NEW YORK STATE | Department of Health | Medicaid Redesign Team

Behavioral Health
Substance Use Disorder (SUD)

Clinical Advisory Group #6

Meeting Date: July 8, 2016

Tentative Meeting Schedule & Agenda

Depending on the number of issues address during each meeting, the meeting agenda for each CAG meeting will consist of the following:

Meeting 1

- Clinical Advisory Group - Roles and Responsibilities
- Introduction to Value Based Payment
- HARP Population Definition and Analysis
- Introduction to Outcome Measures

Meeting 2

- Recap First Meeting
- HARP Population Quality Measures

Meeting 3

- Episodes - Understanding the Approach
  - Depression Episode
  - Bipolar Disorder Episode
- Introduction to Bipolar Disorder Outcome Measures

Meeting 4

- Behavioral Health CAG – Status Recap and Scope Refinement
- CVG Behavioral Health Episode Restructuring Process
- Behavioral Health Episodes and the Big Picture
- Depression & Anxiety (D&A) – Trauma & Stressor (T&S) Episode Definition
- Introduction to D&A – T&S Outcome Measures

Meeting 5

- Depression & Anxiety and Trauma & Stressor Quality Measure – Recap and Finalization
- Behavioral Health Scope Refinement
- Understanding the Approach – Introduction to HCI3
- Schizophrenia Episode Definition
- Introduction to Schizophrenia Outcome Measures

Meeting 6

- Welcome for new SUD CAG members
- Introduction to Value Based Payment
- BH CAG
- Understanding the Approach – Introduction to HCI3
- SUD Episode Definition
- SUD Quality Measures

Agenda

Introductions & Tentative Meeting Schedule and Agenda:

- Welcome for new SUD CAG members
- Introduction to Value Based Payment
- BH CAG
    - Roles and Responsibilities
    - Progress to Date
    - BH CAG Scope
- Understanding the Approach – Introduction to HCI3
- SUD Episode Definition
- SUD Quality Measures

Appendices

A. Introduction to Value-Based Payment

Brief background and context

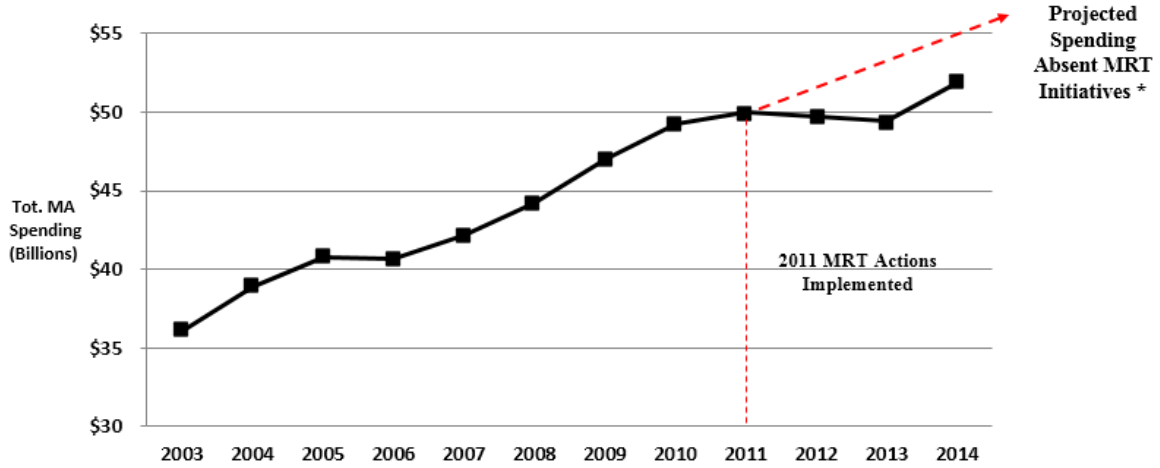
NYS Medicaid in 2010: the Crisis

- > 10% growth rate had become unsustainable, while quality outcomes were lagging
  - Costs per recipient were double the national average
  - NY ranked 50th in country for avoidable hospital use
  - 21st for overall Health System Quality

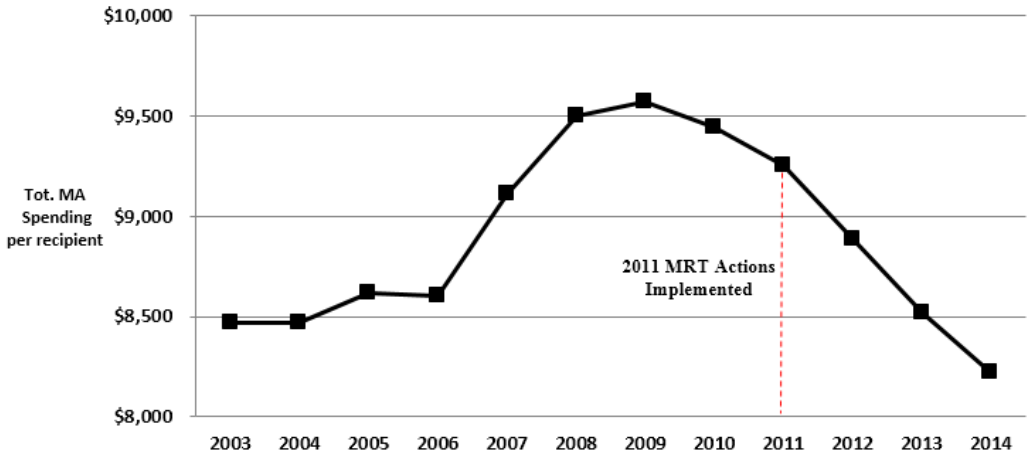
2009 Commonwealth State Scorecard on Health System Performance

CARE MEASURE	*NATIONAL RANKING*
Avoidable Hospital Use and Cost	**50th**
✓ Percent home health patients with a hospital admission	49th
✓ Percent nursing home residents with a hospital admission	34th
✓ Hospital admissions for pediatric asthma	35th
✓ Medicare ambulatory sensitive condition admissions	40th
✓ Medicare hospital length of stay	50th

Medicaid Redesign Initiatives Have Successfully Brought Back Medicaid Spending per Member to below 2003 Levels



Since 2011, total Medicaid spending has stabilized *while number of members has grown > 12%*



Medicaid spending per-member has continued to decrease

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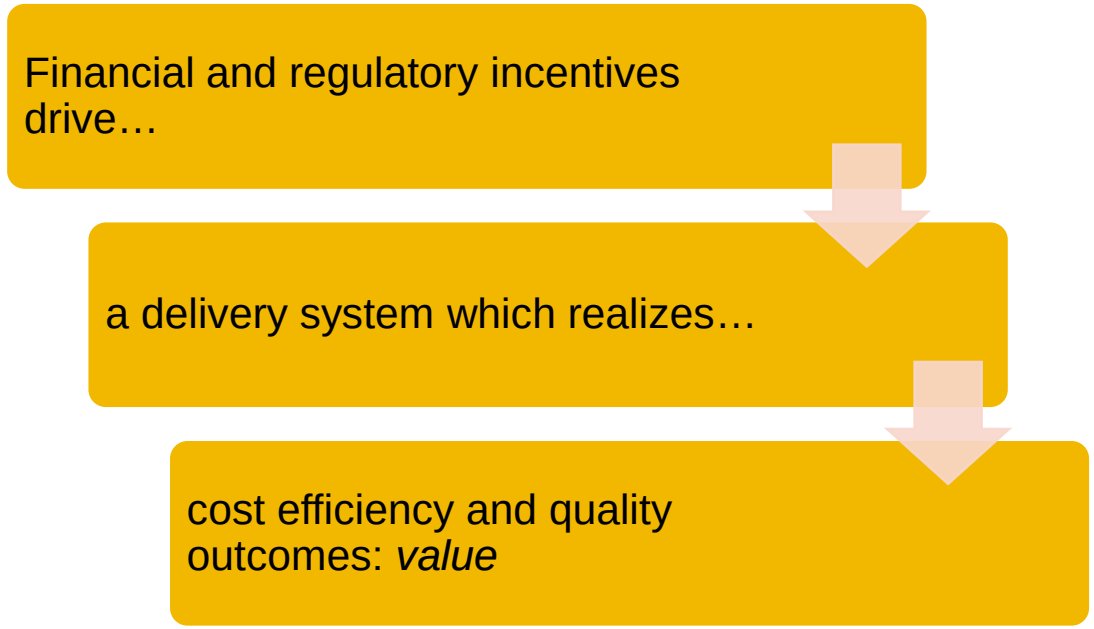
Delivery Reform and Payment Reform: Two Sides of the Same Coin

- A thorough transformation of the delivery system – DSRIP - can only become and remain successful when the payment system is transformed as well
- Many of NYS system's problems (fragmentation, high re-admission rates) are rooted in how the State pays for service
  - FFS pays for inputs rather than outcome; an avoidable readmission is rewarded more than a successful transition to integrated home care

- Current payment systems do not adequately incentivize prevention, coordination, or integration



Payment Reform: Moving Towards Value Based Payments

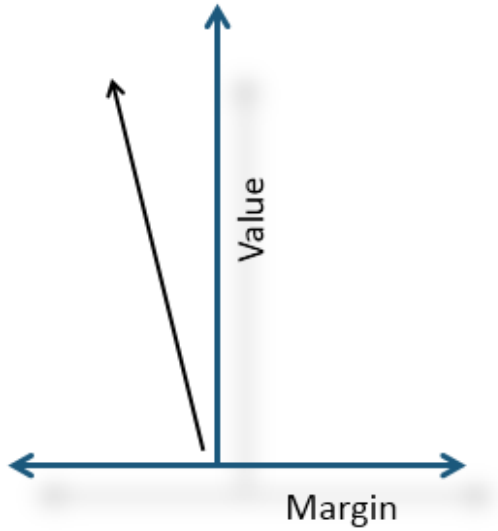
- A Five-Year Roadmap outlining NYS' plan for Medicaid Payment Reform was required by the MRT Waiver
- By DSRIP Year 5 (2019), all Managed Care Organizations must employ non fee-for-service payment systems that reward value over volume for at least 80-90% of their provider payments (outlined in the *Special Terms and Conditions* of the waiver)
- Core Stakeholders (providers, MCOs, unions, patient organizations) have actively collaborated in the creation of the Roadmap

