CQMC Core Quality Measures Collaborative

Meeting Summary

Core Quality Measures Collaborative (CQMC) Behavioral Health Workgroup Web Meeting 1

The National Quality Forum (NQF) convened a web meeting for the Behavioral Health Workgroup on June 8, 2022.

Welcome, Roll Call, and Review of Web Meeting Objectives

NQF staff welcomed participants to the meeting, as well as introducing the co-chairs of the Behavioral Health Workgroup, who provided welcoming remarks. NQF staff reviewed the antitrust statement, as well as acknowledging 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 and reminded the group that the 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 2021 Behavioral Health core set
- Discuss potential additions to and removals from the Behavioral Health core set as part of the annual maintenance

CQMC Overview and Recap of Previous Work

NQF staff reviewed the background and aims of the CQMC, recent accomplishments, current work, and future opportunities. Last year, in addition to core set maintenance, the CQMC updated and released the following reports: Approaches to Future Core Set Prioritization, Measure Selection Criteria, and the Implementation Guide. NQF staff shared that the CQMC convened a new Health Equity Workgroup, which met for the first time in early April, to analyze disparities-sensitive measures and identify health equity measures for future consideration.

2021 Behavioral Health Core Set Work

NQF staff shared that the Behavioral Health Workgroup met twice in June 2021 to review and update their core set. The Behavioral Health core set currently includes a total of 12 measures in the domains of Attention Deficit Hyperactivity Disorder, Depression, Serious Mental Illness, Substance Use, and Other. The Workgroup-identified gap areas for measurement include coordinated care, patient-reported measures, suicide risk measures, anxiety disorder measures, and depression remission measures with adjusted timeframes.

NQF staff then shared previous updates to the Behavioral Health core set. The 2021 update to the core set presentation included updates on notes related to telehealth eligibility for all measures, including the measure *Pharmacotherapy for Opioid Use Disorder (POD),* which was adjusted to reflect accommodations for telehealth visits. Also, measures #0108, #0418/0418e, #2152, and #0028/0028e remained telehealth eligible (i.e., telehealth visits can be used for CMS reporting on the measure, or the developers explicitly stated that telehealth visits can be used to calculate the measure in the specifications shared with NQF). In addition, #0418/0418e *Preventative Care and Screening: Screening*

for Clinical Depression and Follow-Up Plan is no longer NQF endorsed but the developer plans to maintain this measure independently; a note was added to the core set to reflect this change.

Measures for Maintenance

NQF staff shared 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 measure selection principles were updated in 2022 to ensure they remain relevant, focus on outcome measures and digital measures, and address priority topic areas such as care coordination and health equity. NQF staff noted that the CQMC will not consider cost measures in the future, as cost is captured as part of the payment models in which the core set measures may be used.

NQF staff then reminded the Workgroup that annual maintenance helps the core sets remain aligned with the measure selection principles. As part of the process, NQF will bring forward major updates for the Workgroup's consideration (i.e., changes to endorsement and program use; recently endorsed or fully developed measures in the topic area; measures recommended for use in federal programs), as well as measures identified for discussion by Workgroup members prior to the meeting. No formal voting will be conducted during the Workgroup meetings. Also, proposed changes to the core set will proceed to voting after the conclusion of all measure discussions. As a reminder, organizations can use summaries and other meeting materials to help inform voting.

Potential Removals from the Core Set

NQF staff shared the process used to identify potential removals from the Behavioral Health core set. The process includes reviewing the current core set and assessing measures based on changes in endorsement status, changes in program use (e.g., removal from Merit-Based Incentive Payment System [MIPS], Healthcare Effectiveness Data and Information Set [HEDIS]), and suggestions from Workgroup members. NQF did not identify any current measures in the core set for removal during this cycle.

Potential Addition to the Core Set

NQF staff shared that measures proposed for potential addition to the Behavioral Health core set are reviewed based on the following criteria: new NQF endorsement; new HEDIS measures; measures recommended for use in programs by the Measure Applications Partnership (MAP); review of Behavioral Health gap areas within the CMS Measure Inventory Tool (CMIT) and NQF's Quality Positioning System; and suggestions for discussion from Workgroup members. NQF staff shared that they identified two measures for potential addition to the core set.

