CQMC Core Quality Measures Collaborative

Meeting Summary

Core Quality Measures Collaborative (CQMC) Behavioral Health Workgroup Web Meeting

The National Quality Forum (NQF) convened a web meeting for the Behavioral Health Workgroup on January 17, 2023.

Welcome, Roll Call, and Review of Web Meeting Objectives

NQF staff welcomed participants to the meeting and introduced the co-chairs of the Behavioral Health Workgroup, Dr. Thomas Smith (provider co-chair) and Dr. Vikram Shah (payer co-chair). NQF staff reviewed the antitrust statement and acknowledged that CQMC is a member-funded effort with additional support from the Centers for Medicare & Medicaid Services (CMS) and America's Health Insurance Plans (AHIP).

NQF staff facilitated roll call. The Behavioral Health Workgroup roster includes both voting and non-voting members; while both types of members can participate in discussion, only voting members will be asked to cast votes on any changes to the core set. NQF staff reviewed the meeting objectives:

- Review the CQMC's work from last year, including the draft 2022 Behavioral Health core set
- Discuss updates and potential removals from the Behavioral Health core set as part of this year's streamlined measure maintenance

Review of Last Year's Work

NQF staff shared a recap of 2022 CQMC initiatives. Last year, in addition to core set maintenance, the CQMC posted the 2021 core sets and updated the measure selection principles and Analysis of Measurement Gap Areas and Measure Alignment report. The CQMC convened four of its high-priority workgroups, including the Measure Model Alignment, Digital Measurement, Cross-Cutting, and Implementation Workgroups. Additionally, the CQMC introduced and convened a new Health Equity Workgroup to review health equity and disparities in the core sets.

2022 Behavioral Health Core Set Work

NQF staff shared that the Behavioral Health Workgroup (hereafter referred to as "the Workgroup") last met in June 2022 to review and update its core set. Following that meeting, the Workgroup added two measures (NQF #3589 and NQF #3590) to the core set. NQF staff clarified the measures were voted on and confirmed at the Workgroup and full Collaborative level, and the core sets are currently being updated. After the updates, the core set will be sent out to the Workgroup for final review before being posted online. Overall, the current 2022 core set includes a total of 14 measures in the domains of Attention Deficit Hyperactivity Disorder (ADHD), depression, serious mental illness, substance use, and other. The two measures that were added to the core set last year include:

- NQF #3589 *Prescription or administration of pharmacotherapy to treat opioid use disorder*
- NQF #3590 *Continuity of Care After Receiving Hospital or Residential Substance Use Disorder (SUD)*

NQF staff then shared that the Workgroup also updated the list of gaps and priorities for the core set for future consideration. NQF staff noted that Workgroup members would have an opportunity to discuss the updates to the gaps list later in the meeting.

Measures for Maintenance

NQF staff reminded participants that the CQMC measure selection principles ensure that measures in the core sets remain person-centered and holistic; relevant, meaningful, and actionable; parsimonious, promoting alignment and efficiency; scientifically sound; balanced between burden and innovation; and unlikely to promote unintended adverse consequences. The updated measure selection principles emphasize the importance of the inclusion of outcome measures and digital measures, and address priority topic areas such as care coordination and health equity. NQF staff noted that in alignment with the measure selection principles, the CQMC will not consider cost measures in the future, as cost is captured as part of the payment programs.

NQF staff then reviewed the maintenance process for the Behavioral Health core set, noting that the Workgroup would conduct a streamlined maintenance process that supports a limited core set review to ensure measures are still available and valid. For this streamlined review, NQF brought forward core set measures that had received major updates (e.g., changes in their endorsement status and program use, or recently endorsed or fully developed measures in the topic area), as well as updates from measure developers for specific measures that the Workgroup has been following. Measures for Discussion

Prior to the web meeting, NQF staff reviewed the current Behavioral Health core set and assessed measures based on changes in endorsement status, changes in program use (e.g., removal from the Merit-Based Incentive Payment System [MIPS] program, Healthcare Effectiveness Data and Information Set [HEDIS], and Medicaid Core Set), and gaps based on previous Workgroup discussion. Through this process, NQF identified one measure (NQF #1885 *Depression Response at Twelve Months – Progress Towards Remission*) that is no longer endorsed and one measure (NQF #1884 *Depression Response at Six Months – Progress Towards Remission*) that may merit further discussion due to inactivity in federal programs.

