Requested Comments

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Behavioral Health Quality Framework: A Roadmap for Using Measurement to Promote Joint Accountability and Whole-Person Care

A White Paper

May 2021
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The National Committee for Quality Assurance (NCQA)

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Current Quality Measures Being Considered by AHRQ, CQMC, CMS, Mathematica, and NQF – Strong AAHD and Lakeshore Foundation Support; in response to NCQA Behavioral Health Quality Framework Interview; submitted April 17, 2023

1. American Board of Family Medicine (CQMC-NQF #3617)
   Primary Care Provider Continuity of Care

2. American Board of Family Medicine (CQM-NQF #3568)
   Person-Centered Primary Care Patient-Reported Outcome (PRO) Measure

3. CAHPS Experience of Care Measure in Psychiatric Inpatient Hospitals and Units [MUC2022-78)

4. Mathematica Core Child and Adult Measures: LTSS (Including HCBS) Care Plan Transmitted to the Patient's Primary Care Practitioner. [And Primary Care Record shared with LTSS/HCBS providers]

5. Cross-Setting LTSS Discharge [MUC2022-83,85,86,87]; Home Health Discharge to the Community [02943 and 02944]; Functional Assessments and Care Plans in LTSS discharge [05853]

6. Screen Positive for Social Drivers of Health (MUC2022-050]; Screen Positive for Health-Related Social Need and Resulting Contact with a Community Provider [MUC2022-098]; and Resolution of at least one health-related social need within 12 months [MUC2022-111]

7. Continuing Advocacy and Monitoring of CAHPS HCBS; NCI; NCI-AD; and POM

In Brief

Mental health (MH) conditions and substance use disorders (SUD), collectively referred to in this report as "behavioral health (BH) conditions," are a leading cause of disease burden in the United States, surpassing both cardiovascular disease and cancer.[1] As of 2019, nearly 1 in 5 adults in the United States had a diagnosed MH condition, and 1 in 12 people over the age of 12 had a diagnosed SUD.[2] Individuals with BH conditions experience higher morbidity, poorer health outcomes, and a 20-year lower life expectancy than the general population.[3] These poorer outcomes occur even though care for people with BH conditions accounts for a disproportionate share of total health care spending. Payers and stakeholders are increasingly looking to value-based payment models to integrate BH and physical health (PH) care to improve outcomes and manage costs.

The current fragmented and inequitable state of BH care calls for a quality measurement framework that can be used to guide and hold entities jointly accountable for improving care access and outcomes for individuals with BH conditions. To guide development of this framework, the National Committee for Quality Assurance (NCQA) employed a mixed-methods approach involving an environmental scan and key stakeholder interviews to evaluate the current BH quality measurement landscape and better understand the needs and challenges of entities responsible for BH care across the health care system.

Findings

An environmental scan of 39 active federal programs that collectively use over 1,400 quality measures and metrics uncovered the following:

- Federal programs, especially those focused on BH care, rely heavily on metrics and nonstandardized quality measures, limiting use for benchmarking and value-based payment models.
- Standardized quality measures used in federal programs are a mix of BH and PH measures.
- Standardized BH quality measures used in federal programs focus on narrowly specified conditions or processes and are misaligned and used variably across programs.
  - *Only 35 unique standardized BH quality measures were used across all federal programs; 16 were used only in a single program.*
  - *Four measures were most frequently used across programs: Follow-Up After Hospitalization for Mental Illness; Screening for Depression and Follow-Up Plan; Initiation and Engagement of Alcohol and Other Drug Abuse and Dependence Treatment; Preventive Care and Screening: Tobacco Use—Screening and Cessation Intervention.*
- BH integration is inconsistently and insufficiently measured by current standardized measures.