Learning from Earlier Attempts: VBP as the Path to a Stronger System

VBP arrangements are not intended primarily to save money for the State, but to *allow providers to increase their margins* ***by realizing value***

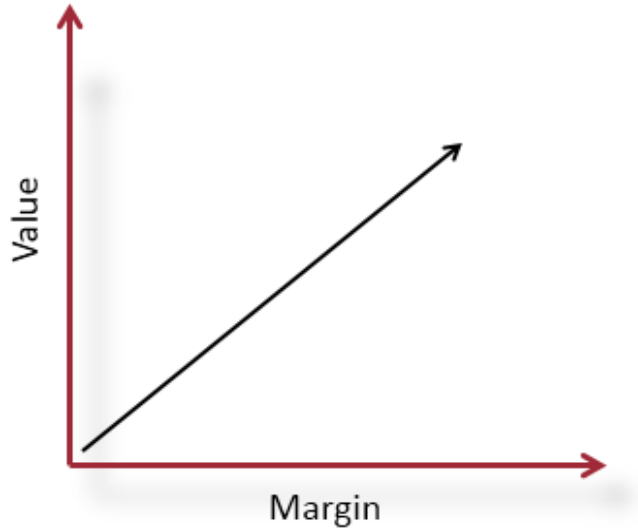
Current State

Increasing the value of care delivered more often than not threatens providers' margins



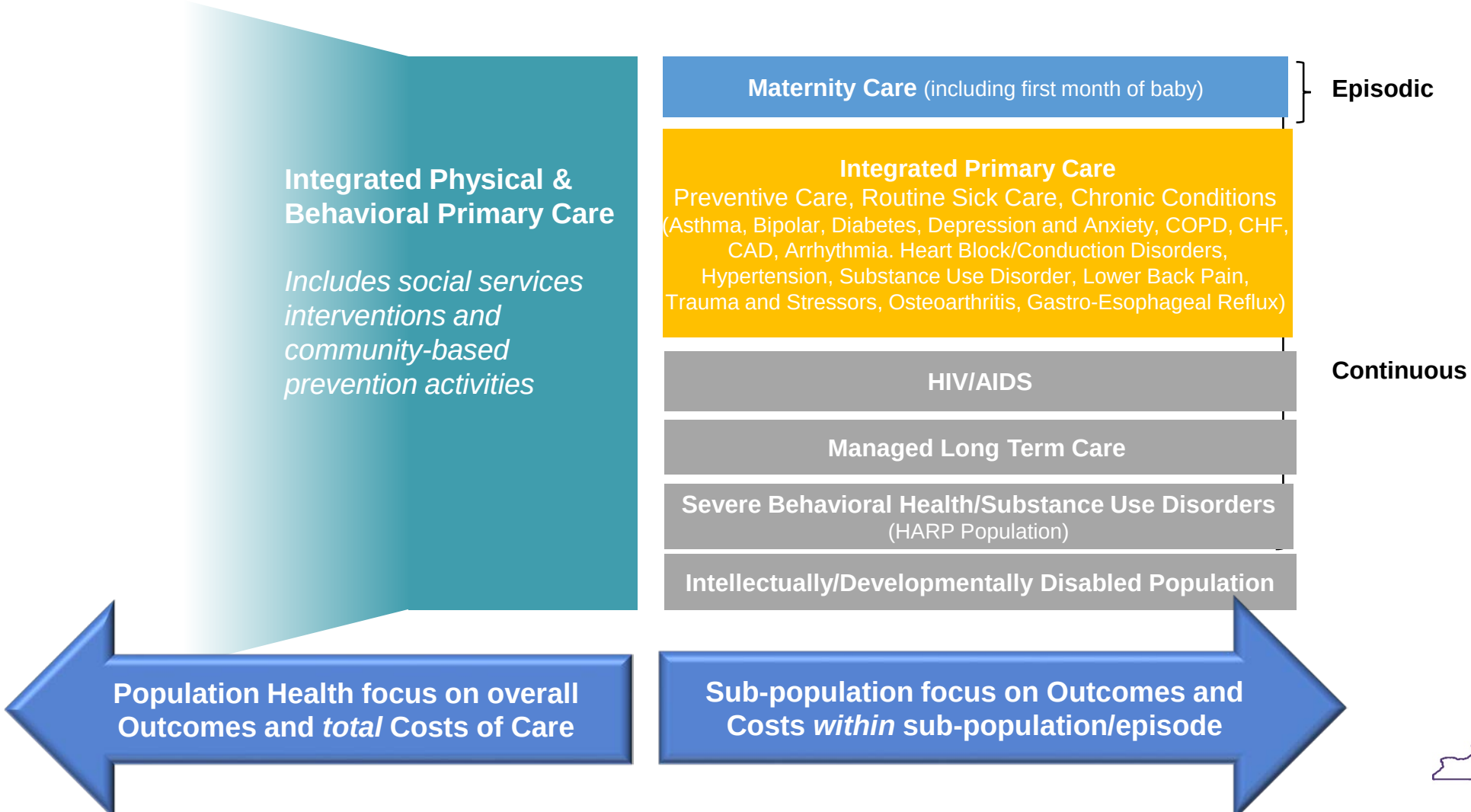
Future State

When VBP is done well, providers' margins go up when the value of care delivered increases



Goal – Reward Value not Volume

The VBP Roadmap starts from DSRIP Vision on How an Integrated Delivery System should Function

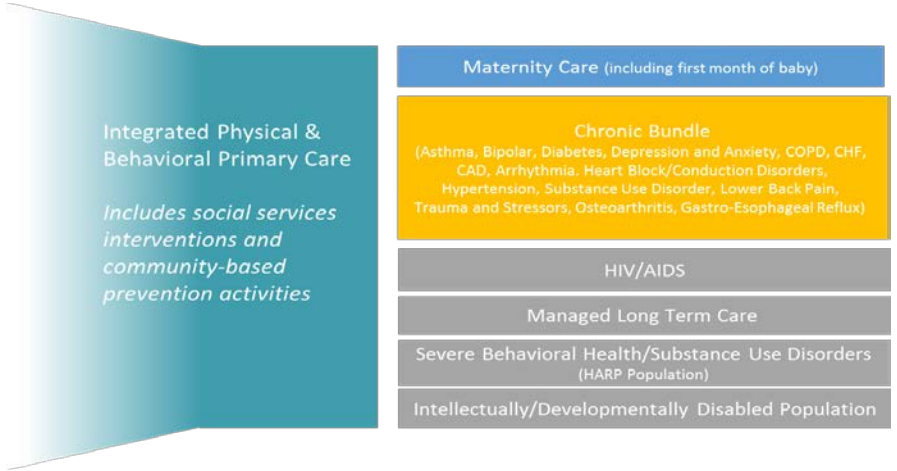


The Path Towards Payment Reform: A Menu of Options

There is not one path towards Value Based Payments. Rather, there will be a variety of options that MCOs and PPSs/providers can jointly choose from.

PPSs and MCOs can opt for different shared savings/risk arrangements (often building on already existing MCO/provider initiatives):

- For the total care for the total attributed population of the PPS (or part thereof) – ACO model
- Per integrated service for specific condition (acute or chronic bundle): maternity care; diabetes care
- For integrated Advanced Primary Care (APC)
- For the total care for a subpopulation: HIV/AIDS care; care for patients with severe behavioral health needs and comorbidities



MCOs and PPSs can make shared savings arrangements for the latter types of services between MCOs and groups of providers within the PPS rather than between MCO and PPS.

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MCOs and PPSs Can Choose Different Levels of Value Based Payments

In addition to choosing *what integrated services* to focus on, the MCOs and PPSs can choose different levels of Value Based Payments:

Level 0 VBP	Level 1 VBP	Level 2 VBP	Level 3 VBP (only feasible after experience with Level 2; requires mature PPS)
FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings available when quality scores are sufficient (For PCMH/APC, FFS may be complemented with PMPM subsidy)	FFS with risk sharing (upside available when quality scores are sufficient)	Prospective capitation PMPM or Bundle (with quality-based component)

- Goal of ≥80-90% of total MCO-provider payments (in terms of total dollars) to be captured in Level 1 VBPs at end of DY5
- 35% of total managed care payments (full capitation plans only) tied to Level 2 or higher. For Level 2 (risk-bearing VBP arrangements), the State excludes partial capitation plans such as MLTC plans from this minimum target.

B. Clinical Advisory Group

- Roles and Responsibilities Overview
- Progress to Date
- BH Scope

Clinical Advisory Group Details

Comprehensive Stakeholder Engagement

- Comprehensive stakeholder engagement has been a key component to the development of the Value Based Payment Roadmap.
- We will continue engaging stakeholders as we develop and define opportunities for value based payment arrangements.