3589: Prescription or administration of pharmacotherapy to treat opioid use disorder

The first measure discussed for potential addition was NQF #3589 *Prescription or administration of pharmacotherapy to treat opioid use disorder (OUD).* NQF staff shared that this measure was recently endorsed as part of the Consensus Development Process (CDP) Behavioral Health and Substance Use Fall 2020 cycle. Measure #3589 reports the percentage of a provider's patients who were Medicaid beneficiaries ages 18 to 64 with an OUD diagnosis who filled a prescription for, or were administered or ordered, a U.S. Food and Drug Administration (FDA)-approved medication to treat OUD within 30 days of the first attributable OUD treatment encounter with that provider. NQF staff also shared that this is a process measure and is endorsed at the clinician and facility levels of analysis and it addresses the substance use domain in the current Behavioral Health core set. It was noted that there is currently a measure in the core set related to pharmacotherapy to treat OUD, *Pharmacotherapy for Opioid Use*

Disorder (POD). NQF staff shared a comparison of #3589 *Prescription or administration of pharmacotherapy to treat OUD* and N/A *Pharmacotherapy for Opioid Use Disorder (POD)* below for discussion.

	3589: Prescription/administration of pharmacotherapy to treat OUD	N/A: Pharmacotherapy for Opioid Use Disorder (POD) *(in current core set)*
Steward	RTI International	NCQA
Endorsement	Endorsed	Not endorsed
Description	Percentage of a provider's Medicaid beneficiaries with an OUD diagnosis who filled a prescription for, or were administered or ordered, an FDA-approved medication to treat OUD within 30 days of the first attributable OUD treatment encounter with that provider.	Percentage of new OUD pharmacotherapy events with OUD pharmacotherapy for 180 or more days among members with a diagnosis of OUD.
Level of Analysis	Clinician: Individual, Facility	Health Plan
Population	Medicaid beneficiaries 18 to 64	All members 16 and older
Exclusions	Dual eligible beneficiaries	Members in hospice
Programs	N/A	HEDIS

NQF staff highlighted differences between the measures' level of analysis and current use. #3589 is not used in any federal programs, but is used by the New York Office of Addiction Supports and Services (i.e., approximately 274 addiction treatment facilities) and the Shatterproof Addiction Treatment Locator, Assessment, and Standards Platform (ATLAS) (i.e., approximately 400 addiction treatment providers across New York, Massachusetts, Delaware, and West Virginia). NQF staff also noted that both are process measures without risk adjustment or stratification.

A Workgroup member shared concerns that *N/A Pharmacotherapy for Opioid Use Disorder (POD)* measure does not give providers credit for the initial work of treating the patient if the patient started on an OUD medication but did not complete 180 or more days of treatment. Another Workgroup member agreed and shared that the average performance data for this measure from Medicare and Medicaid ranges from 28 to 34 percent, demonstrating opportunity to improve initiating and maintaining OUD treatment for patients. Additionally, the member shared that 38 to 44 percent of patients have OUD treatment initiated, but only 28 to 34 percent of continue treatment through the 180-day period. A member commented that ideally #3589 would have been the initial priority (how many patients have initiated pharmacotherapy) since the rates of initiation are so low. Then, after the performance on #3589 (focus on initiation) has improved, the POD measure (focus on maintaining treatment would become more important. A Workgroup member agreed that the POD measure appears to be the "next step" from #3589 and suggested it may be helpful to couple these measures or recommend them as stepwise measures.

A Workgroup member asked whether pharmacy claims would be a data source for #3589 and if pharmacy claims identify if a prescription was ordered and not filled. A co-chair responded that the pharmacy is unable to submit the claim until the medication has been dispensed and shared there is an issue obtaining data on prescription orders for the state or nationwide population of Medicaid recipients. The Workgroup member asked if the word "administered" or "ordered" should be eliminated from the measure description; NQF staff clarified that the goal is to not change the specifications of the measures that the Workgroup considers for inclusion but to evaluate measures for inclusion as they are specified. The numerator states that administration or prescription can be from any provider (e.g.,

office-based physician, hospital) and does not need to be from the attributed provider, because all providers who treat patients with an OUD diagnosis should be held accountable for ensuring they receive gold standard treatment. NQF staff shared that they will follow up with the measure developer for additional information on how data on medication administration is captured for the measure. A member shared that typically, the information is captured through claims through provider attestation that the prescription was ordered and/or from the data file exchange where the provider shares a list of patients who have been ordered medications with insurers. A Workgroup member agreed that it is difficult to capture medication orders through claims.