Key stakeholder interviews with entities operating at different levels of the delivery system in five diverse state Medicaid models that participate in federal programs yielded the following insights about the current use of quality measures for delivery, management, and improvement of care for populations with BH needs:

- BH care is supported through a complex assortment of funding streams, often to augment inadequate BH coverage with ancillary services.
- Current BH quality reporting efforts are burdensome and limit resources for improving and measuring aspects of BH care most meaningful to different levels of the delivery system.
- Entities across the delivery system have unique and unmet quality measurement needs, as illustrated in the table below *(Meaningful Aspects of BH Care Quality)*.
- BH integration is viewed as key to addressing access and stigma, but entities are unclear on who is accountable for driving integration and how to measure its quality.
- Large-scale solutions and incentives are seen as necessary to improve BH data challenges.
- Existing BH quality measures have challenged efforts to monitor quality during COVID-19.

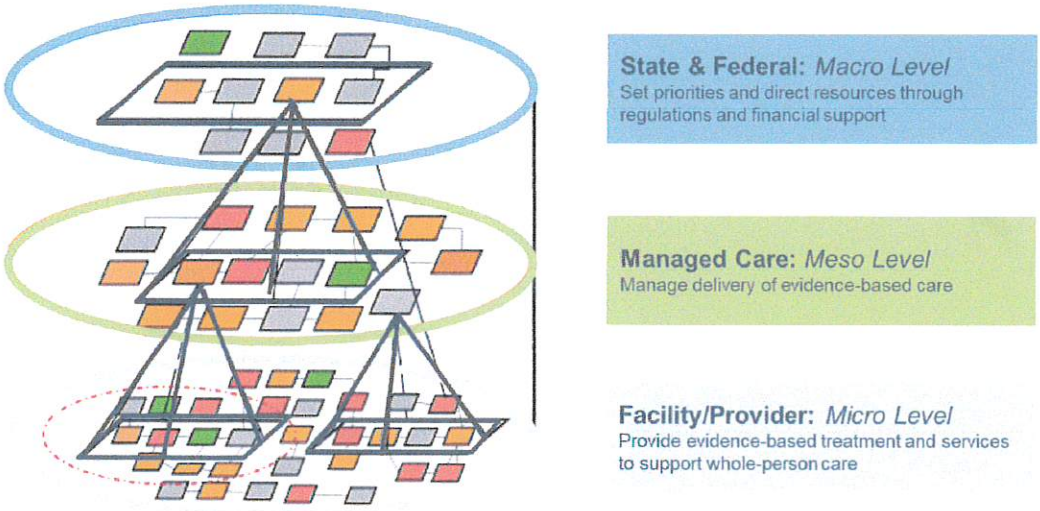
Meaningful Aspects of BH Care Quality, by Delivery System Level

	Measure Category	State	Managed Care	Facility
OUTCOMES	BH symptom and functioning improvement (i.e., measurement-based care)	X	X	X
	Patient goal attainment		X	X
	Patient experience		X	X
	Social outcomes (e.g., kindergarten readiness, crime rate, employment rate)	X		
	BH integration—outcomes and effectiveness	X	X	
	Cost	X	X	
	Equity in BH outcomes	X	X	X
PROCESSES	Social service coordination (e.g., link to social service agency)		X	X
	Health care coordination/referral success		X	X
	Evidence based treatment (e.g., Fidelity to Cognitive Processing Therapy model)	X		X
	Patient goal setting	X	X	X
	BH integration—processes (e.g., data sharing, warm handoffs)		X	X
	Equity (e.g., equitable access to BH care)	X	X	X

Recommendations

To drive improvements in BH quality and promote joint accountability across entities responsible for serving individuals with BH needs, we propose a **BH Quality Framework,** adapted from the Applegate Alignment Model. This framework prioritizes alignment and use of meaningful sets of quality measures, uniquely targeted to each level of the health care system, that coordinate and assess progress towards population-level goals. Bundles of measures and metrics are transparently defined, measured, and coordinated, and data use is based on each entity's unique position and relationship with respect to goals and populations served. The illustration below shows how this framework can be applied to promote collaboration and joint accountability for whole-person care.

