducing Substance Use Disorders

- Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs

- Promoting Community Integration through Long-Term Services and Supports

- Supporting Physical and Mental Health Integration

Medicaid IAP Quality Measurement Efforts

Goals is to improve states' capacity related to quality measurement for their Medicaid delivery system reform efforts, by:

- Filling critical Medicaid-relevant quality measurement gaps through the development and/or refinement of measures
- **Supporting states' efforts to select, use/report, and align standardized quality measures**
  - *Collaboration with NQF to identify sets of existing, standardized measures for states Medicaid agencies' use*
- Addressing challenging measurement issues
- Spreading best practices and innovations in quality measurement issues

Goals for the IAP-NQF Project Measure Set

The resulting listing/set of measures will:

- Reflect the various quality domains related to IAP's four program areas

- Be of value to state Medicaid agencies in their delivery system reform efforts

- Focus on existing, standardized measures that can be collected by states "tomorrow"

- Reflect input from wide range of stakeholders and perspectives

- Consider measure alignment across payers and settings

CMS Quality Measurement Domains

The CMS Quality Measurement domains should serve as an organizing framework for today's discussions and resulting measurement sets:

- *Access*
- *Clinical Care*
- *Care Coordination*
- *Safety*
- *Patient/caregiver experience*
- *Prevention and Population Health*

What will IAP do with the Measure Sets from this Project?

- *Which states are our audience for these measure sets?*
  - All states whether or not they are participating in IAP

- Who will have access to the measures sets?
  - *IAP will post sets online for interested states & stakeholders*

- *How can states use these measure listings?*
  - Resource for state Medicaid agencies developing measurement strategies for their delivery system reform efforts

- This project differs from other federal measurement sets
  - *Not part of a requirement or reporting program, but should consider alignment with relevant measure sets*
  - *Helpful resource for states and CMCS*

Questions?

Overview of Project Goals and Key Points from Staff Literature Review

NQF-Medicaid Innovation Accelerator Project Goals

- Identify and recommend measure sets related to the four program areas of CMS's Medicaid Innovation Accelerator Program (IAP)
  - *Reducing Substance Use Disorders (SUD)*
  - *Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs (BCN)*
  - *Promoting Community Integration – Community-Based Long-Term Services and Supports (CI-LTSS)*
  - *Supporting Physical and Mental Health Integration (PMH)*

- Measure sets will support states' ongoing efforts related to Medicaid delivery system reform

- Measure sets should include measures that can be implemented immediately and represent the full continuum of care across various providers and care settings

- All state Medicaid agencies, regardless of whether they participate in CMS' IAP, will have access to the measure sets

Key Terminology

Definitions

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

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

- **Tools** *- Instruments that can be used for screening, are not measures but can be used in measures*

- **Surveys** *- Not performance measures but they can have measures in them.*

Terminology and Examples

Example of a tool within a measure:

- *Depression Remission at Twelve Months: Adult patients age 18 and older with a major depression or dysthymia and an initial PHQ-9 score >9 who demonstrate remission at twelve months defined as a PHQ-9 less than 5.*

Example of a measure within a survey

- *The CAHPS HCBS survey has 19 performance measures. Many surveys have testing of the psychometric properties of the survey but not of the performance measures within the survey. These performance measures also have testing for reliability and validity.*

Reducing Substance Use Disorders (SUD)

- This program area focuses on Medicaid beneficiaries who experience significant impairment such as health problems, disability, and failure to meet major responsibilities.

- Substance abuse, specifically alcohol and substance use diagnoses, are two of the top ten reasons for hospital readmissions among Medicaid beneficiaries.*

- An estimated 12% of adult and 6% of adolescent Medicaid beneficiaries have a substance abuse issue.*

* Center for Medicare and Medicaid Services. Reducing Substance Use Disorders. https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/reducing-substance-use-disorders/reducing-substance-use-disorders.html. Last accessed December 2016. **IAP Learning Collaborative: Substance Use Disorder. Webinar presented on November 7, 2014 by Medicaid Innovation Accelerator Program. Accessed December 2016. https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/iap-sud-webinar.pdf

Reducing Substance Use Disorders (SUD)

- Research shows that Medicaid-only patients had the highest combined rate of both illicit drug use and use of prescription drugs when compared to patients with commercial insurance, patients on Medicare, or dually eligible patients.

- Medicaid Patient Review and Restriction programs (or "Lock-in" programs) have previously been used to curb substance use disorders in the Medicaid system as early as the 1970s. Lock-in programs are again being considered to address opioid misuse

Reducing Substance Use Disorders (SUD)

- Measure sets should focus on CMS quality domains:
  - *Access*
  - *Care coordination*
  - *Clinical care*
  - *Patient and caregiver experience*
  - *Population health and prevention*
  - *Safety*

- Examples of a theme or issue raised during project deliberations to-date:
  - *Identification of people with substance use disorders or co-occurring conditions*

Promoting Community Integration through Community-Based Long-Term Services and Supports

- This program area focuses on supporting states' efforts to design and implement Medicaid delivery system reform for Medicaid beneficiaries living in the community and using home and community-based services and social supports. It does not include institutional care.

- Measure sets should focus on:
  □ Access
  □ Care coordination
  □ Clinical care
  □ Patient and caregiver experience
  □ Population health and prevention
  □ Safety

- Examples of themes and issues raised during project deliberations to-date:
  □ Having the right measures to address this changing and growing service area
  □ Examining ways to align measures in use across multiple states and programs

Promoting Community Integration through Community-Based Long-Term Services and Supports

- Evidence shows that planning for care following transition from an institution to community living should focus on personal medical and mental health needs and home selection that patients like and from which they can participate in the community in order to improve life satisfaction

  - *Predictors of re-institutionalization include mental health disability, difficulties with family members before transition, and not exercising choice and control in daily life. These predictors present opportunities for possible interventions to reduce re-institutionalization.*

Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs

- This program area focuses on supporting states' efforts to design and implement Medicaid delivery reforms for Medicaid beneficiaries who, because of their health and/or social conditions, are likely to experience high levels of costly but preventable service utilization and whose care patterns and costs are potentially "impactable."

- They are a small but expensive portion of the Medicaid population
  - *5% of beneficiaries account for 54% of total expenditures and 1% of beneficiaries account for 25% of total expenditures**

- They are a heterogeneous group
  - *Within this 1% of beneficiaries, 83% have at least 3 chronic conditions and more than 60% have 5 or more chronic conditions**

NATIONAL QUALITY FORUM

Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs

- There is evidence of effective strategies to improve care and reduce costs. For instance, studies found that areas served by Federally Qualified Health Centers (FQHCs) have lower rates of emergency department use and lower rates of hospitalizations for ambulatory care–sensitive conditions.*

- But, there is difficulty in appropriately addressing this population:
  - *Variations in design, focus, and setting among care management interventions make comparisons challenging.**
  - *There is a lot of churn 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.****

*Wright B, Potter AJ, Trivedi A. Federally Qualified Health Center Use Among Dual Eligibles: Rates Of Hospitalizations And Emergency Department Visits. *Health Affairs.* 2015; 34(7): 1147-1155.
**Lynch CS, Wajnberg A, Jervis R, et al. Implementation Science Workshop: a Novel Multidisciplinary Primary Care Program to Improve Care and Outcomes for Super-Utilizers. *J Gen Intern* Med. 2016;31(7):797-802.
***Johnson TL, Rinehart DJ, Durfee J, et al. For Many Patients Who Use Large Amounts Of Health Care Services, The Need Is Intense Yet Temporary. *Health Affairs.* 2015;34(8):1312-1319.

Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs

- Measure sets should focus on CMS quality domains:
  - *Access*
  - *Care coordination*
  - *Clinical care*
  - *Patient and caregiver experience*
  - *Population health and prevention*
  - *Safety*

- Examples of themes and issues raised during project deliberations to-date:
  - *Identifying people with complex care needs*
  - *Promoting coordination of care*
  - *Identifying types of services or social supports appropriate for this population*

Supporting Physical and Mental Health Integration

- This program area focuses on supporting states' efforts to design and implement Medicaid delivery system reform efforts around the integration of care and services for Medicaid beneficiaries with mental and physical health conditions.