A Workgroup member noted that both #3589 and POD address similar concepts, but they are intended to hold different entities accountable (i.e., individual/facility level and health plan level). The member asked whether other members would find it helpful to include both measures in the set given that they address different entities. Another member responded that it could be helpful to include these measures to address an important topic area at multiple levels.

A member noted that #3589 is specified for Medicaid beneficiaries, but the commercial population also faces the same challenges with starting and maintaining OUD medications for patients. The member asked whether there are potential issues with using the measure for the commercial population. NQF staff commented that they recognized the measure focuses on Medicaid beneficiaries but brought it forward since it potentially fills an important gap area and could conceptually be applicable to all patients 18 to 64 years of age, beyond just Medicaid beneficiaries. NQF will follow up with the measure developer regarding any testing or application considerations for the commercial population.

NQF shared that #3589 *Prescription or administration of pharmacotherapy to treat OUD* will proceed to formal voting for potential addition to the core set. NQF confirmed that Workgroup members were not interested in removing or replacing the existing POD measure, but rather potentially adding #3589.

3590: Continuity of Care After Receiving Hospital or Residential Substance Use Disorder (SUD) Treatment

The second measure discussed for potential addition was #3590 *Continuity of Care After Receiving Hospital or Residential Substance Use Disorder (SUD) Treatment.* This measure was also recently endorsed as part of NQF's CDP Behavioral Health and Substance Use Fall 2020 cycle. NQF staff shared that #3590 measures the percentage of Medicaid discharges ages 18 to 64 years being treated for a SUD from an inpatient or residential provider who received SUD follow-up treatment within seven or 30 days after discharge. SUD follow-up treatment includes outpatient, intensive outpatient, or partial hospitalization visits; telehealth encounters; SUD medication fills or administrations; or residential treatment (after an inpatient discharge). Two rates are reported: continuity within seven and 30 days after discharge. Based on information submitted at the time of NQF endorsement, this measure is being used by New York State (approximately 90 addiction treatment facilities) and Shatterproof ATLAS (approximately 130 addiction treatment providers across New York, Massachusetts, and West Virginia).

A member asked whether there is a difference between this measure and another newly endorsed measure, #3453 *Continuity of Care After Inpatient or Residential Treatment for Substance Use Disorder.* NQF staff shared that measure #3453 is specified at the population level of analysis, which is a higher level of attribution than is typically represented in the CQMC core sets. A Workgroup member shared that from a patient advocacy perspective, it may be helpful for the CQMC to consider the role of wider system measures as patients may be more concerned with the overall way the healthcare system

functions instead of the performance of an individual provider. NQF staff acknowledged that understanding system function is helpful and suggested that the CQMC could explore the value of considering systems-level supplemental measures in the future. NQF staff also clarified that #3453 is not in the core set for removal and is not being proposed for potential addition.

A Workgroup member asked if information from provider-level measures can be translated into system performance measures. NQF staff reminded the group that the CQMC is primarily focused on clinician level measures since the goal of the Collaborative is to reduce provider burden and limit the number of measures that providers and clinician groups are held accountable for in various value-based programs used across payers in the private and public sector. A Workgroup member asked for clarification on whether including a measure in the core set implies a recommended level of use (e.g., if a facility-level measure is included in the core set, is the Workgroup recommending that the measure be used at the clinician level or is the Workgroup recommending that the measure be used at the level it is specified?). NQF staff responded that measures are included in the core sets for use as they are specified. The member agreed with this approach. The core set presentations include notes related to the level of analysis in which the measures are specified. The member suggested that the CQMC consider making the level in which the measure is specified more prominent in the core set presentations.