BH Quality Framework: Approach for Aligning Measures Across Levels of a Delivery System



To support implementation of the BH Quality Framework, we propose a roadmap that includes three primary components:

1. Identification of population goals and priority populations, with a strong focus on care equity,
2. Purposeful, coordinated alignment of measures and metrics across different levels of the delivery system to drive common goals, and
3. Alignment of policies and payment models to support and sustain efforts.

Roadmap to Joint Accountability for Behavioral Health: BH Quality Framework

Identify Population Goals and Priority Populations	• **Set population level goals** • **Identify priority populations** relevant to population goals
Choose the Right Tools and Strategies	• Use the **BH Quality Framework** to develop bundles of evidence-based quality measures and metrics to align efforts across delivery system towards population goals • **Publicly report** performance data for measures/metrics at each level of the delivery system
Align Policies and Payment to Support and Sustain	• Improvements to BH financing (i.e., coverage and reimbursement, value based or alternative payment models) • Investment in BH data infrastructure • Improvements and investments in communication and collaboration across system • Investment in workforce development and cultural sensitivity

Federal and state entities are positioned to drive improvements in BH care and impact population health goals by setting priorities and directing resources through regulations and financial support—but stakeholders, organizations, and individuals at all levels of the delivery system play a critical role. The BH Quality Framework calls for convening a diverse group of stakeholders that includes state policymakers, payers, providers, and consumers to jointly prioritize population goals for BH, develop relevant measure bundles, and address known inequities in care that stymie progress toward high-quality BH care.

By aligning and coordinating efforts across the delivery system, meaningful quality measures can spur accountability through transparency and payment. Purposeful alignment and coordinated quality measurement activities that consider each entity's sphere of influence while keeping a line of sight to shared goals can empower stakeholders to make informed decisions and minimize burden. There have recently been momentous federal and state investments to help mitigate the COVID-19 pandemic's impact on BH, but there is a critical need for a clear framework and approach to driving and measuring BH care quality and outcomes. The BH Quality Framework provides a testable model for guiding these efforts.

missing: persons with a variety of co-occurring conditions - See attached: AAHD + Lakeshore: (1) March 7, 2022 to Senate HELP; (2) March 30, 2022 to Senate Finance

Section 1: The Challenge of Measuring BH Care Quality

State of behavioral health care in the United States

Mental health (MH) conditions and substance use disorders (SUD), collectively referred to in this report as "behavioral health (BH) conditions," are a leading cause of disease burden in the United States, surpassing both cardiovascular disease and cancer.[4] As of 2019, nearly 1 in 5 adults (51.5 million) in the United States had a diagnosed MH condition, and 1 in 12 (20.4 million) individuals over the age of 12 had a diagnosed SUD.[5]

Individuals with BH conditions experience higher morbidity, poorer health outcomes, and lower life expectancy than the general population. The excess in mortality—particularly among those with severe mental illness—has been referred to as a "public health scandal."[3,6,7] This inequity reflects several factors, including higher risks for chronic diseases (including cancer), higher rates of accidental and nonaccidental deaths, and poorer access to medical care among those with BH needs, compared to the general population.[8] Yet despite the high prevalence and social and economic impact of BH in the United States, only 12% of individuals with SUD and 45% with MH receive specialty services, underscoring pervasive challenges to care access and coordination.[5]

Disparities in access to and engagement in BH care also disproportionately impact communities of color.[9] The COVID-19 pandemic has exacerbated these disparities: Black and Latinx communities both suffer a greater COVID-19 disease burden and worse access to BH services.[10]

State and federal policy solutions to address these challenges include BH parity; expansion of Medicaid; efforts to integrate BH with medical care; and broad legislation related to improving access to treatment for MH and SUD (e.g., 2018 Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment [SUPPORT] for Patients and Communities Act). The BH crisis, worsened by the COVID-19 pandemic, brought about additional policies to promote BH care access (e.g., Coronavirus Aid, Relief, and Economic Security [CARES] Act, American Rescue Plan Act of 2021).[11,12,13] missing: Medicare