The Workgroup co-chair introduced the first measure for potential removal, NQF #1885 *Depression Response at Twelve Months – Progress Towards Remission.* Endorsement of the measure was removed during the Consensus Development Process (CDP) Behavioral Health and Substance Use (BHSU) Spring 2022 cycle, and the measure is currently inactive in federal programs. The co-chair shared that #1885 is stewarded by Minnesota Community Measurement (MNCM). The co-chair reviewed the specifications for the measure, highlight how measure #1885 reports the percentage of adolescent patients (12 to 17 years of age) and adult patients (18 years of age or older) with major depression or dysthymia who are progressing towards remission by achieving a response (Patient Health Questionnaire (PHQ)-9 or PHQ-9M score reduced by 50% or greater) twelve months (+/- 60 days) after an index visit.

At the start of the Workgroup discussion, a co-chair provided context that #1885 lost endorsement because of the conceptual question about what progression without remission truly means at the 12 month time point. The measure steward shared that the measure is part of a suite of four outcome measures, which collectively follow patients over time through their inclusion in the denominator. Patients are included in the denominator when they have a PHQ-9 score greater than nine *and* a diagnosis of depression. The steward shared that patients are evaluated at six months, +/- 60 days, to determine the patient remission status and their response to treatment, then the patients are reassessed at 12 months. The steward clarified that during endorsement deliberations, the CDP

committee opined that at 12 months, patients should clearly be experiencing remission (rather than just response), although the committee expressed that response at six months was reasonable. The steward noted that within participating groups in the state of Minnesota, response at 12 months still shows significant room for improvement.

A Workgroup member shared that their organization uses measure #1885, but stated that the suite of measures may often not be applied as intended, noting that clinics or institutions might select only one of the measures that they find most useful. The member also shared that one challenge with #1885 is capturing patients within the identified timeframe because as patients improve, they are less like to be seen. Regarding other active uses of the measure, the steward clarified that although the measure is not active in federal programs, #1885 is used in one CMS Innovation model (e.g., Kidney Care Choices [KCC]) and in the CQMC Accountable Care Organizations (ACO)/Patient-Centered Medical Homes (PCMH)/Primary Care (PC) core set. Additionally, the steward shared that measure #1884 *Depression Response at Six Months – Progress Towards Remission* was adopted by National Committee for Quality Assurance (NCQA), as part of their HEDIS electronic clinical data submission.

Workgroup members expressed concerns that if the Workgroup removed #1884 and #1885 from the core set, then the core set will no longer include outcome measures. A member also suggested that the Workgroup consider the inclusion of the two remission measures in the intended suite (e.g., NQF #0711 *Depression Remission at Six Months* and *Depression Remission at Twelve Months*) and specify their intended use as a set. NQF staff shared that the core set includes a "notes" column that could be used to highlight details for recommended use for organizations implementing the core set. The co-chair asked the measure steward if the two remission measures are being maintained. The steward shared that all four measures are reported together with the annual follow-up rates in their healthcare quality report. A Workgroup member suggested that comments in the notes section in the core set should include a note that these measures are part of a broader suite of four measures.

The co-chair noted that the entire suite of measures had been brought forward for consideration previously and asked for context regarding the Workgroup decision to not include the other two remission measures in the core set. Members clarified that the Workgroup had decided to start with the measures of progress toward remission with the possibility to revisit the remission measures in future discussions. In past discussions, members also expressed concerns about the ability to meet the six-month remission measure. A co-chair suggested removing #1885 and replacing it with #0711. A Workgroup member shared that including the suite of measures in the core set gives an opportunity for individuals to decide on which ones to use. NQF staff shared that #1885 will proceed to formal voting for potential removal from the core set, but clarified that any additions to the set would need to be brought forth and considered in a future meeting for full discussion and presentation of the measure specifications. Finally, a co-chair prompted the Workgroup to consider if there could be any unintended consequences from use of #1885, noting that the measure could be met even if suboptimal care were provided due to the natural course of depression. The co-chair requested clarification on inclusions in the denominator related to this concern or loss to follow up. The measure steward explained that patients who are not assessed again at the 12-month period remain in the denominator, but are regarded as if there has been no remission or response.

The co-chair transitioned the Workgroup to discuss measure #1884. The co-chair reviewed the specifications for the measure, noting that measure #1884 reports the percentage of adolescent patients (12 to 17 years of age) and adult patients (18 years of age or older) with major depression or dysthymia who are progressing towards remission by achieving a response (PHQ-9 or PHQ-9M score reduced by 50% or greater) six months (+/- 60 days) after an index visit.