- Individuals with mood disorders or schizophrenia and other psychotic disorders represented the top two most common diagnoses for re-hospitalizations among Medicaid beneficiaries. **

- Individuals with mental health needs often have comorbid physical health conditions that require medical attention.*
  - *Over 50% of the Medicaid-enrollees in the top 5% of expenditures who had asthma or diabetes also had a behavioral health condition.*

* US Government Accountability Office (GAO). *Medicaid: A Small Share of Enrollees Consistently Accounted for a Large Share of Expenditures, U.S.* Washington, DC: GAO; 2015. Available at http://www.gao.gov/assets/680/670112.pdf. Last acceded December 2016.

**Centers for Medicare and Medicaid Services. Physical and Mental Health Integration IAP Website. Available at https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/physical-and-mental-health-integration/physical-and-mental-health-integration.html. Last accessed on December 2016.

Supporting Physical and Mental Health Integration

- Effective integrated care models exist, but are not widely implemented. Barriers to the implementation of integration include:*

  - *Payment – in 24 states there are limits on same-day Medicaid billing for behavioral and mental health services ***

  - *Budget cuts - Numerous states reduced mental health service budgets during the Recession[ɣ]*

  - *Workforce issues - There is a significant workforce shortage in many parts of the country. An estimated 91 million people live in areas without enough mental health professionals[ɣ]*

  - *EHR capabilities - Many EHRs have limited ability to document relevant behavioral health and physical health information and to support communication and coordination of care among integrated teams[ɣɣ]*

*Goldman ML, Spaeth-Rublee B, Puncus HA. Quality Indicators for Physical and Behavioral Health Care Integration. *JAMA.* 2015;314(8):769-770

**Roby DH, Jone EE. Limits on Same-Day Billing in Medicaid Hinders Integration of Behavioral Health into the Medical Home Model. *Psychol Serv*. 2016;13(1):110-119.

ɣCrowley RA, Kirschner N. The Integration of Care for Mental Health, Substance Abuse, and Other Behavioral Health Conditions into Primary Care: Executive Summary of an American College of Physicians Position Paper. *Ann. Intern. Med.* 2015;163(4):298-299.

ɣɣCifuentes M, Davis M, Fernald D, et al. Electronic Health Record Challenges, Workarounds, and Solutions Observed in Practices Integrating Behavioral Health and Primary Care. *JABFM.* 2015;28:S63-S72.
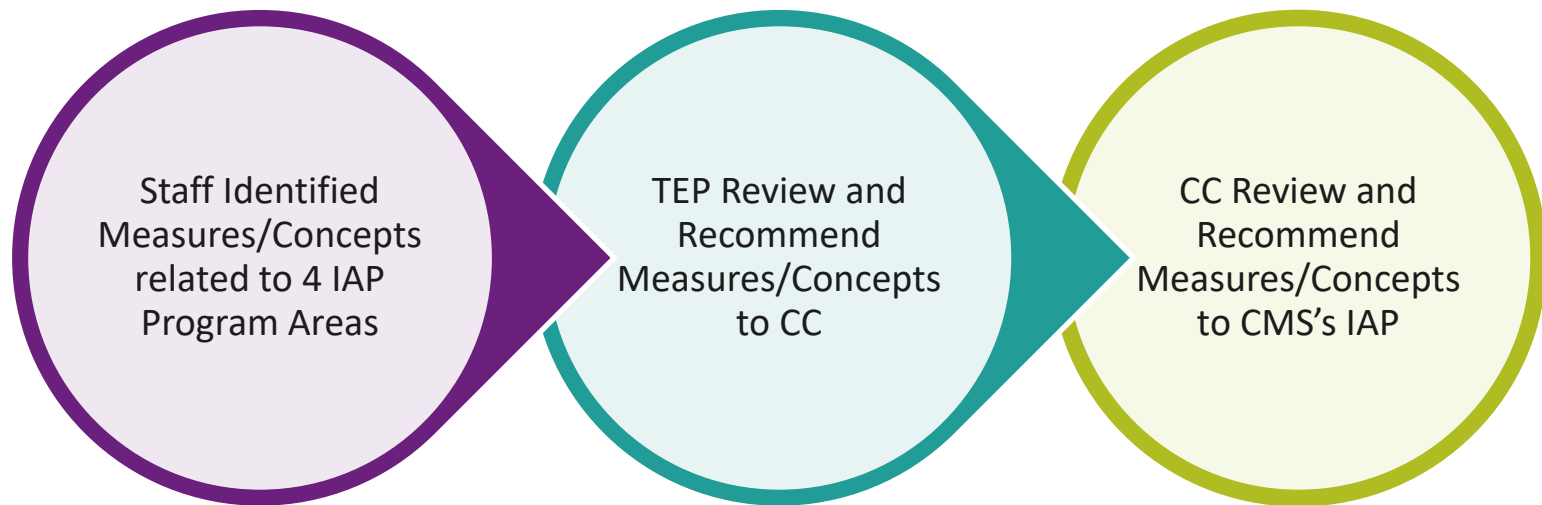
Supporting Physical and Mental Health Integration

- Measure sets should focus on CMS quality domains:
  - *Access*
  - *Care coordination*
  - *Clinical care*
  - *Patient and caregiver experience*
  - *Population health and prevention*
  - *Safety*

- Examples of themes and issues raised during project deliberations to-date:
  - *Knowledge of integration occurring*
  - *Enhanced coordination*
  - *Enhanced collaboration*
  - *Is care occurring at primary care physician's office or remotely?*
  - *Is care coordination the same as integration?*

Questions?

Overview Measure Selection Process

Overview of Measure Selection Process

Staff Identified Measures/Concepts related to 4 IAP Program Areas

TEP Review and Recommend Measures/Concepts to CC

CC Review and Recommend Measures/Concepts to CMS's IAP

Overview TEP Measure Selection Process

TEP Measure Selection Process

- The TEP measure selection process is a standardized approach for selecting "best-available" measures for each IAP program area measure set

- During the in-person meeting, TEP members used this standardized approach to build consensus and vote on measures to include in their measure set recommendations to the CC

- Using a similar standardized approach, the CC will discuss the recommendations made by each TEP and finalize recommendations for measure sets in each IAP program area during an in-person meeting on June 7-8, 2017

Process for Identifying Measure Sets

Step 1. Scan Universe of Measures

Step 2. Capture Measures for Potential Inclusion in the Measure Sets

Step 3. Assign Rankings to Specific Measure Criteria

Step 4. Assign Overall Score to Each Measure

Step 5. Conduct Initial Review and Remove Measures by Measure Score

Step 6. Analyze Measures to Recommend to the Coordinating Committee

Step 1: Scan Universe of Measures

- NQF staff performed a comprehensive search for measures using relevant measure sources

- NQF staff identified measures based on feedback from CMS and multi-stakeholder experts regarding the goals of each program area and the current measurement activities of states' delivery system reform efforts

Step 2: Capture Measures for Potential Inclusion in the Measure Sets

- NQF staff captured measure details on each IAP program area measure summary sheet

- Measures were grouped by CMS quality measurement domain (e.g. access, clinical care, care coordination, safety, patient and caregiver experience, population health and prevention)

- Measures can be organized by type, NQF endorsement, key words, etc.

Step 3: Assign Rankings to Specific Measure Criteria

Measure scores are based on four measure components

- **Feasibility -** the extent to which the specifications require data that are readily available or could be captured without undue burden
  - *High (3): Administrative/Claims*
  - *Medium (2): Paper Record/Medical record/EHR/ Registry data*
  - *Low (1): PRO-PM*
  - *Unsure (0)*

- **Usability** - the extent that potential audiences are using or could use performance results for both accountability and quality improvement
  - *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)*

Step 3: Assign Rankings to Specific Measure Criteria (cont.)