Tackling BH to manage health care costs

As national health care reform efforts focus on reducing costs and increasing efficiency, the spotlight has shifted to variations and inequities in care and cost across health conditions and settings. Individuals with comorbid SUD and MH conditions have been identified as a high-need, high-cost group that accounts for a disproportionate share of total health care spending across publicly and commercially insured lives.[14] And BH conditions have an outsized impact on medical costs: The average cost of treatment for medical conditions is between 2.8 and 6.2 times higher for individuals with BH conditions than for those without BH conditions.[14] Although individuals with BH conditions account for more than half of all health care spending, BH services account for only 4.4% of this cost.[14] Payers and stakeholders are increasingly looking to value-based payment models and opportunities to integrate BH and physical health (PH) care to improve outcomes and manage costs.[15,16]

Role of quality measurement

Quality measures provide information about health care quality, evaluate the impact of policies and service delivery initiatives on care quality, and inform stakeholder decisions. Impactful quality measures can be leveraged to create accountability through transparency (public reporting) and can be incorporated into payment programs to drive improvement in care quality. Although quality measures to assess MH and SUD care are available, there is a paucity of measures for many important conditions and relevant outcomes, a limited focus on high-need, high-cost populations, and limited use in quality improvement and value-based payment programs. Among the MH and SUD measures used in accountability programs, the average performance has remained stable or has declined over time.[17] These trends in performance stand in contrast to trends in PH measures, which have shown modest incremental gains over the same period.[17]

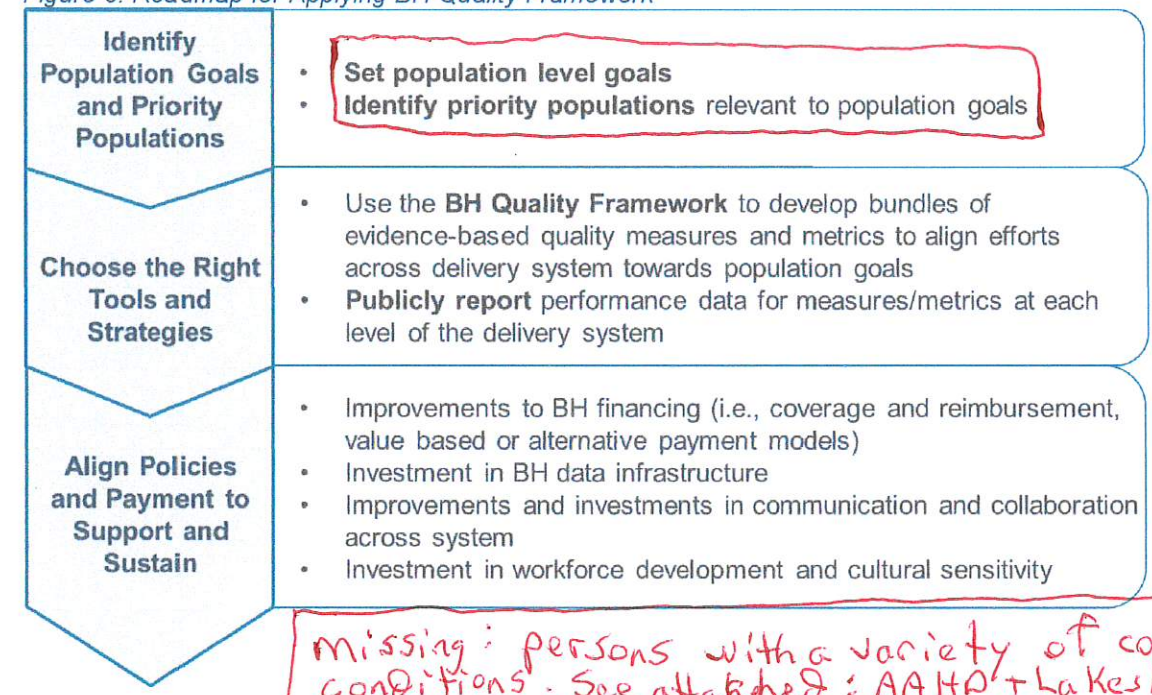
As national efforts evolve to pay for value rather than volume, value-based payment models that are guided by robust quality measures are urgently needed to support equitable, coordinated care for