Composition of the CAG includes:

- Clinical experience and knowledge focused on the specific care or condition being discussed
- Industry knowledge and experience
- Geographic diversity
- Total care spectrum as it relates to the specific care or condition being discussed

CAG Objectives:

- Understand the State's visions for the Roadmap to Value Based Payment
- Review clinical bundles/subpopulations that are relevant to NYS Medicaid
- Make recommendations to the State on:
  - quality measures
  - data and other support required for providers to be successful
  - other implementation details related to each bundle/subpopulation

❖ *Definitions are standard, but financial arrangements between plans and providers around the bundles are not set by the State.*

❖ *We will discuss the specific characteristics of the Behavioral Health population & the challenges of the Medicaid-Medicare divide later in the presentation*

BH CAG Progress to Date

	Description				
COMPOSITION	▪ Approximately 40 members from a variety of organizations: OMH, OASAS, NYS and NYC DOH, Empire, GNHYA, MSSNY, Maimonides, Bronx-Lebanon, Lake Shore Health, etc. ▪ The CAG membership was created with an emphasis on clinical experience and knowledge focused on behavioral health, industry knowledge and experience, geographic diversity and total care spectrum as it relates to the specific care or condition being discussed.				
SCHEDULE	▪ The CAG first convened in August 2015 ▪ There have been 4 meetings thus far ▪ Meetings occur in both Albany and NYC				
MEETINGS & AGENDAS	CAG 1 (HARP pt. 1)	CAG 2 (HARP pt. 2)	CAG 3 (Bipolar)	CAG 4 (Depression & Anxiety; Trauma & Stressor)	CAG 5 (Depression & Anxiety; Trauma & Stressor; Schizophrenia)

	▪ Clinical Advisory Group - Roles and Responsibilities
	▪ Introduction to Value Based Payment
	▪ HARP Population Definition and Analysis
	▪ Introduction to Outcome Measures
		▪ Recap First Meeting
		▪ HARP Population Quality Measures
			▪ Episodes - Understanding the Approach
			  ▪ Depression Episode
			  ▪ Bipolar Disorder Episode
			▪ Introduction to Bipolar Disorder Outcome Measures
				▪ Understanding the Approach – Introduction to HCI3
				▪ CVG Behavioral Health Episode Restructuring Process
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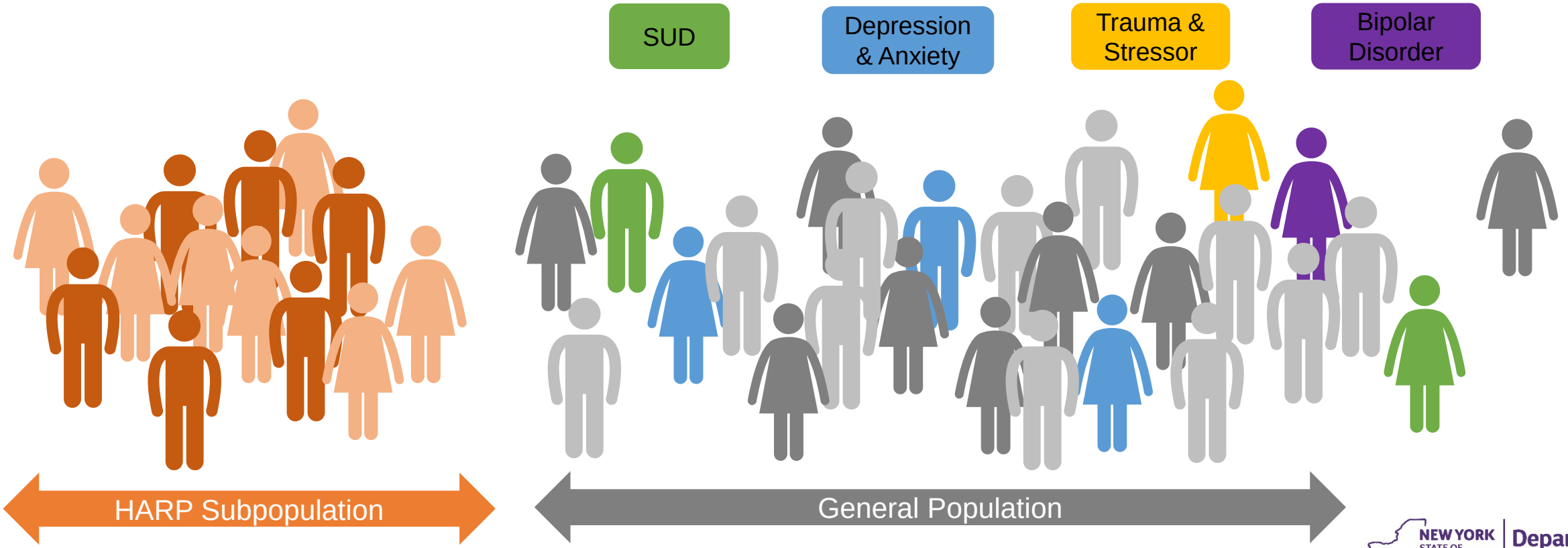
					▪ Introduction to Schizophrenia Outcome Measures

Behavioral Health CAG Scope

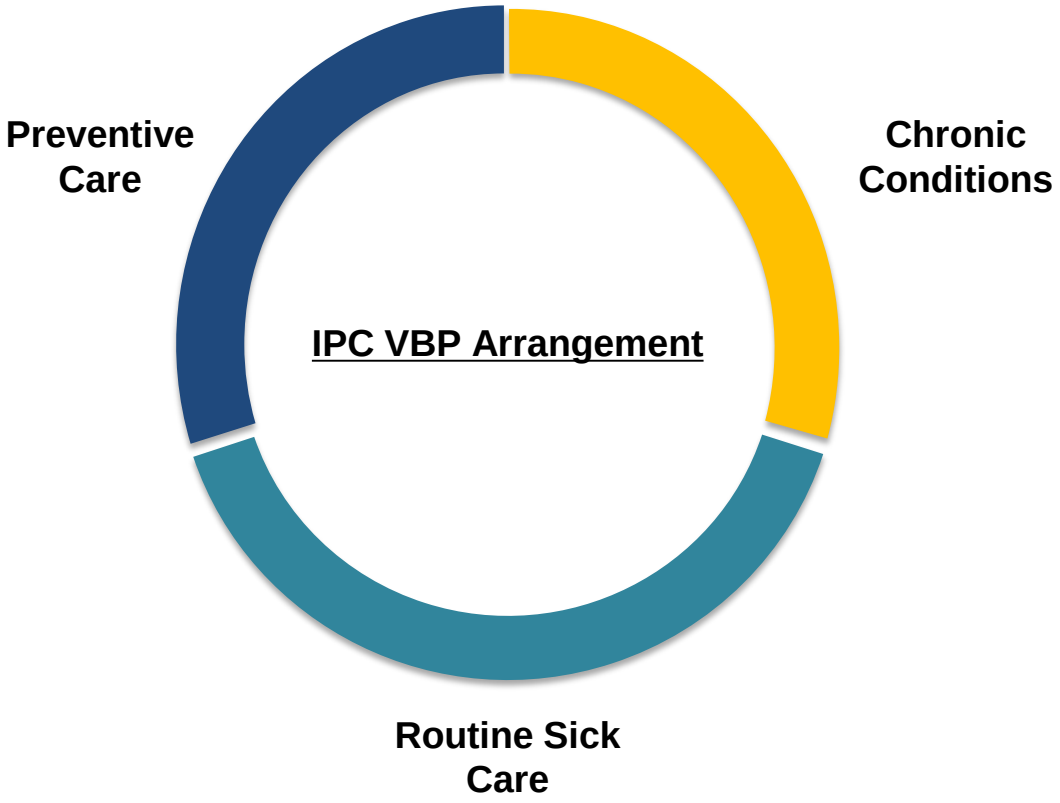
- The BH CAG comprises:
  - The HARP subpopulation which is contracted separately in a Total Cost For Subpopulation arrangement.
  - It also includes episodes which are contracted in the general population through the Integrated Primary Care (IPC) arrangement.



How would SUD episode be contracted?

Includes e.g.:
- Wellness visits
- Immunizations, vaccinations (Medicaid-covered)
- Screening
- Routine diagnostics

Similar to ACA list of preventive care activities.



Two criteria determined the current list of chronic conditions:
1. Lead provider is, should and/or can be part of Integrated Primary Care (coordination with specialty care when needed is key)
2. Highest volume and costs within Medicaid program

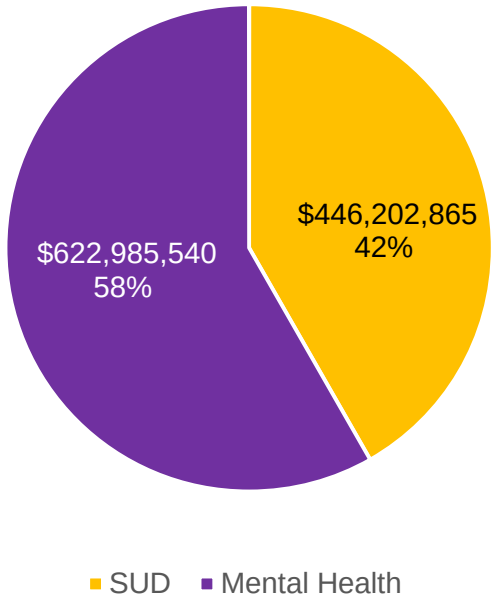
Includes 14 chronic conditions:
Asthma, Bipolar, Diabetes, Depression and Anxiety, COPD, CHF, CAD, Arrhythmia, Heart Block/Conduction Disorders, Hypertension, **Substance Use Disorder**, Lower Back Pain, Trauma and Stressors, Osteoarthritis, Gastro-Esophageal Reflux

Includes e.g.:
- Symptom-related care (headache, tiredness) not resulting in diagnosis
- Care for e.g. routine upper respiratory infections, rhinitis etc.