- **Scientific Acceptability** - the extent to which a measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care
  - *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** - 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): There is no evidence of importance to measure*
  - *Unsure (0)*

Step 4: Assign Overall Score to Each Measure

- NQF staff used the criteria to assign an *overall measure score* to each measure in order to rank and organize measures within the measure summary sheets

- The following describes the weight of each of the four criteria in the overall measure score calculation:
  - *Feasibility - 30%*
  - *Usability - 30 %*
  - *Scientific Acceptability - 25%*
  - *Evidence - 15%*

- The overall measure score was used to eliminate measures

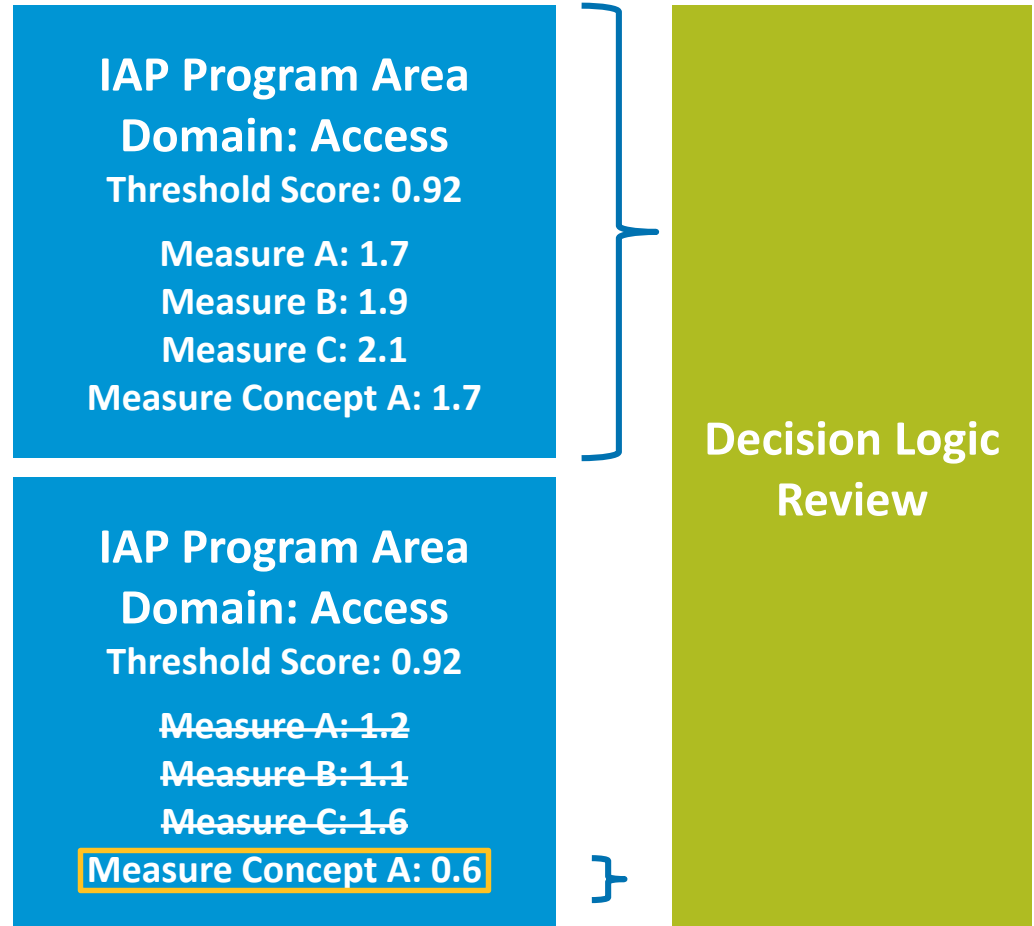# Step 5: Conduct Initial Review and Remove Measures by Measure Score

- In March 2017, TEP members completed a survey to provide feedback on the initial measures captured by staff. The survey included the following questions:
  - *Do these measures capture the most important issues in the program area? If not, are there other measures you think should be added to this list? Please identify.*
  - *Are there measures that you think should NOT be on this list? Please identify.*
  - *Did you identify any measures that would be best placed in a different program area?*
  - *Do you have additional information on any of the measures listed?*

- Staff updated the measure summary sheets based on TEP feedback

Step 5: Conduct Initial Review and Remove Measures by Measure Score (cont.)

- Prior to the in-person meeting, TEP members reviewed their program area measure summary sheet
  - *Summary sheets included overall measure scores as well as the mean score for all measures/concepts in the program area*

- Measures/measure concepts with scores under the mean will not be considered by the TEPs during the in-person meeting with the following exception:
  - » Exception: TEP members can identify measures/concepts that scored under the threshold that they want to retain. TEP members are responsible for providing a rationale for retaining the measure/concepts for consideration. These measures/concepts will then be added to the list of measures for further review.

TEP Decision Process

✓ **Measures/Concepts that meet or exceed the threshold score (total program area-specific mean) automatically continue to the decision logic review**

✓ **Only Measures/Concepts with scores that fall below the mean that TEP members choose to retain in advance of the meeting will move on to the decision logic review**

✓ **Note: TEP members may only select up to 3 measures to retain**

IAP Program Area Domain: Access
Threshold Score: 0.92

Measure A: 1.7
Measure B: 1.9
Measure C: 2.1
Measure Concept A: 1.7

IAP Program Area Domain: Access
Threshold Score: 0.92

~~Measure A: 1.2~~
~~Measure B: 1.1~~
~~Measure C: 1.6~~
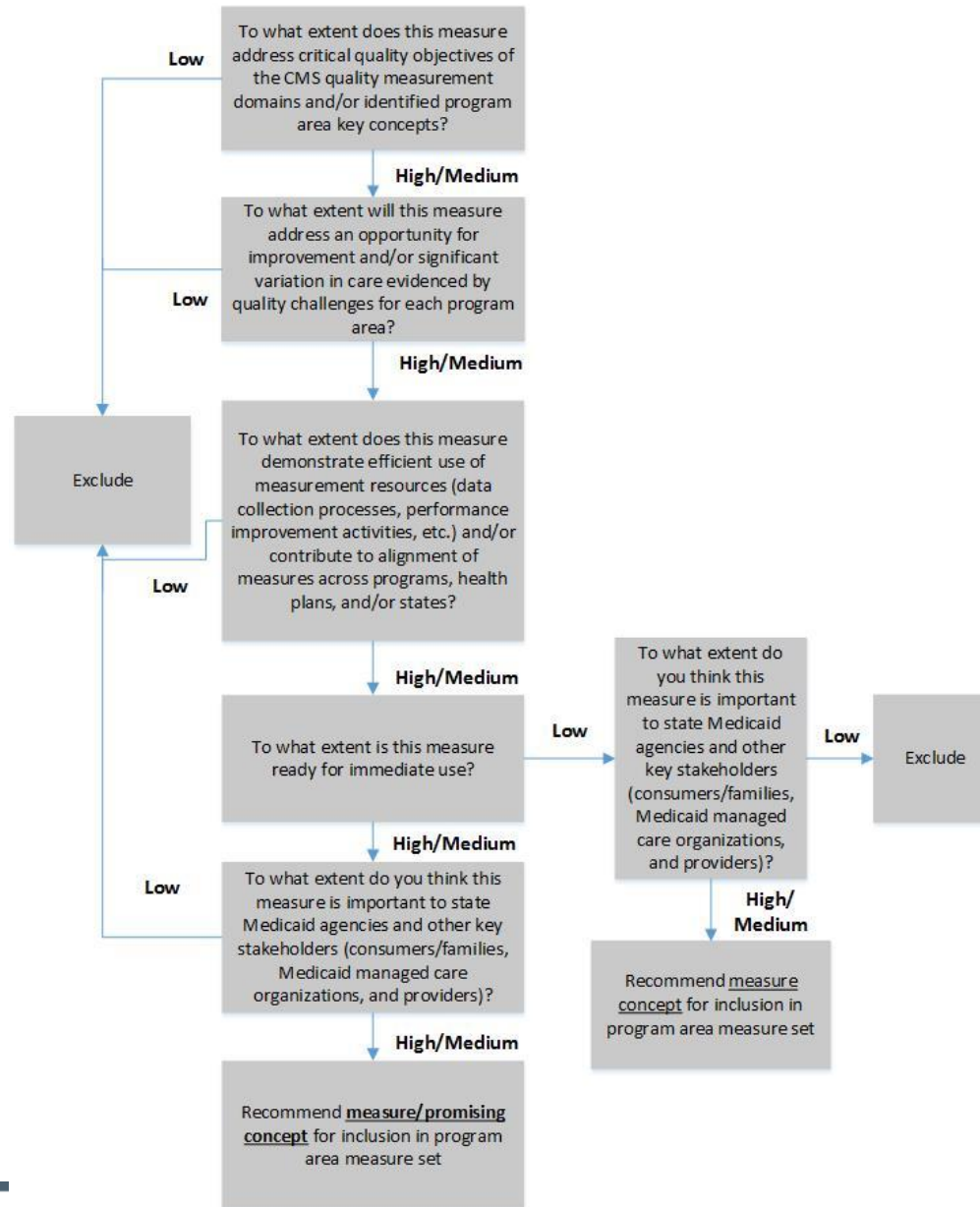Measure Concept A: 0.6

Decision Logic Review

Step 6: Analyze Measures to Recommend to the Coordinating Committee (CC)

- TEPs evaluated the remaining measures individually against criteria of the decision logic
  - *TEPs leveraged discussion questions to guide their conversation*

- Each measure was considered against specific criteria (questions) using the following indicators: High (H); Medium (M); and Low (L)

- The indicators describe the degree to which the measure fits each criterion. The measures/concepts continued through the decision logic based on the TEP vote of High (H); Medium (M); and Low (L)

Decision Logic

Step 6: Analyze Measures to Recommend to the Coordinating Committee (CC) (Cont.)