A member suggested that this measure may overlap with the HEDIS Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) measure and asked if the overlap was considered in measure development, and how #3590 and the HEDIS IET measure are different. The HEDIS IET measure assesses adults and adolescents 13 years of age and older with a new episode of alcohol or other drug dependence (i.e., diagnosis of SUD) for whom treatment was started and engaged (i.e., an initial visit and at least two related services 34 days within the initiation visit). The co-chair clarified that the primary difference between #3590 and the IET measure is the level of analysis (i.e., the IET measure is at the health plan level).

NQF staff shared that #3590 *Continuity of Care After Receiving Hospital or Residential Substance Use Disorder (SUD) Treatment* will proceed to formal voting for potential addition to the core set.

Additional Discussion on Newly Endorsed Measures

A Workgroup member shared that #3622 *National Core Indicators for Intellectual and Developmental Disabilities (ID/DD) Home- and Community-Based Services (HCBS) Measures* is currently used in every state. On a yearly basis, 30 to 40 percent of patients in the state ID/DD system have a co-occurring mental illness. The member also shared that this measure is more appropriate for people with severe mental illness and asked if #3622 will be discussed with the Workgroup in a future meeting. NQF staff commented that #3622 assesses performance at a population level (e.g., regional, state) and due to the level of analysis, staff determined that it did not fit the scope of the CQMC. Additionally, the member shared that the National Core Indicators, the National Core Indicators for Aging and Disability, and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) measure are currently used by the Medicaid Home and Community-Based Services (HCBS) program. Measurement in this area affects an estimated $12 billion dedicated to the home and community-based service programs for millions of recipients across the country. In the coming months, CMS plans to issue proposed core quality measures for home and community-based services under the Medicaid program, which will include some of the National Core Indicators. NQF staff thanked the member for the additional information and shared that the CQMC's potential role related to measurement of HCBS and population health measurement could be shared at the full Collaborative or Steering Committee meeting.

Additional Updates on Existing Measures

NQF staff shared that two measures (#1884 *Depression Response at Six Months – Progress Towards Remission* and #1885 *Depression Response at Twelve Months – Progress Towards Remission*) are currently in the Behavioral Health core set and are being reviewed for maintenance as part of NQF's Behavioral Health and Substance Use Spring 2022 endorsement cycle. The measures have been redesigned with the following major changes:

- Expanded age range
- Add PHQ-9M patient-reported outcome tool
- Expand follow-up window from +/- 30 days to +/- 60 days
- Add exclusions for schizophrenia, pervasive developmental disorder
- Remove requirement that major depression/dysthymia diagnosis must be in the primary position

NQF shared with the Workgroup that there is no action needed at this time regarding the changes to #1884 and #1884.

Additional Updates on Gaps List

NQF staff shared updates on measures under development included on the Behavioral Health measure gaps list, including measures from the American Psychological Association (APA), National Committee for Quality Assurance (NCQA), Wisconsin Collaborative on Healthcare Quality (WCHQ), and the Agency for Healthcare Research and Quality (AHRQ).

A representative from the APA provided a brief update regarding the 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*
- *Improvement or Maintenance in Recovery for Individuals with a Mental Health and/or Substance Use Disorder*
- *Initiation and Update to Suicide Safety Plan for Individuals with Suicidal Ideation, Behavior of Suicide Risk*
- *Reduction in Suicide Ideation or Behavior Symptoms*

APA shared that these measures have been fully developed and they are currently being tested to collect more data. Data have been collected for initial reliability and validity testing; these measures have also been recently submitted for potential inclusion in the MAP measures under consideration (MUC) list. NQF staff asked if the additional testing will be completed this year, and if APA was interested in presenting the measures at another meeting as part of this year's maintenance process. APA shared that the timeline for completing these measures has not been finalized; it would be best to discuss the measures during next year's maintenance cycle. APA shared that they will keep NQF updated via email. NQF staff reminded the Workgroup that measures should be fully developed and tested to be considered for inclusion in the CQMC core sets, but they are not required to be endorsed by NQF.

NQF shared that during last year's ad hoc maintenance process, NCQA shared an update on development of a person-driven outcomes measure for patients and caregivers. The person-driven outcome measure identifies outcomes that matter most to each patient; after establishing these goal-

related outcomes, providers and individuals revisit the goals and monitor progress over time. NQF shared that NCQA has confirmed that the measure has gone through initial pilot testing and is currently in a second phase of development related to implementation and implementation tools.