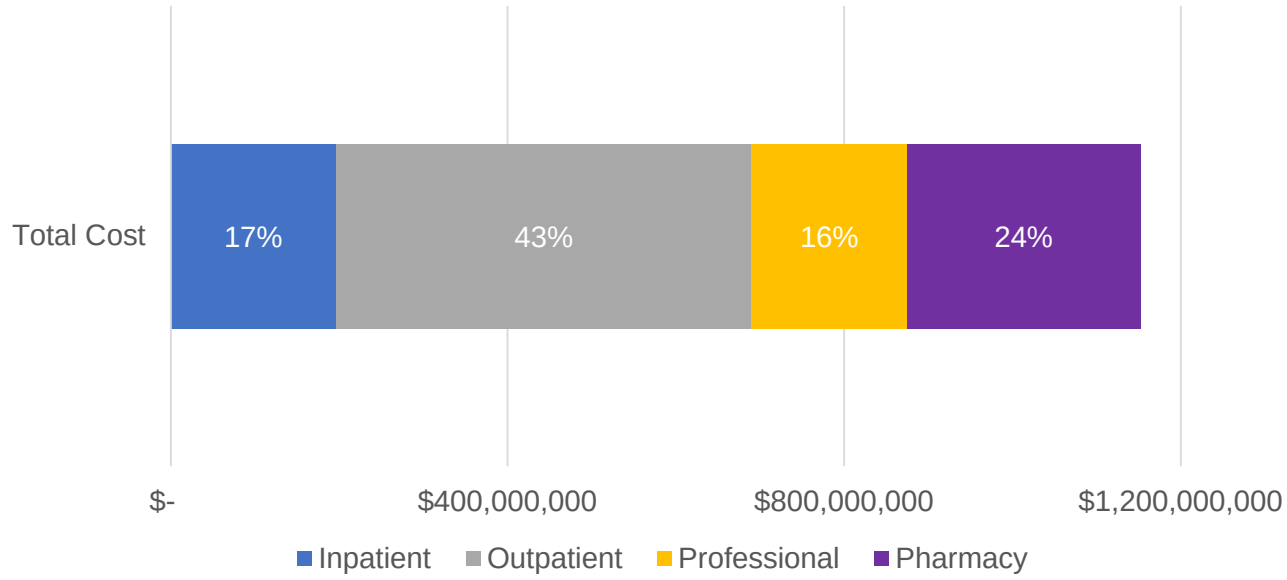
Behavioral Health Cost Breakdown

- Drilling into the Behavioral Health conditions (32%) of the Chronic Bundle
  - The Mental Health episodes represent slightly more than half of the total cost
  - The majority of typical care cost is comprised of outpatient visits

SUD vs. Mental Health Episodes, by Total Cost (CY2014)



Behavioral Health Total Cost, by Service Category (CY2014)



*Service category analysis is performed at level 1 instead of level 5.

Costs Included:

- Fee-for-service and MCO payments (paid encounters);
- Caveat: add-on payments included in some cost data, not in others (GME/IME, HCRA, Capital). Data not yet standardized.

Source: CY2014 Medicaid claims, Real Pricing, Level 5 (Level 1 for Service Category graph), General Population

Mental Health is defined as Bipolar Disorder, Depression & Anxiety and Trauma & Stressor Episodes

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C. Understanding the Approach

Introduction to HCI3

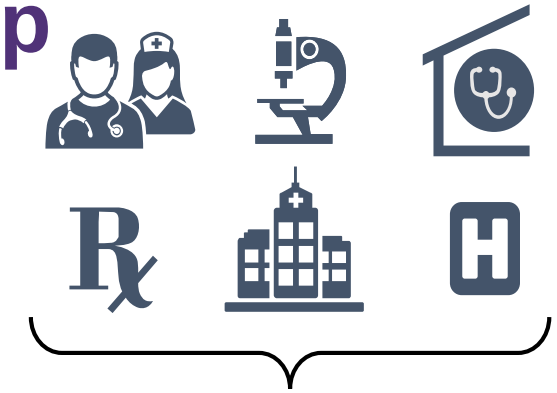
Why HCI3? – **Recap**

- One of two nationally used bundled payment programs
- Specifically built for use in value based payment
- Not-for-profit and independent
- Open source
- Clinically validated
- National standard which evolves based on new guidelines as well as lessons learned

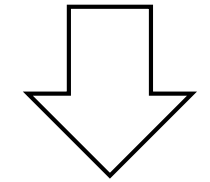
Source: HCI3 Homepage, available at – http://www.hci3.org/

Evidence Informed Case Rates (ECRs) – **Recap**

- Evidence Informed Case Rates (ECRs) are the HCI3 episode definitions
- ECRs are patient centered, time-limited, episodes of treatment
- Include all covered services related to the specific condition
  - E.g.: surgery, procedures, management, ancillary, lab, pharmacy services
- Distinguish between “typical” services from “potentially avoidable” complications
- Are based on clinical logic: Clinically vetted and developed based on evidence-informed practice guidelines or expert opinions



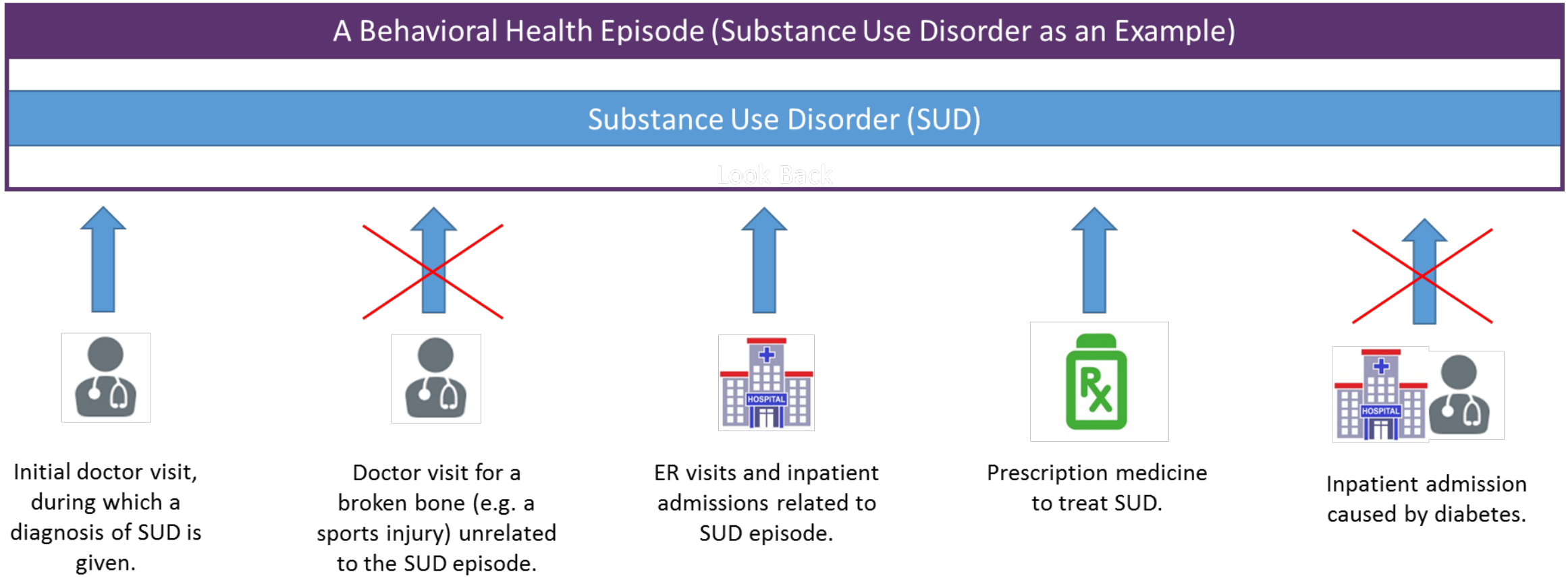
All patient services related to a single condition



Sum of services (based on encounter data the State receives from MCOs).

Source: HCI3 Presentation, available at – http://216.70.89.98/onlinecourses/Module201prt1.htm

Clinical Logic – **Recap**



Source: HCI3 Presentation, available at – http://216.70.89.98/onlinecourses/Module201prt1.htm

Episode Component: Triggers – **Recap**

A trigger signals the opening of an episode, e.g.:

- Inpatient Facility Claim
- Outpatient Facility Claim
- Professional Claim

More than one trigger can be used for an episode

- A confirming claim is used to reduce false positives

Triggers for SUD:

1. Inpatient claim with a SUD diagnosis as the principal diagnosis code

2. Outpatient claim with a SUD diagnosis in any position accompanied by an Evaluation & Management (E&M) procedure code on the same claim

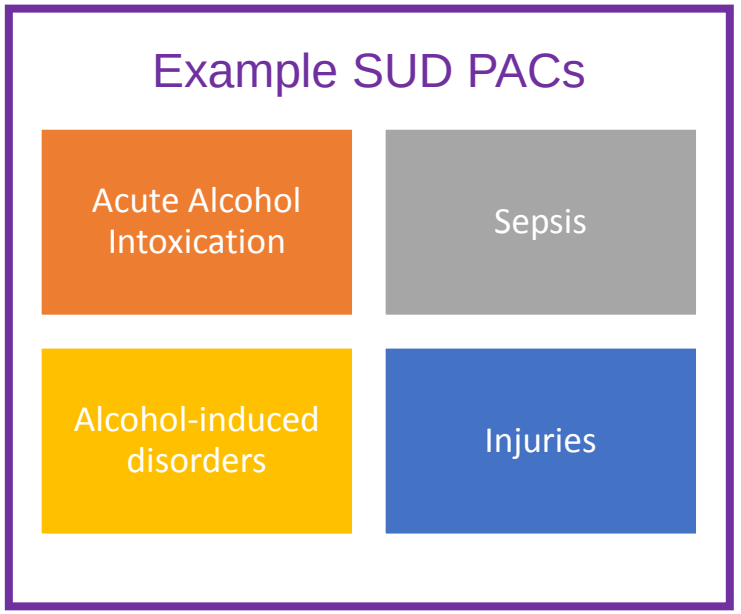
3. Professional service claim with a SUD diagnosis in any position accompanied by an E&M procedure code on the same claim *with a confirming claim*, which…