- The decision logic results for each measure/concept will yield the following:
  - *The measure/ (promising) measure concept is recommended for inclusion in the program area measure set; or*
  - *The measure/ (promising) measure concept is NOT recommended for inclusion in the program area measure set*

TEP Voting

- TEP members utilized a hand vote
  - *State presenters did not participate in voting*

- A vote required at least 60% agreement to move forward
  - *Each decision to support or not support was accompanied by one or more statements of rationale as to how and why each decision was reached.*

- TEPs voted on measures and measure concepts by CMS quality measurement domain

- The measure sets were recommended to the Coordinating Committee for consideration

Questions?

Overview CC Measure Selection Process

CC Measure Selection Process Overview

- Following the TEPs' review of the program area measures, the CC will:
  - *Review measures evaluated by the TEPs to assure agreement with the recommendations*
  - *Review newly submitted measures and measures recommended to move to another TEP for recommendation using the decision logic*
  - *Review related measures in order to determine the "best in class" for final recommendation*
  - *Submit four sets of measures that can be used to support states' health care delivery efforts to CMS's IAP*

CC Process for Selecting Program Measure Sets

Step 1. Evaluate newly submitted measures/concepts and items moved from one program area to another using the decision logic/vote

Step 2. Evaluate measures identified for reconsideration during the CC pre-work using the decision logic

Step 3. Review related measures within the program area and determine "best in class"

Step 4. Review measure set in full and use decision logic to vote to remove measures identified as unsuitable

Step 5: Vote en bloc on all remaining measures/concepts for final recommendation to CMS's IAP.

Step 1: Evaluate New and Moved Measures and Concepts

- The CC will use an updated decision logic to review:
    - *Late submitted measures that were not reviewed by the TEPs; and*
    - *Measures that the TEPs recommended for consideration by a different program area.*

- The CC will evaluate the measures/concepts using the updated decision logic. Measures that receive >60% vote will be added to the measure sets for final recommendation to CMS.

- CC members will use a hand-held device to cast votes on these measures

Step 2: Evaluate Measures the CC Identified for Reconsideration

- Prior to the in-person meeting, members of the CC received the Measure Summary Sheets for all four program areas. CC members were able to identify <u>one</u> measure or concept for reconsideration.
  - *Measures eligible for reconsideration were those that the TEPs discussed during their in-person meeting but that did not pass the decision logic and were therefore not recommended.*

- CC members will serve as lead discussants and present a rationale for measures they choose to recover.

- The CC will reconsider the measures/concepts using the updated decision logic. Measures that receive >60% vote will be added to the measure sets for final recommendation to CMS.

- CC members will use the voting system to cast votes on these measures.

Step 3: Review Related Measures within the Program Area and Determine "Best in Class"

- Next, NQF staff will present tables of measures that are identified as related.
  - *Related measures are those that have either the same measure focus or the same target population.*

- The Committee will discuss the related measures to identify the "best in class" among the group.
  - *A best in class measure is one that captures a broad population (encompassing a population of different ages, multiple conditions, etc.); is targeted on a key issue in the program area; and contributes to alignment.*

- The CC will vote to remove measures from the bloc based on the examination of related measures. Measures that receive >60% vote will be eliminated from the bloc of recommended measures.

Step 4: Review Measure Set in Full and Identify Unsuitable Measures for Elimination

- Next the CC will review the program area measure set as a whole. This set of measures will include:
  - *All measures/concepts recommended by the TEPs*
  - *Additional measures reviewed by the CC that received >60% vote*
  - *Measures that were moved from one measure set to another and received >60% vote*
  - *Measures that remained following the review of related measures*

- At this time, CC members may move to remove a measure/concept from the set. The motion must receive a second in order to open discussion. Following CC discussion of the measure/concept, the CC will vote to remove the measure from the set.

- Measures must receive >60% vote to be eliminated from the measure set.

Step 5: Vote en bloc on all Remaining Measures/Concepts for Final Recommendation to CMS

- Following review of the measure set as a whole, the CC will vote en bloc to recommend all remaining measures.

- Each measure set must receive >60% vote for final recommendation to CMS's IAP.

Voting Procedure

- Members of the CC will cast their votes using the voting system for:
  - *Evaluation of newly submitted measures*
  - *Evaluation of measures in a new program area*
  - *Evaluation of measures recovered by a member of the CC*
  - *Final block vote on measure set recommendations*

- Members of the CC will utilize a hand vote to:
  - *Review and remove of related measures*
  - *Review measures pulled from bloc of measures for possible removal*

Decision Logic
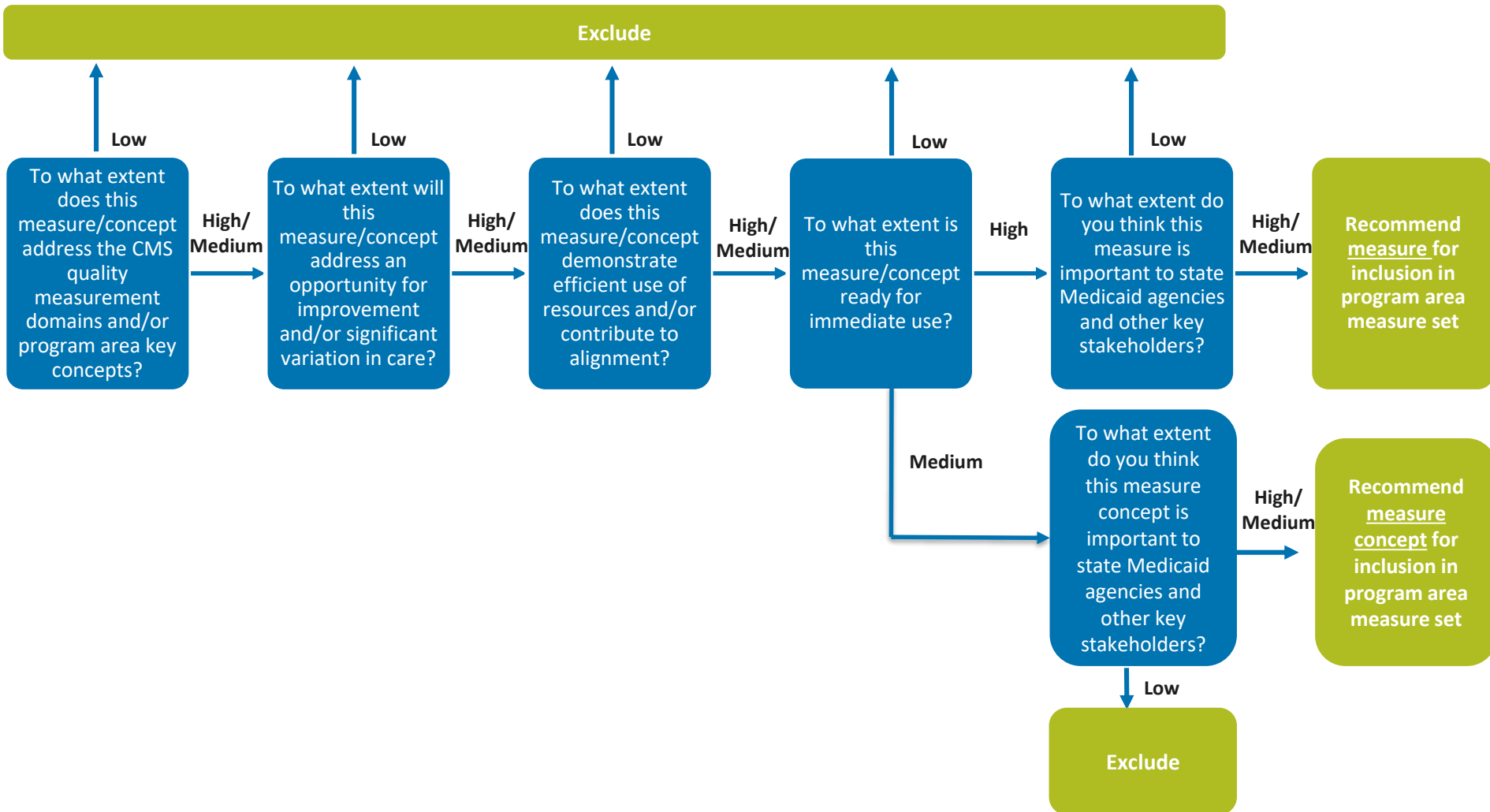
Coordinating Committee Decision Logic