NQF staff shared that the measure steward submitted specification changes to NQF's CDP BHSU Spring Cycle 2022, and #1884 ultimately maintained endorsement. NQF staff identified the measure for Workgroup discussion since it is not active in any CMS programs. The steward noted that #1884 and #0711 were adapted for health plan use. Other Workgroup members commented that this measure is even more well-suited than #1885 to use for progress towards remission, since six months aligns better with the natural course of a therapeutic trial for first line treatment of depression. Another Workgroup member expressed concerns that adding more measures can result in too many measures in the Behavioral Health core set, and therefore, the member would support the inclusion of #1884 over #1885 if only one were selected to remain in the core set. Another Workgroup member agreed and asked if there was a way to represent this measure as part of a complete suite as opposed to four individual measures to reduce burden.

A Workgroup member asked if the measure could be used at both primary care sites and specialty behavioral health sites. The steward confirmed that it can be captured at both sites, and based on the data, over 80 percent of included patients are being treated in primary care. When patients are shared between primary care and behavioral health care providers, the data can follow the patient because #1884 is a digital measure. The measure steward also noted that while there are a multitude of electronic health record systems (EHRs) currently in use, many do utilize the PHQ-9, and interoperability is improving, which increases transferability of the data for this measure.

The co-chair asked the steward if MNCM has developed any other outcome measures for psychiatric conditions that the Workgroup could consider in the future. The steward shared that their organization has explored measures focused on anxiety, but has decided to not move forward with a measure concept.

Many Workgroup members expressed agreement that #1885 and #1884 should remain in the Behavioral Health core set. NQF staff shared that both #1885 and #1884 will proceed to formal voting via a survey. NQF staff shared that the two remission measures will be revisited at a future maintenance meeting to be considered for addition to the core set.

Additional Updates on Measures Under Development

NQF staff then shared updates on the measures under development included on the gaps list, including measures from the American Psychological Association (APA), Wisconsin Collaborative for Healthcare Quality (WCHQ), and NCQA, which were discussed in last year's Workgroup meeting. Prior to the web meeting, NQF reached out to each organization to solicit progress on the development of these measures. Additionally, members heard updates from the measure developers of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Mental Health survey.

NQF reviewed the APA measures related to measurement-based care:

- *Measurement-based Care Process: Baseline Assessment, Monitoring, and Treatment Adjustment*
- *Improvement of Maintenance of Functioning for Individuals with a Mental and/or Substance Use Disorder (MUC2022-122)*
- *Improvement or Maintenance in Recovery for Individuals with a Mental Health and/or Substance Use Disorder*
- *Initiation, Review, and/or Update to Suicide Safety Plan for Individuals with Suicidal Thoughts, Behavior, or Suicide Risk (MUC2022-127)*
- *Reduction in Suicide Ideation or Behavior Symptoms (MUC 2022-131)*

NQF staff shared that three of the above measures (MUC2022-122, MUC2022-127, and MUC2022-131) are under consideration in the Measure Applications Partnership (MAP) for recommendation into the MIPS program. All three measures received conditional support for rulemaking pending endorsement by a consensus-based entity during the initial MAP Clinician Workgroup review. NQF staff shared that final recommendations will be made following the MAP Coordinating Committee web meetings on January 24-25, 2023.

NQF staff also reviewed progress on the WCHQ measure under development addressing opioid overdoses in the emergency department. The developer provided updates stating that the measure still requires validation, and WCHQ has been working with their health systems to resolve data collection and submission challenges.

NQF staff shared that the NCQA person-centered outcomes measure (previously titled the "person-driven outcomes measure") has undergone a name change to limit confusion from both clinicians and individuals seeking care while remaining aligned with the intent of the measure. NQF also shared that a measure testing learning collaborative with 5-10 primary care/long-term services and supports organizations is planned for completion by Fall 2023. Due to high levels of interest from behavioral health organizations, NCQA will additionally conduct a second learning collaborative that is now planned with 12 Certified Community Behavioral Health clinics that will implement the measure over the next year, with final testing results expected in early 2024. NQF noted that NCQA continues to build additional electronic measures that address behavioral health. While these measures are specified at the health plan level, the Workgroup may consider them in future maintenance cycles.