- Must occur within a certain time period following the initial professional claim
- Can be an inpatient, outpatient, or professional claim which meet the criteria described above

Source: http://www.hci3.org/content/hci3s-measures-improve-quality-and-outcome-care-patients-endorsed-nqf

Episode Components: PACs – **Recap**

- Costs are separated for “typical” care, from costs associated with care for Potentially Avoidable Complications (PACs)
- PACs can stem from care avoidance, poor coordination, failure to implement evidence-based practices or from medical error
- As all aspects of the episode definitions, PACs are established as a national standard by clinical expert groups, and constantly evolve on the basis of feedback and validation work
- Risk-adjusted expected costs of PACs are built in as an incentive towards a shared savings
- Only events that are generally considered to be (potentially) avoidable by the caregivers that manage and co-manage the patient are labeled as ‘PACs’ by clinical expert groups
- Examples of PACs: exacerbations, ambulatory-care sensitive admissions, and inpatient-based patient safety features

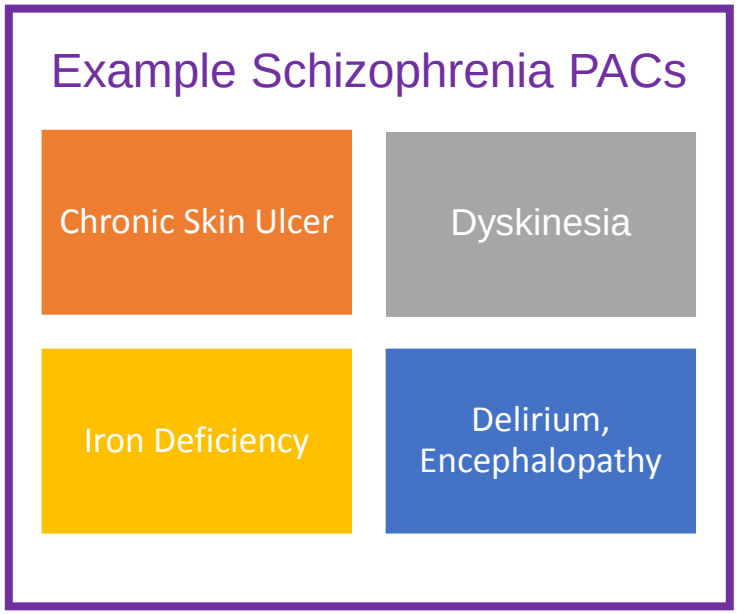


Source: http://www.hci3.org/content/hci3s-measures-improve-quality-and-outcome-care-patients-endorsed-nqf

Episode Components: PACs – **Recap**

Two uses of PACs:

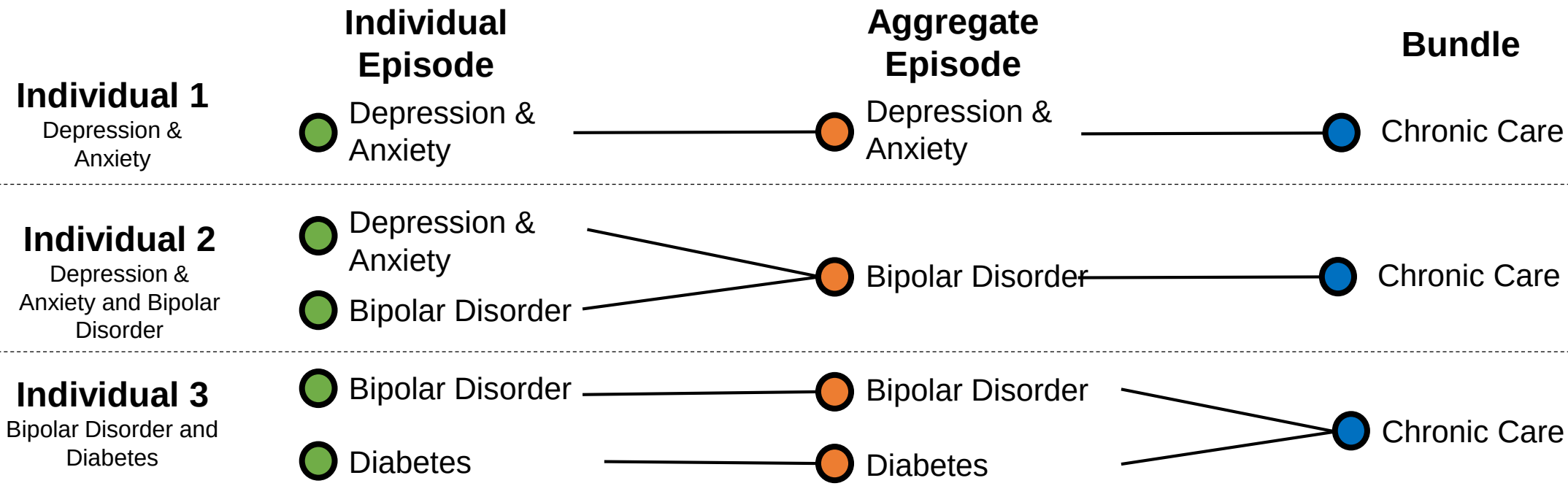
- **% of episode costs that are PACs**: indication for improvement opportunity
- **% of episodes without a PAC:** endorsed by NQF for several physical chronic episodes. Validation of use as *overall* outcome measure for chronic episodes and the Chronic Bundle is ongoing
- *All risk-adjusted measures*



Source: http://www.hci3.org/content/hci3s-measures-improve-quality-and-outcome-care-patients-endorsed-nqf

Episode Components: Leveling – **Recap**

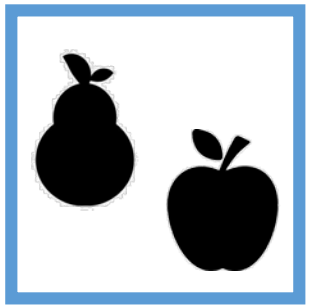
The grouper uses the concept of leveling (individual episode, aggregate episode and bundle), in which individual associated episodes may get grouped together to reflect a primary diagnosis as you move higher in the levels



As you move higher up in levels, associated episodes get grouped together to reflect a primary diagnosis

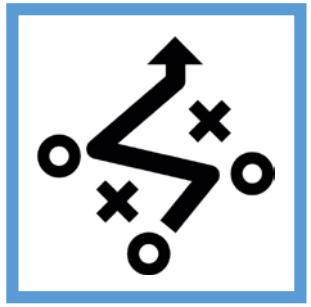
Source: More information can be found at – http://www.hci3.org/programs-efforts/prometheus-payment/ecr-analytics

Risk Adjustment for Episodes – **Recap**



Make “apples-to-apples” comparisons between providers by accounting for differences in their patient populations

Takes the patient factors (co-morbidity, severity of condition at outset, etc.) out of the equation



Separate risk adjustment models are created for ‘typical’ services and for ‘potentially avoidable complications’

Source: More information can be found at – : http://www.hci3.org/programs-efforts/prometheus-payment/ecr-analytics

Inclusion and Identification of Risk Factors – **Recap**

The CVG helped redefine the parameters of age and developed subtypes for SUD.

Risk Factors

- Patient demographics – Age, gender, etc.
- Risk factors - Co-morbidities
- Subtypes - Markers of clinical severity within an episode

Patient related risk factors

Episode related risk factors

Examples of Subtypes
SUD Subtypes: alcohol dependence, drug induced mental disorder, SUDS in remission, and cocaine and amphetamine dependence.

- **Identification Risk Factors**
  - Risk factors come from historic claims (prior to start of an episode) and same list is applied across all episode types
  - Subtypes identified from claims at start of the episode and specific to episode type

Four Important Costs Drivers for Episodes are Price, Volume, PACs and Service Mix – **Recap**

Cost Drivers

Price

The price of a service can vary based on providers' own costs (e.g. wages). In NYS, we will in the beginning only use price-standardized ('proxy-priced') data for comparative purposes.

Volume

The volume of services rendered (e.g. doing 1 psychiatric evaluation vs. 3 in the first 2 months).

PACs

Potentially avoidable complications (e.g. acute situation).

Service Mix

The mix of services and intensity of care received during the episode (e.g. inpatient vs. outpatient point of care).

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D. SUD Episode Definition

SUD Episode

Trigger

- One or more claims that carry a diagnosis code for SUD and meet the trigger criteria that is specified for this episode

Confirming trigger

- Another trigger as stated above at least 30 days after the first trigger (for a Professional Billing E&M service *only*).