- To what extent does this measure/concept address critical quality objectives of the CMS quality measurement domains (e.g., access, clinical care, care coordination, safety, patient and caregiver experience, and population health and prevention) and/or identified program area key concepts (please refer to program area measure summary sheets for a list of key concepts)?

  - *High: Measure addresses a CMS quality measurement domain(s) and program area key concepts*

  - *Medium: Measure addresses CMS quality measurement domains but does not address program area key concepts*

  - *Low: Measure does not clearly address CMS quality measurement domains or program area key concepts*

Coordinating Committee Decision Logic (Cont.)

- To what extent will this measure/concept address an opportunity for improvement and/or significant variation in care evidenced by quality challenges (e.g. access to care/services, readmission rates, etc.) for each program area?

  - *High: Addresses multiple quality challenges and opportunities for improvement within a program area*

  - *Medium: Measure has the potential to address variation in care and quality challenge*

  - *Low: Measure does not address quality challenges or opportunities for improvement within a program area*

Coordinating Committee Decision Logic (Cont.)

- To what extent does this measure/concept demonstrate efficient use of measurement resources (data collection processes, performance improvement activities, etc.) and/or contribute to alignment of measures across programs, health plans, and/or states? The measure is not duplicative of existing measures within the measure set, captures a broad population (encompasses population of different ages, multiple conditions, etc.).

  - *High: Measure demonstrates efficient use of measurement resources, addresses a broad population, is not duplicative of existing measures and contributes to alignment across states/programs and health plans*

  - *Medium: Measure is not duplicative of other measures and does address some areas of alignment but does not encompass broad populations.*

  - *Low: No evidence that the measure demonstrates/addresses any of the above criteria (e.g., does not demonstrate efficient use of measurement resources, address a broad population, nor contribute to alignment. There are other measures similar to this one already in use.*

Coordinating Committee Decision Logic (Cont.)

- To what extent is this measure/concept ready for immediate use?
  - *High: A fully developed measure that includes detailed specifications and may have undergone scientific testing and is currently in use or planned to be used in states*
  - *Medium: A measure concept that includes a description, numerator and denominator and is currently in use or planned to be used in states*
  - *Low:*
    - » A measure or measure concept that is not in use or planned for use in the Medicaid populations, OR
    - » A measure concept with no indication of specifications (cannot be easily replicated)

Coordinating Committee Decision Logic (Cont.)

- To what extent do you think this measure/concept is important to state Medicaid agencies and other key stakeholders (consumers/families, Medicaid managed care organizations, and providers)?
  - *High: Important to state Medicaid agencies and beneficiaries/families*
  - *Medium: Important to two stakeholders including state Medicaid agencies*
  - *Low: Important to one stakeholder*

Questions?

Opportunity for Public Comment

Break

Review of BCN Measure Set

CC's Role in Reviewing Measure Sets

- For each measure set review, members of the CC will:
  - *Evaluate new and moved measures for inclusion in the final measure set*
  - *Evaluate measures that were not recommended by the TEPs but were recovered by a member of the CC for possible inclusion in the measure set*
  - *Examine related measures and remove measures that are redundant*
  - *Remove measures that were recommended by the TEPs from the final recommendations*
  - *Cast final vote on overall measure sets*

Review of BCN TEP Discussion

- The TEP reviewed 46 measures/measure concepts and recommended 14 measure and 6 measure concepts to the Coordinating Committee.

- Throughout their deliberations, the TEP discussed several themes:

  - *Ambiguity surrounding the definition of the BCN population posed a challenge in identifying best-available quality measures.*

    » 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 favored broad measures that encompass multiple conditions over measures with a single condition (e.g. follow-up measures focusing on mental illness versus schizophrenia)*

Review of BCN TEP Discussion (cont.)

- TEP members noted that 7 measures they voted to include were currently specified for Medicare and may not be appropriate. NQF staff and CMS agreed that they do not align with the scope of the project and removed them from consideration.

  - *NQF #1789 Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)*
  - *NQF #2380 Rehospitalization During the First 30 Days of Home Health*
  - *NQF #2502 All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Inpatient Rehabilitation Facilities (IRFs)*
  - *NQF #2505 Emergency Department Use without Hospital Readmission During the First 30 Days of Home Health*
  - *NQF #2510 Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM)*
  - *NQF #2860 Thirty-day all-cause unplanned readmission following psychiatric hospitalization in an inpatient psychiatric facility (IPF)*
  - *NQF #2888 Risk-Standardized Acute Admission Rates for Patients with Multiple Chronic Conditions*

New BCN Measures for review

- BCN received no late-submission measures for consideration

- TEP members recommended 4 measures from other program areas for consideration
  - *Adult Access to Preventive/Ambulatory Care 20-44, 45-64, 65+*
  - *Clinical Risk Score*
  - *Referral To Community Based Health Resources*
  - *NQF #1888 Workforce development measure derived from workforce development domain of the C-CAT*

- CC vote to support/not support inclusion of TEP recommended measures

BCN Measures for Reconsideration

- The CC identified 2 measures for reconsideration among those not recommended by the BCN TEP.
  - *NQF #2483 Gains in Patient Activation (PAM) Scores at 12 Months*
  - *NQF #2631 Percent of Long-Term Care Hospital (LTCH) Patients With an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function*

- CC vote to support/not support inclusion of reconsidered measures

BCN Related Measures for Review

- No related measures were identified under the LTSS program area.

Lunch

BCN Measure Set

- Follow-up after all-cause emergency department visit*
- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)*
- Medication reconciliation post-discharge: percentage of discharges from January 1 to December 1 of the measurement year for members 18 years of age and older for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days)
- NQF #0097 Medication Reconciliation Post-Discharge
- NQF #0105 Antidepressant Medication Management (AMM)
- NQF #0576 Follow-Up After Hospitalization for Mental Illness (FUH)
- NQF #0648 Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)
- NQF #0709 Proportion of patients with a chronic condition that have a potentially avoidable complication during a calendar year.
- NQF #1598 Total Resource Use Population-based PMPM Index
- NQF #1604 Total Cost of Care Population-based PMPM Index

*(Promising) Measure Concept

BCN Measure Set (cont.)

- NQF #2371 Annual Monitoring for Patients on Persistent Medications (MPM)
- NQF #2456 Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient
- NQF #2605 Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence
- NQF# 1768 Plan All-Cause Readmissions (PCR)
- Potentially avoidable emergency department utilization*
- Potentially Preventable Emergency Room Visits*
- Potentially Preventable Emergency Room Visits (for persons with BH diagnosis)*
- Potentially Preventable Readmissions*
- Prevention Quality Indicators #90 (PQI #90)
- Psychiatric Inpatient Readmissions – Medicaid (PCR-P)

*(Promising) Measure Concept

Vote on Final Measure Set

- After a removal discussion and vote, the CC will vote en bloc to pass the final measure set.