Stakeholders at each level of the system (macro or state/federal; meso or MCO; micro or facility) will identify the most salient, meaningful, and relevant performance measures and metrics. In this model, the goal is not to replicate measures across system levels; rather, measure bundles are transparently defined, measured, and coordinated, with each entity using data to improve care based on its unique position and relationship to its populations and the prioritized goal. Below, we illustrate how this framework can promote collaboration and joint accountability for whole-person care.

Proposed Roadmap to Joint Accountability: Applying the BH Quality Framework

Federal and state entities are positioned to drive improvements in BH care and impact population health goals by setting priorities and directing resources through regulations and financial support. The BH Quality Framework calls for convening a diverse group of stakeholders that includes state policymakers, payers, providers, and consumers to jointly prioritize population goals for BH and target underserved, marginalized populations. Below, we highlight key steps that could drive joint accountability efforts *(Figure 6)*.

Figure 6: Roadmap for Applying BH Quality Framework



missing: persons with a variety of co-occurring conditions. See attached: AAHD + Lakeshore: (1) March 7, 2022 to Senate HELP; (2) March 30, 2022 to Senate Finance

Step 1: Identify Priority Goals and Relevant Populations

To achieve a joint accountability framework for BH, stakeholders across the system should convene to identify population health goals and priority populations. They should apply an equity lens and systematically address gaps in access and outcomes among populations with BH needs. For example, given the ongoing opioid epidemic in the United States and the exacerbation and increase in deaths during the COVID-19 pandemic, a priority population goal may involve reducing opioid-related overdose and mortality. Populations at risk may include individuals with diagnosed opioid use disorder (OUD), individuals who have experienced an adverse opioid-related drug event (e.g., intentional or unintentional opioid overdose), and individuals who rely on prescribed opioid analgesics to manage pain associated with a chronic condition or medical procedure (e.g., fibromyalgia, dental surgeries). When setting goals, opportunities to address known disparities in health care should not be overlooked, such as poorer follow-up rates following non-fatal opioid overdose events among Black individuals compared to non-Hispanic White individuals, or the disproportionate number of OUD deaths among Black patients.[26,27]

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March 7, 2022

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RE: Persons with Co-Occurring Mental Illness and Substance Abuse Disorder; Persons with Co-Occurring Mental Illness and Chronic Medical Conditions; Persons with Co-Occurring Mental Health and Intellectual and Other Developmental Disabilities; Persons with Co-Occurring Behavioral Health Conditions and Disabilities

Thank you Susannah and Charolotte for your availability, openness, and responsiveness to the Mental Health Liaison Group (MHLG).

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LAKESHORE

RE: StatementsfortheRecord@finance.senate.gov

RE: March 30 Senate Committee on Finance Hearing: Behavioral Health Care When Americans Need It: Ensuring Parity and Care

RE: Persons with Co-Occurring Mental Illness and Substance Abuse Disorder; Persons with Co-Occurring Mental Illness and Chronic Medical Conditions; Persons with Co-Occurring Mental Health and Intellectual and Other Developmental Disabilities; Persons with Co-Occurring Behavioral Health Conditions and Disabilities

March 30, 2022

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The American Association on Health and Disability (AAHD) (www.aahd.us) is a national non-profit organization of public health professionals, both practitioners and academics, with a primary concern for persons with disabilities. The AAHD mission is to advance health promotion and wellness initiatives for persons with disabilities. AAHD is specifically dedicated to integrating public health and disability into the overall public health agenda.