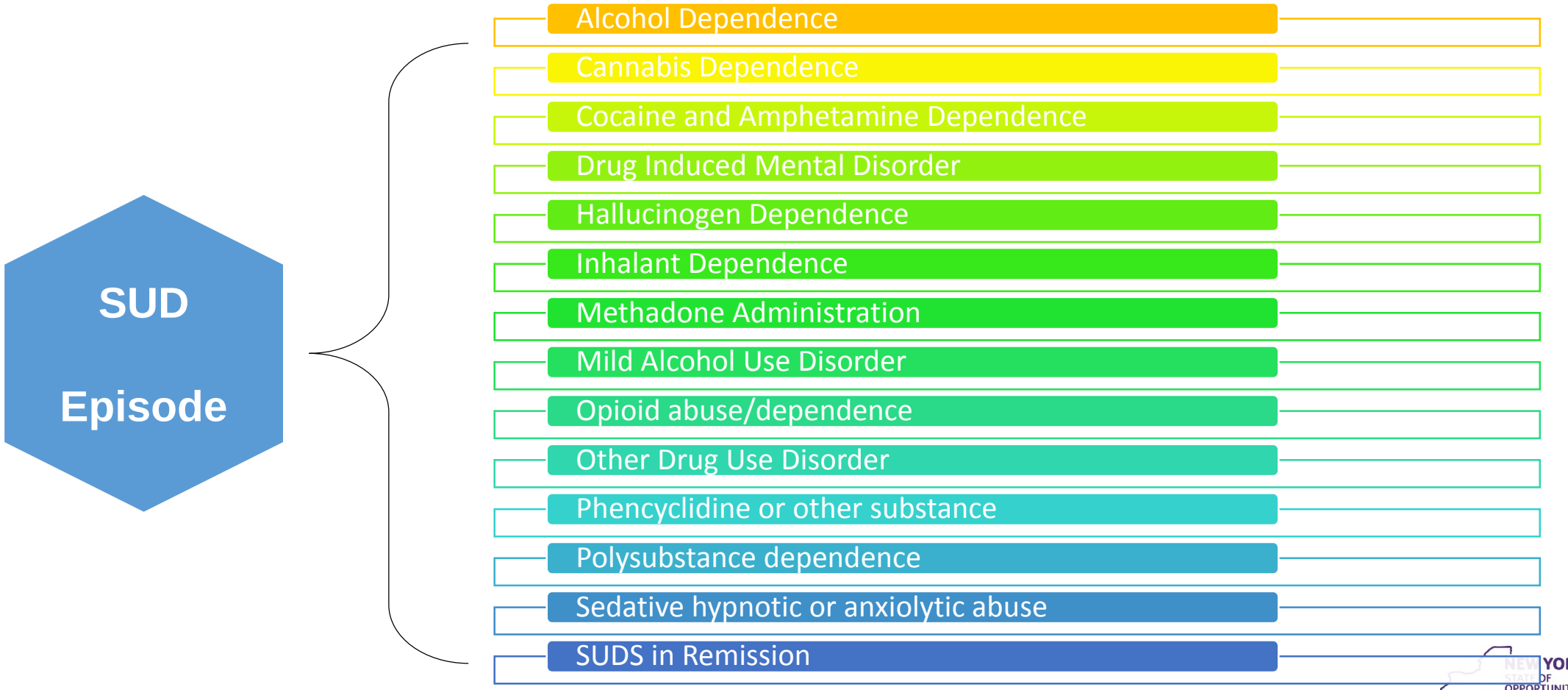
Included in episode:

- All typical and complication costs for schizophrenia during the duration of the episode

- In addition to hospitalizations, complications include, but are not limited to:
  - Acute Alcohol Intoxication
  - Alcohol-induced disorders
  - Injuries
  - Sepsis

SUD Episode Subtypes

- An example of some of the ICD-9 SUD subtypes captured within the episode are listed below (ICD-10 subtypes are still in development and will be validated by clinical validation group):



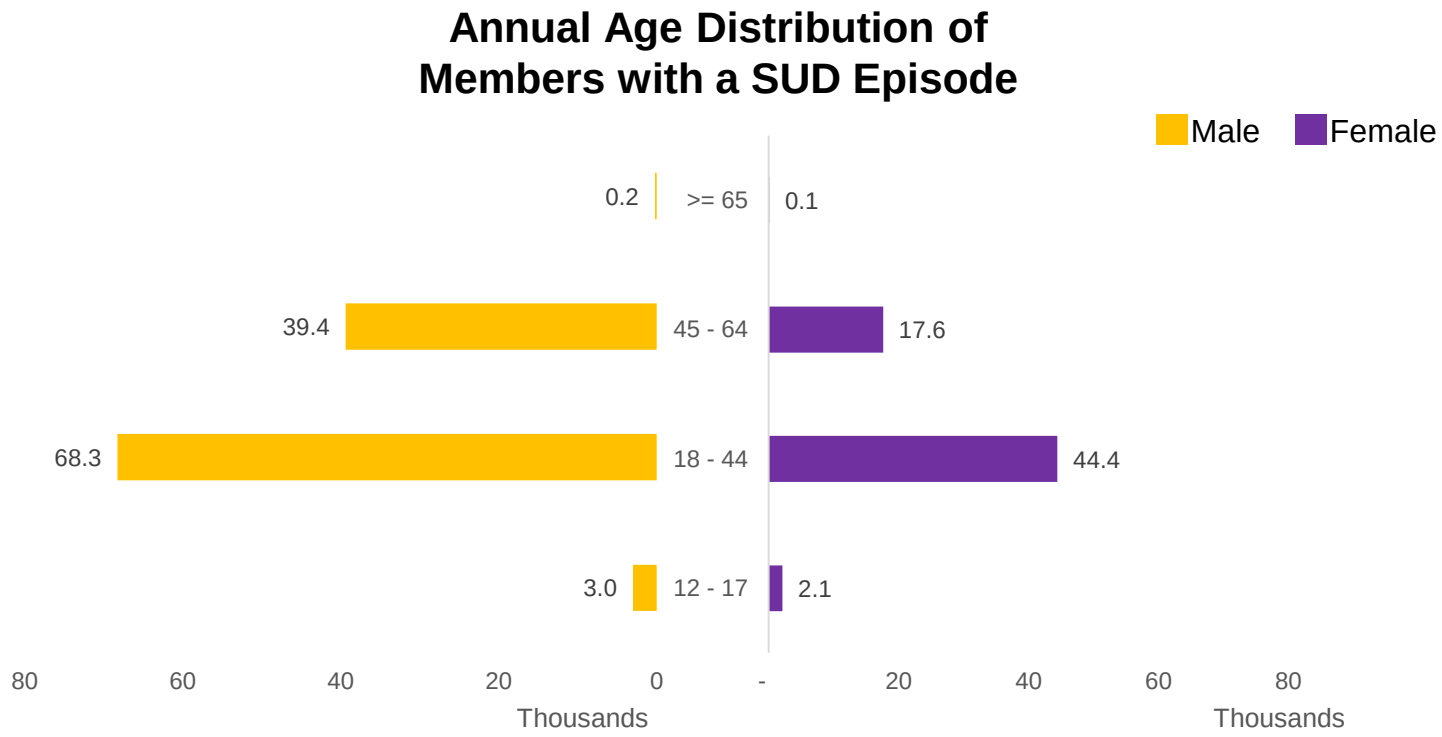
SUD episodes account for approximately $446M in Annual Medicaid Spend

Total Annual Cost of SUD (to the State)

$446M

Average Costs per Episode for Members with SUD

$2,552



Costs Included:

- Fee-for-service and MCO payments (paid encounters);
- Caveat: add-on payments included in some cost data, not in others (GME/IME, HCRA, Capital). Data not yet standardized.

Source: CY2014 Medicaid claims, Real Pricing, Level 5, General Population

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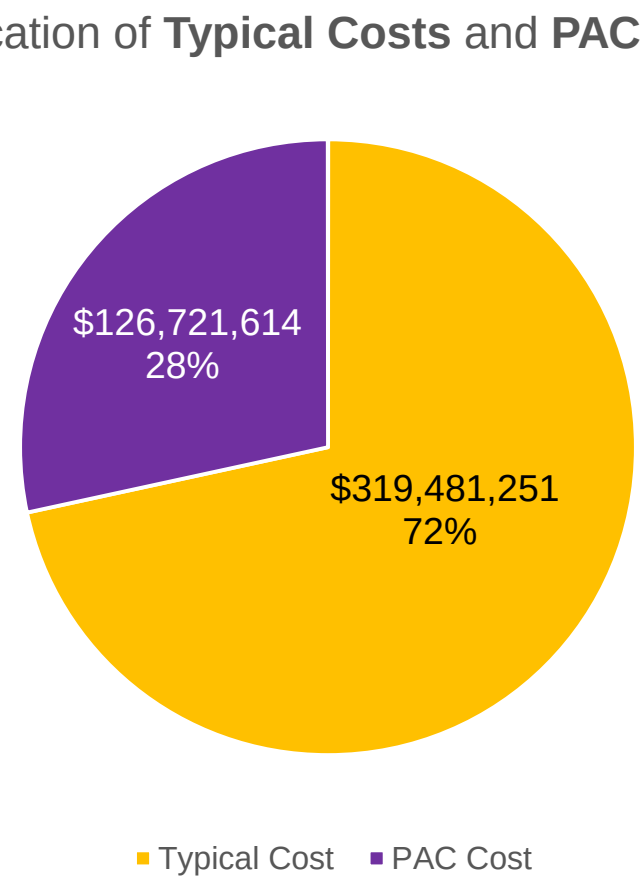
PAC Costs Represent $127M of All SUD Annual Costs