Opportunity for Public Comment

Break

Review of SUD Measure Set

CC's Role in Reviewing Measure Sets

- For each measure set review, members of the CC will:
  - *Evaluate new and moved measures for inclusion in the final measure set*
  - *Evaluate measures that were not recommended by the TEPs but that were recovered by a member of the CC for possible inclusion in the measure set*
  - *Examine related measures and remove measures that are redundant*
  - *Remove measures that were recommended by the TEPs from the final recommendations*
  - *Cast final vote on overall measure sets*

Reducing Substance Use Disorders (SUD)

- Overall, the SUD TEP reviewed 43 measures/ measure concepts and recommended 19 measures and 6 measure concept to the CC

- During the in-person meeting, several themes emerged as part of the TEP's discussion:
  - *The need for a cascade of SUD measures that started with screening and ended with assessment and intervention.*
  - *The need to broaden the existing tobacco measures to include tobacco, drugs, and other nicotine products.*
  - *Critical gap areas including: substance abuse measures that focus on pregnant women and the lack of available outcome measures.*
  - *Available process measures that set a low bar.*

New SUD Measures for Review

- SUD received no late-submission measures for consideration

- TEP members recommended 1 measure from another program area for consideration
  - *Adult Access to Preventive/Ambulatory Care 20-44, 45-64, 65+*

- CC vote to support/not support inclusion of reconsidered measures

SUD Measures for Reconsideration

- The CC identified 3 measures for reconsideration among those not recommended by the SUD TEP.

- CC vote to support/not support inclusion of:
  - *Mental Health/substance abuse: mean of patients' overall change on the BASIS 24-survey*
  - *NQF #2806: Screening for SUD in child/adolescents with psychosis*
  - *NQF #2951: Use of Opioids at High Dosages from Multiple Providers in Persons with Cancer*

SUD Related Measures for Review

	NQF #2599: Alcohol Screening and Follow-up for People with Serious Mental Illness	NQF #2597: Substance Use Screening and Intervention Composite (Composite Measure)	NQF #2600: Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence
Description	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.	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	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. Two rates are reported. (Full description available in SUD Discussion Guide)
Numerator	Patients 18 years and older who are screened for unhealthy alcohol use during the last 3 months of the year prior to the measurement year through the first 9 months of the measurement year and received two events of counseling if identified as an unhealthy alcohol user.	Patients who received the following substance use screenings at least once within the last 24 months AND who received an intervention for all positive screening results: **Tobacco use component:** (full text available in SUD Discussion Guide) **Unhealthy alcohol use component:** (full text available in the SUD Discussion Guide) **Drug Use Component:** (full text available in the SUD Discussion Guide)	**Rate 1**: Screening for tobacco use in patients with serious mental illness during the measurement year or year prior to the measurement year and received follow-up care if identified as a current tobacco user. **Rate 2**: Screening for tobacco use in patients with alcohol or other drug dependence during the measurement year or year prior to the measurement year and received follow-up care if identified as a current tobacco user.
Denominator	All patients 18 years of age or older as of December 31 of the measurement year with at least one inpatient visit or two outpatient visits for schizophrenia or bipolar I disorder, or at least one inpatient visit for major depression during the measurement year.	All patients aged 18 years and older who were seen twice for any visits or who had at least one preventive care visit during the 12 month measurement period	**Rate 1**: All patients 18 years of age or older as of December 31 of the measurement year with at least one inpatient visit or two outpatient visits for schizophrenia or bipolar I disorder, or at least one inpatient visit for major depression during the measurement year. **Rate 2**: All patients 18 years of age or older as of December 31 of the measurement year with any diagnosis of alcohol or other drug dependence during the measurement year.
Data Source	EHR (Only), Claims, Paper Records	EHR (Only), Other	Claims, EHR (Only), Paper Records
Level of Analysis	Health Plan	Clinician: Group/Practice, Clinician: Group/Practice	Health Plan
Care Setting	Behavioral Health: Outpatient, Clinician Office/ Clinic /Physician Practice	Behavioral Health: Outpatient, Clinician Office/ Clinic /Physician Practice	Behavioral Health: Outpatient, Clinician Office/ Clinic /Physician Practice

SUD Related Measures for Review

	NQF #2940: Use of Opioids at High Dosage in Persons Without Cancer	NQF #2950: Use of Opioids from Multiple Providers in Persons Without Cancer	NQF #2951: Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer. (Recovered measure)
Description	The proportion (XX out of 1,000) of individuals without cancer receiving a daily dosage of opioids greater than 120mg morphine equivalent dose (MED) for 90 consecutive days or longer.	The proportion (XX out of 1,000) of individuals without cancer receiving prescriptions for opioids from four (4) or more prescribers AND four (4) or more pharmacies.	The proportion (XX out of 1,000) of individuals without cancer receiving prescriptions for opioids greater than 120mg morphine equivalent dose (MED) for 90 consecutive days or longer, AND who received opioid prescriptions from four (4) or more prescribers AND four (4) or more pharmacies.
Numerator	Any member in the denominator with greater than 120 MME for > 90 consecutive days*	Any member in the denominator who received opioids from 4 or more prescribers AND 4 or more pharmacies.	Any member in the denominator with greater than 120 MME for > 90 consecutive days* AND who received opioid prescriptions from 4 or more prescribers AND 4 or more pharmacies.
Denominator	Any member with two or more prescription claims for opioids filled on at least two separate days, for which the sum of the days supply is > 15	Any member with two or more prescription claims for opioids filled on at least two separate days, for which the sum of the days supply is > 15.	Any member with two or more prescription claims for opioids filled on at least two separate days, for which the sum of the days supply is > 15
Data Source	Claims	Claims	Claims
Level of Analysis	Health Plan, Population: Community, County, Region or State, Other	Health Plan, Population: Community, County, Region or State, Other	Unsure
Care Setting	Pharmacy, Other	Pharmacy, Other	Unsure

SUD Related Measures for Review

	NQF #3225 (formerly 0028) Preventative Care and Screening: Tobacco Use: Screening and Cessation Intervention	NQF #2600: Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence
Description	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 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. Two rates are reported. **Rate 1:** The percentage of patients 18 years and older with a diagnosis of serious mental illness who received a screening for tobacco use and follow-up for those identified as a current tobacco user. Rate 2: Screening for tobacco use in patients with alcohol or other drug dependence during the measurement year or year prior to the measurement year and received follow-up care if identified as a current tobacco user.
Numerator	Patients who were screened for tobacco use* at least once within 24 months AND who received tobacco cessation counseling intervention** if identified as a tobacco user *Includes use of any type of tobacco ** Cessation counseling intervention includes brief counseling (3 minutes or less), and/or pharmacotherapy	**Rate 1:** Screening for tobacco use in patients with serious mental illness during the measurement year or year prior to the measurement year and received follow-up care if identified as a current tobacco user. **Rate 2**: Screening for tobacco use in patients with alcohol or other drug dependence during the measurement year or year prior to the measurement year and received follow-up care if identified as a current tobacco user.
Denominator	All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period	**Rate 1**: All patients 18 years of age or older as of December 31 of the measurement year with at least one inpatient visit or two outpatient visits for schizophrenia or bipolar I disorder, or at least one inpatient visit for major depression during the measurement year. **Rate 2**: All patients 18 years of age or older as of December 31 of the measurement year with any diagnosis of alcohol or other drug dependence during the measurement year.
Data Source	Claims, Registry	Claims, EHR (Only), Paper Records
Level of Analysis	Clinician: Group/Practice, Clinician: Individual	Health Plan
Care Setting	Behavioral Health: Outpatient, Clinician Office/ Clinic /Physician Practice, Home Health, Other	Behavioral Health: Outpatient, Clinician Office/ Clinic /Physician Practice

SUD Related Measures

- Does a Committee member want to pull a measure for removal?

- CC will vote to remove related measures

SUD Measure Set

- Documentation of Signed Opioid Treatment Agreement
- Evaluation or Interview for Risk of Opioid Misuse
- NQF #0004 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)
- NQF #1664 SUB-3 Alcohol and other Drug Use Disorder Treatment Provided or Offered at Discharge
- NQF #2152 Preventive Care and Screening: Unhealthy Alcohol Use
- NQF #2597 Substance Use Screening and Intervention Composite (Composite Measure)
- NQF #2599 Alcohol Screening and Follow-up for People with Serious Mental Illness
- NQF #2600 Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence
- NQF #2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Dependence

*(Promising) Measure Concept

SUD Measure Set (cont.)