Lastly, NQF staff shared that the CAHPS Mental Health survey developer has conducted various field tests and is currently analyzing the data. The measure developer was present and provided a brief overview and update on the CAHPS Mental Health survey. The CAHPS Mental Health survey was developed based on prior work by the Agency for Healthcare Research and Quality's (AHRQ) Experience of Care & Health Outcomes (ECHO) survey, which primarily assessed patient experiences with behavioral health care and information outcomes with providers, insurers, and managed care organizations. Over time, this survey has been restructured through multiple iterations into its current form, which is recognized as the CAHPS Mental Health survey.

The developer noted that two field tests were conducted on the most updated version of the survey. The field testing of the CAHPS survey was conducted with four health plans through Massachusetts Medicaid in 2021 and four family practices in 2022. Results from these studies demonstrated ongoing issues of low response rates among these populations. Patients also reported difficulties in accessing prescription providers and counselors. The developer noted that this is a well-known experience in this topic area, but remains a challenge, even for patients who are active in care who may not receive adequate coverage or as much care as desired. The developer noted that their team is continuing to refine the tool to address challenges of low response rate and inter-unit reliability that would allow the evaluators to distinguish between differing accountable entities. The developer shared that the data is being finalized to share for discussion with the full CAHPS consortium, after which the tool will be submitted to NQF for endorsement. A Workgroup member asked the developer about their experience regarding national core indicators and personal outcome measures. The developer shared that they have not been engaged in the core indicators, noting that outcomes are not included in the current instrument, but indicated interest in exploring these areas in the future. The developer highlighted that the ECHO survey was focused on the experience of care and health outcomes, noting that the CAHPS survey focuses on process measures.

Gaps Discussion

NQF staff shared updated gap areas for the Behavioral Health Workgroup's future consideration to continue advancing the core set:

- Coordinated care, including assessing bi-directional integrated behavioral healthcare and general healthcare, primary care
- Patient-reported measures, including patient experience with psychiatric care
- Suicide risk measures independent of a major depressive disorder diagnosis, specific age group, or care setting
- Measures for anxiety disorder, trauma, and other stress-related disorders
- Depression remission measures that span beyond 6 months, but count remission if it is achieved earlier than 12 months, and measures for prepartum and postpartum depression
- Psychosocial rehabilitation and/or rehabilitation recovery measures
- Autism measures
- Client performance and function (e.g., engaging in an occupation)
- Specific measures under development – opioid overdoses in the emergency department, Consumer Assessment of Healthcare Providers and Systems (CAHPS) Mental Health Care Survey, and measurement-based care and person-centered outcomes measures

NQF staff reminded the Workgroup that new gaps added during last year's discussion include measures for autism, trauma, and stress-related disorders, measures specific to prepartum and postpartum depression, psychosocial rehabilitation and recovery measures, and measures addressing client performance and function.

The co-chairs opened up a discussion on gap areas by prompting Workgroup members to consider the ongoing applicability of the identified gaps to the core set, or any new additions that should be considered. A Workgroup member expressed that an additional gap area for consideration is the issue of patient access to initial behavioral health appointments, specifically with in-network providers, which has downstream implications for all other identified gap areas. The CAHPS developer acknowledged this issue and shared that their team has developed a small set of supplemental measures for CAHPS surveys to assess access to behavioral health care, and their team is currently writing a white paper on one of those measures addressing behavioral health network adequacy. Another Workgroup member emphasized the importance of the first two listed gaps, which have long been priorities of patient advocacy groups such as the National Alliance on Mental Illness (NAMI) and Mental Health America. The Workgroup member went on to note that the recently passed Omnibus Supplemental Consolidated Appropriations Bill now requires CMS to implement experience of care measures in psychiatric settings comparable to other inpatient settings. The bill includes a title expanding and strengthening the focus on integrated behavioral health and primary care that will promote earlier quality measurement related to behavioral health care. Additionally, the CAHPS developer shared that the AHRQ is also working to address inpatient experiences for behavioral health patients, and has proposed the development of a new inpatient instrument to address this gap, since the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey excludes patients with psychiatric and SUD diagnoses.

Next Steps

NQF staff shared that the Behavioral Health Workgroup discussion will be summarized and posted on the CQMC SharePoint page once available. NQF staff will also circulate a survey for voting workgroup members to vote on measures for potential removal from the core set. Voting will be opened for a 4-week period. After the final votes are tallied, the Steering Committee will review the Workgroup

recommendations, and NQF will follow up with the Workgroup via email for any additional clarifications. The potential changes to the core set will then proceed to the full Collaborative for final discussion and voting. NQF staff thanked the co-chairs and Workgroup for their participation before adjourning the meeting.