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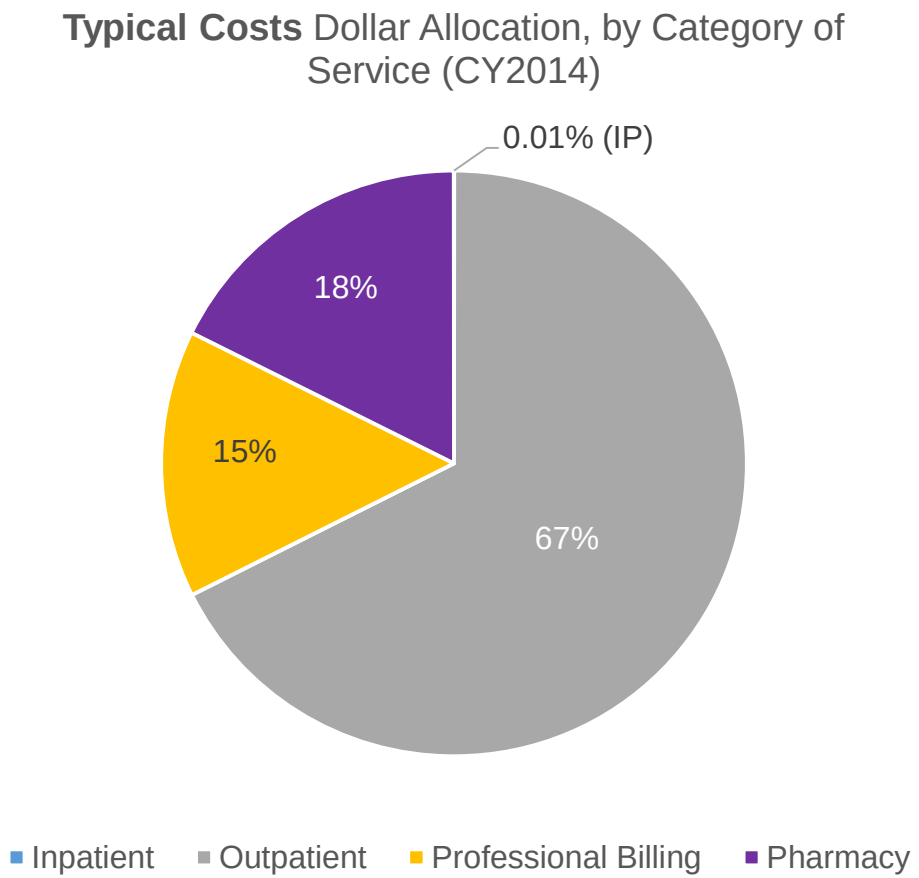
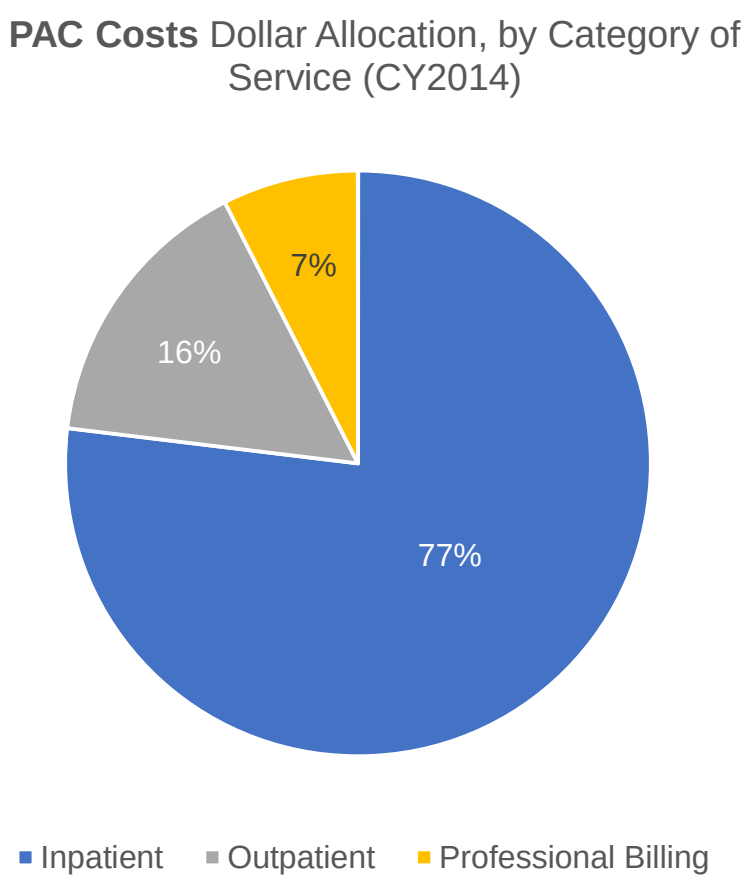
Category of Service Breakdown – SUD Typical vs. PAC Cost





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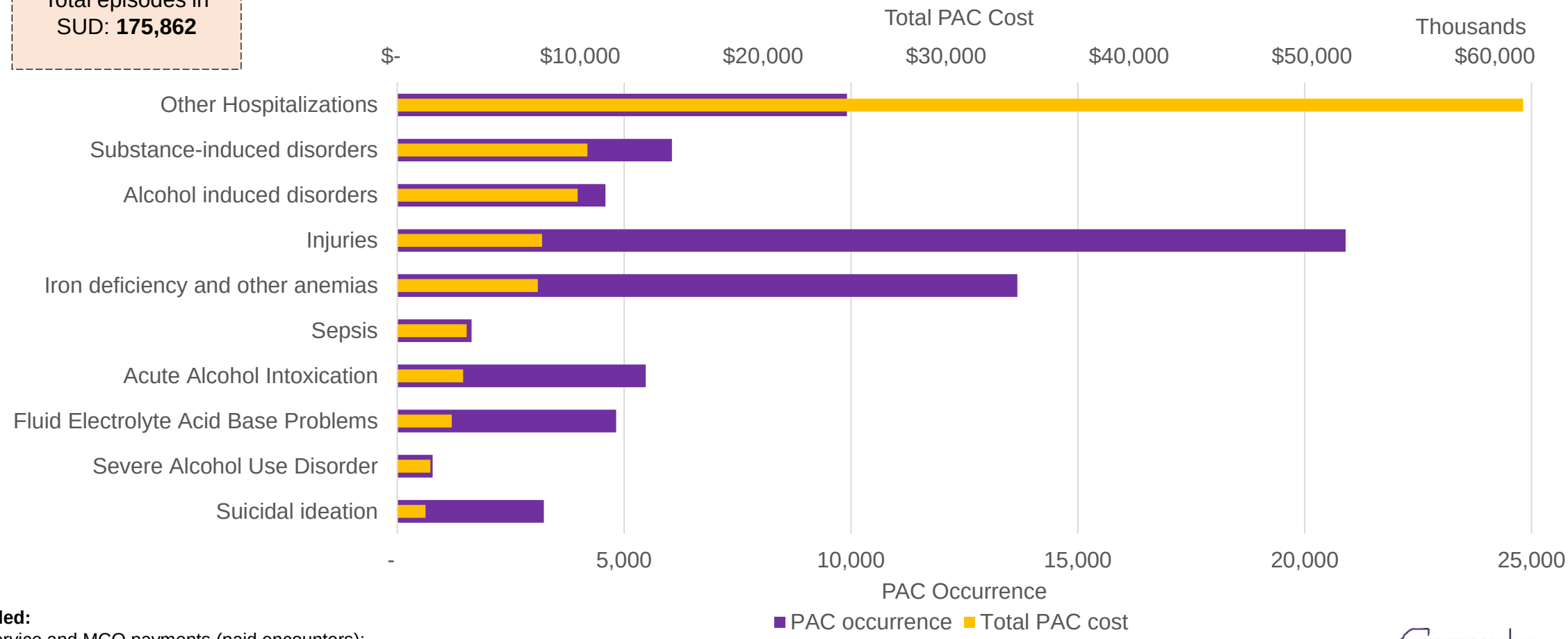
Source: CY2014 Medicaid claims, Real Pricing, Level 5, General Population

Top 10 SUD PACs Represent 88% of the Total Cost of SUD PACs

Total episodes in SUD: **175,862**



Costs Included:

- Fee-for-service and MCO payments (paid encounters);
- Caveat: add-on payments included in some cost data, not in others (GME/IME, HCRA, Capital). Data not yet standardized.

Source: CY2014 Medicaid claims, Real Pricing, Level 5, General Population

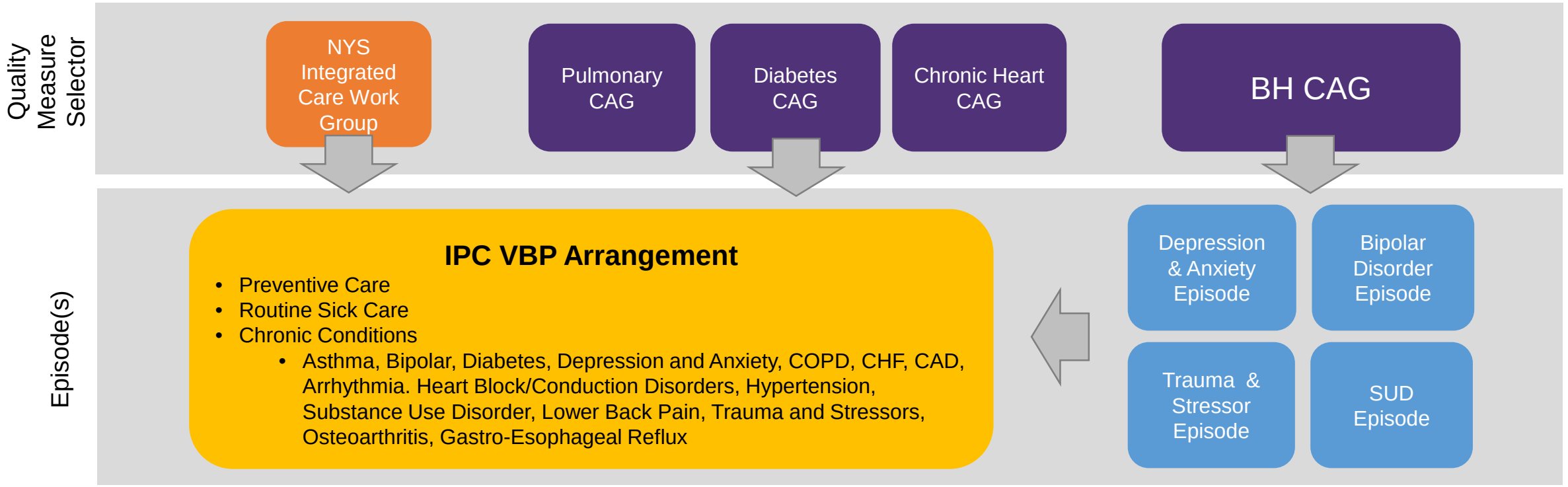
NEW YORK STATE OF OPPORTUNITY. Department of Health

E. Criteria for Selecting Quality Measures

Where do BH quality measures fit?