- NQF# 2940 Use of Opioids at High Dosage in Persons Without Cancer
- NQF# 2950 Use of Opioids from Multiple Providers in Persons Without Cancer
- NQF#1661 SUB-1 Alcohol Use Screening
- NQF#1663 SUB-2 Alcohol Use Brief Intervention Provided or Offered and SUB-2a Alcohol Use Brief Intervention
- NQF: #1654 TOB - 2 Tobacco Use Treatment Provided or Offered and the subset measure TOB-2a Tobacco Use Treatment
- NQF: #1656 TOB - 3 Tobacco Use Treatment Provided or Offered at Discharge and the subset measure TOB-3a Tobacco Use Treatment at Discharge
- NQF: #3225 (formerly #0028) Preventative Care and Screening: Tobacco Use: Screening and Cessation Intervention
- Percent of patients prescribed a medication for alcohol use disorder

SUD Measure Set (cont.)

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

*(Promising) Measure Concept

SUD Measure Set (cont.)

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

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

Vote on Final Measure Set

- After a removal discussion and vote, the CC will vote en bloc to pass the final measure set.

Opportunity for Public Comment

NQF Medicaid Innovation Accelerator Project 2016-2017

Coordinating Committee In-Person Meeting – Day 2

June 7-8, 2017

Review of PMH Measure Set

CC's Role in Reviewing Measure Sets

- For each measure set review, members of the CC will:
  - *Evaluate new and moved measures for inclusion in the final measure set*
  - *Evaluate measures that were not recommended by the TEPs but that were recovered by a member of the CC for possible inclusion in the measure set*
  - *Examine related measures and remove measures that are redundant*
  - *Remove measures that were recommended by the TEPs from the final recommendations*
  - *Cast final vote on overall measure sets*

Review of PMH TEP Discussion

- Overall, the TEP reviewed 44 measures/ measure concepts and recommended 23 measures and 2 measures concepts (including promising).

- Several themes arose during their deliberation:
  - *The need to stratify measures by conditions, which allows providers to identify those individuals who had a behavioral health diagnosis as either primary or secondary. This would allow states or providers to access integrated care.*
  - *Measures that lack the specificity needed to address the targeted population.*
  - *Ease of measure collection, specifically related to electronic health records and paper records.*

New PMH Measures for review

- The CC received 2 late-submission measures for consideration
  - *Post-Partum Followup and Care Coordination*
  - *Parkinson's Disease: Psychiatric Symptoms Assessment for Patients with Parkinson's Disease*

- The TEPs recommended 6 measures from other program areas for consideration
  - *Adult Access to Preventive/Ambulatory Care 20-44, 45-64, 65+*
  - *Clinical Risk Score*
  - *Referral To Community Based Health Resources*
  - *Adherence to Antipsychotics for Individuals with Schizophrenia*
  - *NQF #1922 HBIPS-1 Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths Completed*
  - *NQF: #1888 Workforce development measure derived from workforce development domain of the C-CAT*

- CC vote to support/not support inclusion of late submissions and TEP recommended measures

PMH Measures for Reconsideration

- The CC identified 2 measures for reconsideration among those not recommended by the PMH TEP.
  - *NQF #2602 Controlling High Blood Pressure for People with Serious Mental Illness*
  - *NQF #0710 Depression Remission at Twelve Months*

- CC vote to support/not support inclusion of reconsidered measures

PMH Related Measures for Review

	NQF #0097 Medication Reconciliation Post-Discharge	NQF #0419 Documentation of Current Medications in the Medical Record
Description	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.	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. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration
Numerator	Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist or registered nurse on or within 30 days of discharge. Medication reconciliation is defined as a type of review in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record.	The Numerator statement for the most recent versions of the measure is as follows (for both the 2015 Claims and Registry version and the 2014 e Measure version): Eligible professional attests to documenting, updating, or reviewing patient´s current medications using all immediate resources available on the date of the encounter. This list must include ALL prescriptions, over-the counters, herbals, vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosages, frequency, and route
Denominator	All discharges from an in-patient setting for patients who are 18 years and older.	2015 Claims and Registry Denominator statement: All visits for patients aged 18 years and older 2014 e Measure Denominator statement: Equals the Initial Patient Population (IPP) The IPP is defined as, "All visits occurring during the 12 month reporting period for patients aged 18 years and older before the start of the measurement period"
Data Source	Claims, EHR (Only), Paper Records	Claims (Only), Other, Registry
Level of Analysis	Clinician: Group/Practice, Clinician: Individual, Health Plan, Integrated Delivery System	Clinician : Group/Practice, Clinician : Individual
Care Setting	Clinician Office/ Clinic /Physician Practice	Clinician Office/Clinic

PMH Related Measures for Review

	NQF #0105 Antidepressant Medication Management (AMM)	NQF #1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder
Description	The percentage of patients 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported. a) Effective Acute Phase Treatment. The percentage of newly diagnosed and treated patients who remained on an antidepressant medication for at least 84 days (12 weeks). b) Effective Continuation Phase Treatment. The percentage of newly diagnosed and treated patients who remained on an antidepressant medication for at least 180 days (6 months).	Percentage of individuals at least 18 years of age as of the beginning of the measurement period with bipolar I disorder who had at least two prescription drug claims for mood stabilizer medications and had a Proportion of Days Covered (PDC) of at least 0.8 for mood stabilizer medications during the measurement period (12 consecutive months)
Numerator	a) Effective Acute Phase Treatment: At least 84 days (12 weeks) of continuous treatment with antidepressant medication during the 114-day period following the Index Prescription Start Date (IPSD) (115 total days). The continuous treatment allows gaps in medication treatment up to a total of 30 days during the 115-day period. b) Effective Continuation Phase Treatment: At least 180 days (6 months) of continuous treatment with antidepressant medication during the 232-day period following the IPSD. Continuous treatment allows gaps in medication treatment up to a total of 51 days during the 232-day period.	Individuals with bipolar I disorder who had at least two prescription drug claims for mood stabilizer medications and have a PDC of at least 0.8 for mood stabilizer medications.
Denominator	Patients 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication.	Individuals at least 18 years of age as of the beginning of the measurement period with bipolar I disorder and at least two prescription drug claims for mood stabilizer medications during the measurement period (12 consecutive months).
Data Source	EHR (Only), Other, Paper Records	Claims (Only), Other, Pharmacy
Level of Analysis	Health Plan, Integrated Delivery System	Clinician: Group/Practice, Health Plan, Integrated Delivery System, Population: Regional and State
Care Setting	Clinician Office/ Clinic /Physician Practice	Behavioral Health: Outpatient, Clinician Office/Clinic

PMH Related Measures for Review

	NQF #2599 Alcohol Screening and Follow-up for People with Serious Mental Illness	NQF #2600 Tobacco Use Screening and Follow-up for People with Serious Mental Illness (SMI) 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)
Description	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 percentage of patients 18 years and older with a 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. Two rates are reported. Rate 1: The percentage of patients 18 years and older with a diagnosis of SMI who received a screening for tobacco use and follow-up for those identified as a current tobacco user. Rate 2: The percentage of adults 18 years and older with a diagnosis of alcohol or other drug dependence who received a screening for tobacco use and follow-up for those identified as a current tobacco user.	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. Two rates are reported: (The percentage of discharges for which the patient received follow-up within 30 days of discharge and the percentage of discharges for which the patient received follow-up within 7 days of discharge.)	The percentage of discharges for individuals 18 – 64 years of age who were hospitalized for treatment of schizophrenia and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported. •The percentage of individuals who received follow-up within 30 days of discharge •The percentage of individuals who received follow-up within 7 days of discharge
Numerator	Patients 18 years and older who are screened for unhealthy alcohol use during the last 3 months of the year prior to the measurement year through the first 9 months of the measurement year and received two events of counseling if identified as an unhealthy alcohol user.	Rate 1: Screening for tobacco use in patients with serious mental illness during the measurement year or year prior to the measurement year and received follow-up care if identified as a current tobacco user. Rate 2: Screening for tobacco use in patients with alcohol or other drug dependence during the measurement year or year prior to the measurement year and received follow-up care if identified as a current tobacco user.	30-Day Follow-Up: An outpatient visit, intensive outpatient visit or partial hospitalization with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient visits or partial hospitalizations that occur on the date of discharge. 7-Day Follow-Up: An outpatient visit, intensive outpatient visit or partial hospitalization with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient visits or partial hospitalizations that occur on the date of discharge.	30-Day Follow-Up: An outpatient visit, intensive outpatient encounter or partial hospitalization (Table–C) with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge. 7-Day Follow-Up: An outpatient visit, intensive outpatient encounter or partial hospitalization (Table–C) with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge.