NQF shared that WCHQ is currently developing a measure on opioid overdoses in the emergency department; this was originally identified in 2020 as a promising measure for inclusion by the Behavioral Health Workgroup. NQF staff shared that WCHQ confirmed via email that the measure is still going through continued development and testing. The consideration of this measure for inclusion in the Behavioral Health core set will be revisited at a later date.

Finally, NQF staff shared that the CAHPS Mental Health survey was previously identified as an important measure for the Workgroup to consider. The measure underwent initial field testing in the U.S Department of Veterans Affairs (VA) and a state Medicaid program last summer but did not have a high enough response rate to analyze unit-level reliability. NQF staff shared that the developer, AHRQ, is also looking to test the measure in a commercial population. A Workgroup member shared that AHRQ has also requested feedback from stakeholders on the use of the CAHPS survey in the inpatient mental health setting, with a deadline of July 1. Additionally, NQF staff shared it was confirmed last year by AHRQ that the Experience of Care and Health Outcomes (ECHO) measure would be retired and replaced with the CAHPS mental health survey.

Future Work

NQF staff shared that the team is soliciting feedback from each of the Workgroups on future activities and considerations for the CQMC to continue advancing the core sets. The CQMC received feedback from members on the need to consider the specific mix of subtopics represented in each core set in addition to the selection principles. The CQMC is developing a framework of priority conditions and topic areas for each core set to help guide Workgroup discussion toward conditions and topic areas most important to measure for each specialty area as part of value-based care.

NQF presented the Behavioral Health measure gap areas (page 3) from 2021 and asked the Workgroup to discuss gaps that should be added, removed, or prioritized. NQF reminded the Workgroup that the following topics are currently included in the core set:

- Attention Deficit Hyperactivity Disorder
- Depression
- Serious Mental Illness (e.g., schizophrenia)
- Tobacco, Alcohol, and Other Substance Use
- Other (e.g., care coordination)

A Workgroup member asked if prepartum and postpartum depression are included as a priority area in the Behavioral Health core set. Members suggested that prepartum and postpartum depression should be a priority area due to the disparities that exist for those measures; a member highlighted significant disparities in maternal mortality in the New York area and unknown rates of screenings for peripartum mood disorders, especially in minority groups.

A Workgroup member suggested inclusion of a measure related to autism, since the prevalence of the disorder has increased over the past decade. The member highlighted applied behavioral analysis, which is covered by insurers and could improve functions of children with autism.

A Workgroup member asked if an anxiety disorder measure was being developed and shared that it is a significant gap area. Another member agreed and also suggested inclusion of trauma and other stress related disorders. A member suggested that the Workgroup consider prevalence and the associated cost burden of certain conditions when prioritizing which measures should be represented in the core set.

Additionally, a member shared that the National Health Council (NHC) launched a multistakeholder effort developing a Patient-Centered Core Impact Set (PC-CIS) which prioritizes a list of impacts that a disease and/or treatment has on patients. A member commented that client performance and functions are critical areas to address for successful engagement in daily life (e.g., engaging in an occupation). Another member agreed and shared that there is an increased focus on psychosocial rehabilitation or rehabilitation recovery, which should be prioritized. A Workgroup member shared that assessing integrated behavioral health and primary care is another gap area.

NQF staff asked for additional considerations from the Workgroup for advancing the Behavioral Health core set. A member shared that some behavioral health providers successfully collaborate with peer support workers and community health workers to provide care and address social determinants of health (SDOH) and equity. A member shared that as a starting point, there should be transparency about existing disparities and suggested stratifying measures by race and ethnicity. A co-chair proposed that the important discussion on how to address health equity as part of CQMC's behavioral health work should be continued at a future Workgroup meeting.

Next Steps

NQF staff shared that they would summarize the Workgroup's discussion and post the summary on the CQMC SharePoint page. NQF will also circulate a survey for voting Workgroup members to vote on the measures for addition to the core set. Voting will be open for a 4-week period; after votes are tallied and reviewed by the Steering Committee, 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.