PMH Related Measures for Review (cont.)

	NQF #2599 Alcohol Screening and Follow-up for People with Serious Mental Illness	NQF #2600 Tobacco Use Screening and Follow-up for People with Serious Mental Illness (SMI) 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)
Denominator	All patients 18 years of age or older as of December 31 of the measurement year with at least one inpatient visit or two outpatient visits for schizophrenia or bipolar I disorder, or at least one inpatient visit for major depression during the measurement year.	Rate 1: All patients 18 years of age or older as of December 31 of the measurement year with at least one inpatient visit or two outpatient visits for schizophrenia or bipolar I disorder, or at least one inpatient visit for major depression during the measurement year. Rate 2: All patients 18 years of age or older as of December 31 of the measurement year with any diagnosis of alcohol or other drug dependence during the measurement year.	Patients 6 years and older as of the date of discharge who were discharged from an acute inpatient setting (including acute care psychiatric facilities) with a principal diagnosis of mental illness during the first 11 months of the measurement year (e.g., January 1 to December 1).	Adults 18 – 64 years of age of December 31 of the measurement year Discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal schizophrenia diagnosis.
Data Source	Claims, EHR (Only), Paper Records	Claims, EHR (Only), Paper Records	Claims, EHR (Only)	Claims
Level of Analysis	Health Plan	Health Plan	Health Plan, Integrated Delivery System	Health Plan, Population: Community, County, Region or State
Care Setting	Behavioral Health: Outpatient, Clinician Office/ Clinic /Physician Practice	Behavioral Health: Outpatient, Clinician Office/ Clinic /Physician Practice	Behavioral Health: Inpatient, Behavioral Health: Outpatient, Clinician Office/ Clinic /Physician Practice, Hospital	Other

PMH Related Measures

- Does a Committee member want to pull a measure for removal?

- CC will vote to remove related measures

Break

PMH Measure Set

- Combined BH-PH Inpatient 30-Day Readmission Rate for Individuals With SMI Eligible Population, Denominator and Numerator Specifications*

- Depression Remission or Response for Adolescents and Adults

- Follow-Up After Emergency Department Visit for Mental Illness

- Mental Health Service Penetration

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

- NQF #0097 Medication Reconciliation Post-Discharge

- NQF #0105 Antidepressant Medication Management (AMM)

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

*(Promising) Measure Concept

PMH Measure Set (cont.)

- NQF #0419 Documentation of Current Medications in the Medical Record
- NQF #0576 Follow-Up After Hospitalization for Mental Illness (FUH)
- NQF #1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia
- NQF #1880 Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder
- NQF #1927 Cardiovascular Health Screening for People With Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications
- NQF #1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)
- NQF #1933 Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)
- NQF #1934 Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)
- NQF #1937 Follow-Up After Hospitalization for Schizophrenia (7- and 30-day)

PMH Measure Set (cont.)

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

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

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

- NQF #2604 Diabetes Care for People with Serious Mental Illness: Medical Attention for Nephropathy

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

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

- NQF #2609 Diabetes Care for People with Serious Mental Illness: Eye Exam

- PACT Utilization for Individuals with Schizophrenia*

*(Promising) Measure Concept

Vote on Final Measure Set

- After a removal discussion and vote, the CC will vote en bloc to pass the final measure set.

Opportunity for Public Comment

Lunch

Review of LTSS Measure Set

CC's Role in Reviewing Measure Sets

- For each measure set review, members of the CC will:
  - *Evaluate new and moved measures for inclusion in the final measure set*
  - *Evaluate measures that were not recommended by the TEPs but that were recovered by a member of the CC for possible inclusion in the measure set*
  - *Examine related measures and remove measures that are redundant*
  - *Remove measures that were recommended by the TEPs from the final recommendations*
  - *Cast final vote on overall measure sets*

Promoting Community Integration through Community-Based Long-Term Services and Supports

- Overall, the LTSS TEP reviewed 22 measures/measure concepts and recommended 6 measures and 7 measure concepts (including promising measures).

- Members of the LTSS TEP discussed two main themes during the TEP in-person meeting:

  - *The critical need for standardized language across providers (e.g. 'individual care plan' has a different meaning for different LTSS providers)*

  - *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.

New LTSS Measures for review

- LTSS received no late-submission measures for consideration

- There were no recommended measures from other program areas for consideration

- LTSS TEP members requested CC review of the following measure:

  - *NQF 1888: Workforce development measure derived from workforce development domain of the C-CAT*

LTSS Measures for Reconsideration

- The CC identified 2 measures for reconsideration among those not recommended by the LTSS TEP.
    - *NQF #0097: Measure of Medication Reconciliation*
    - *Percentage of short-Stay Residents who were Successfully Discharged to the Community*

LTSS Related Measures for Review

- No related measures were identified under the LTSS program area.

LTSS Measure Set

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

- NQF #0326: Advance Care Plan

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

- NQF #0101: Falls: Screening for Fall Risk

- NQF #2483: Gains in Patient Activation (PAM) Scores at 12 Months

- Home- and Community-Based Long Term Services and Supports Use Measure Definition (HCBS) *(promising)

- Individualized Plan of Care Completed*

- National Core Indicators – Aging and Disability*(promising)

- National Core Indicators*(promising)

*(Promising) Measure Concept

LTSS Measure Set (cont.)

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

- Referral To Community Based Health Resources*

- 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)

*(Promising) Measure Concept

Vote on Final Measure Set

- After a removal discussion and vote, the CC will vote en bloc to pass the final measure set.

Opportunity for Public Comment

Break

Review of Measure Sets to Inform Future Considerations

Final Review– All Measure Sets

- Balanced measure sets with equal amount of process, outcome, patient-reported outcome (PRO), etc. measures

- Measure sets that address most, if not all, of the critical issues in the program area

- Measure concepts that add significantly to the measure sets and are near the end of the development process

- Measures that can be easily implemented by all states

Final Review– All Measure Sets

- BCN
  - *[List all recommended measures]*

Final Review Discussion

- Does the measure set:
  - *Include equal amount of process, outcome, patient-reported outcome (PRO), etc. measures*
  - *Address most, if not all, of the critical issues in the program area*

- What are some themes from the BCN program area?

- Are there high-level recommendations for future iterations of the measure sets in the BCN program area?

Final Review– All Measure Sets

- SUD
  - *[List all recommended measures]*

Final Review Discussion

- Does the measure set:
  - *Include equal amount of process, outcome, patient-reported outcome (PRO), etc. measures*
  - *Address most, if not all, of the critical issues in the program area*

- What are some themes from the BCN program area?

- Are there high-level recommendations for future iterations of the measure sets in the BCN program area?

Final Review– All Measure Sets

- PMH
  - *[List all recommended measures]*

Final Review Discussion

- Does the measure set:
  - *Include equal amount of process, outcome, patient-reported outcome (PRO), etc. measures*
  - *Address most, if not all, of the critical issues in the program area*

- What are some themes from the BCN program area?

- Are there high-level recommendations for future iterations of the measure sets in the BCN program area?

Final Review– All Measure Sets

- **LTSS**
  - *[List all recommended measures]*

Final Review Discussion

- Does the measure set:
  - *Include equal amount of process, outcome, patient-reported outcome (PRO), etc. measures*
  - *Address most, if not all, of the critical issues in the program area*

- What are some themes from the BCN program area?

- Are there high-level recommendations for future iterations of the measure sets in the BCN program area?

Opportunity for Public Comment

Next Steps

Next Steps

June 20, 2017

- CC Post In-Person Web Meeting (if needed)

July 21-August 21, 2017

- Draft Report Posted for Public Comment

September 14, 2017

- Final Report Due

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- Committee SharePoint Site: http://share.qualityforum.org/Projects/Medicaid%20Innovation%20Accelerator%20Programs/SitePages/Home.aspx

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

Closing Remarks

Adjourn