BH quality measures are used in 3 different VBP arrangements:

- BH Episodes
- Chronic Bundle
- Integrated Primary Care (IPC) – includes Depression & SUD Screen



Remember: Criteria for Selecting Quality Measures

CLINICAL RELEVANCE

- **Focused on key outcomes of integrated care process**

  I.e. outcome measures are preferred over process measures; outcomes of the total care process are preferred over outcomes of a single component of the care process (i.e. the quality of one type of professional's care).

- **For process measures: crucial evidence-based steps in integrated care process that may not be reflected in the patient outcome measures**

- **Existing variability in performance and/or possibility for improvement**

RELIABILITY AND VALIDITY

- **Measure is well established by reputable organization**

  By focusing on established measures (owned by e.g. NYS Office of Quality and Patient Safety (OQPS), endorsed by the National Quality Forum (NQF), HEDIS measures and/or measures owned by organizations such as the Joint Commission, the validity and reliability of measures can be assumed to be acceptable.

- **Outcome measures are adequately risk-adjusted**

  Measures without adequate risk adjustment make it impossible to compare outcomes between providers.

Remember: Criteria for Selecting Quality Measures

FEASIBILITY

- **Claims-based measures are preferred over non-claims based measures (clinical data, surveys)**
- **When clinical data or surveys are required, existing sources must be available**

  I.e. the link between the Medicaid claims data and this clinical registry is already established.

- **Preferably, data sources be patient-level data**

  This allows drill-down to patient level and/or adequate risk-adjustment. The exception here is measures using samples from a patient panel or records. When such a measure is deemed crucial, and the infrastructure exists to gather the data, these measures could be accepted.

- **Data sources must be available without significant delay**

  I.e. data sources should not have a lag longer than the claims-based measures (which have a lag of six months).

KEY VALUES

- **Behavioral health transformation focus**

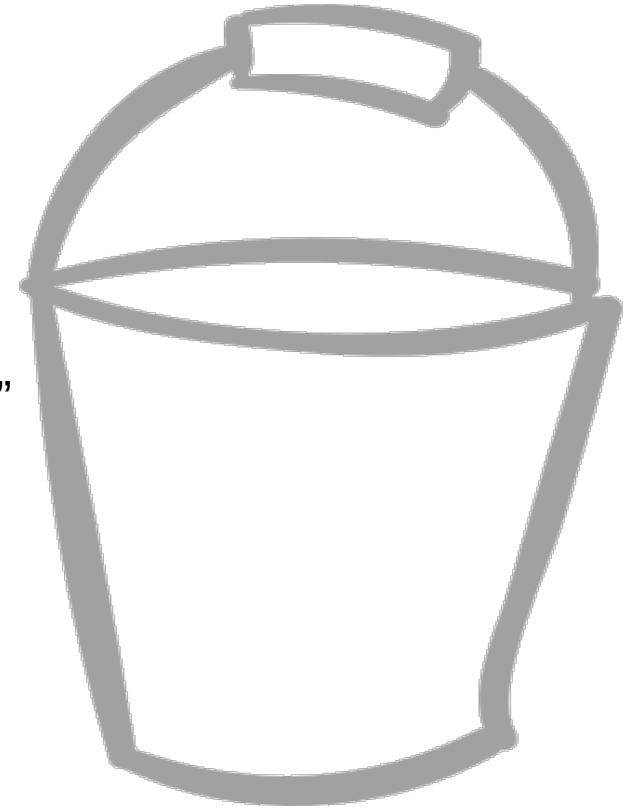
  i.e., measures are person-centered, recovery-oriented, integrated, data-driven and evidence-based

Measure Review Process

Similar process as was used in that last meeting: decide on measures by theme.

- Assessment and Screening
- Monitoring and Education
- Medication and Treatment Management
- Outcomes of care

After reviewing the list, assign measures to a categorization “bucket.”



Categorizing and Prioritizing Measures by Category (or 'Buckets')

CATEGORY 1
Approved quality measures that are felt to be both clinically relevant, reliable and valid, and feasible.

CATEGORY 2
Measures that are clinically relevant, valid and probably reliable, but where the feasibility could be problematic. These measures should be investigated during the 2016 or 2017 pilot.

CATEGORY 3
Measures that are insufficiently relevant, valid, reliable and/or feasible.

F. Quality Measures

Substance Use Disorder

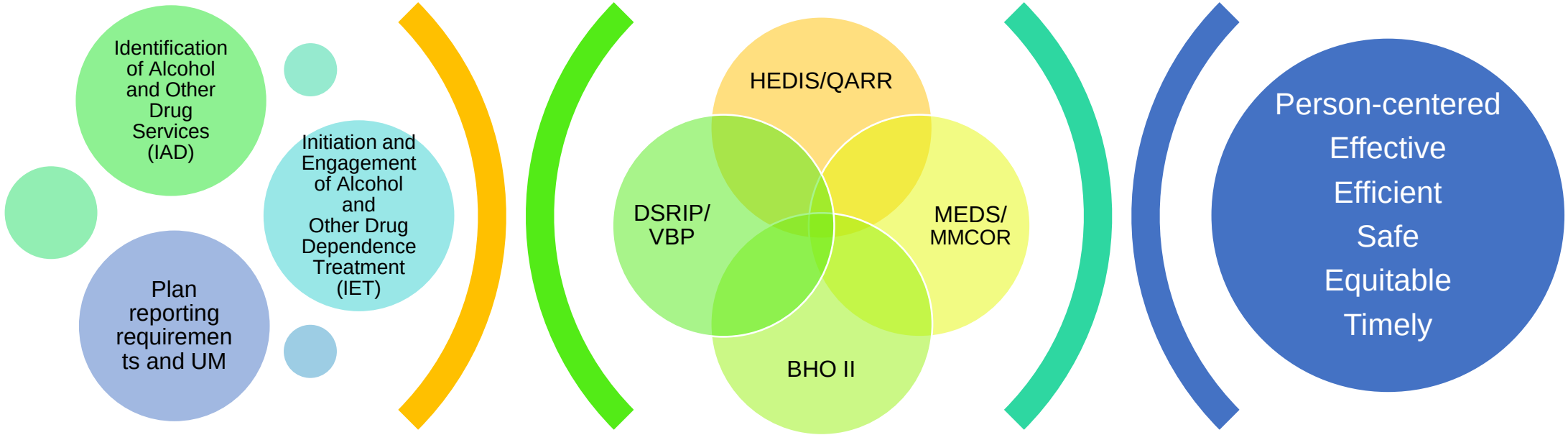
Current State versus Future State

- Current State
  - HEDIS 2016
  - HEDIS 2017

- Future State
  - Washington Circle
  - Other
    - Measures that Capture Additional Aspects of Treatment, Recovery, Functioning, Symptom Burden, Person-Centered Care

Aligning SUD Quality Measures

- OASAS is leading the effort to develop a set of SUD quality measures



Currently there is a dearth of SUD measures—in particular outcome measures

Need to Develop and Align Measures with other State Initiatives and Systems

The goal is to develop a comprehensive set of SUD measures which conform to IOM principles

HEDIS Measure – Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

- This measure assesses the percentage of adolescents and adults with a new episode of AOD dependence who received the following care *Initiation of AOD Treatment*: The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.
- *Engagement of AOD Treatment*: The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

- See more at: http://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality/2015-table-of-contents/alcohol-treatment#sthash.pOn3KJHs.dpuf

Proposed New Measures for HEDIS 2017

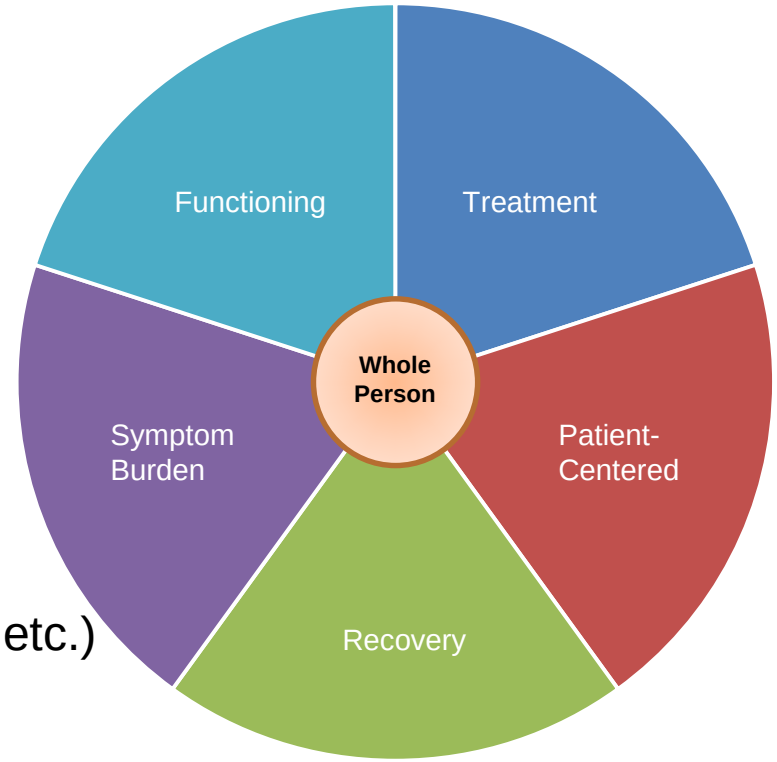
NCQA seeks comments on two new proposed measures for inclusion in the HEDIS 2017 measurement set:

1. *Follow-Up After Emergency Department Visit for Mental Illness*. The percentage of emergency department (ED) visits for members 6 years of age and older with a primary diagnosis of mental illness, who had an outpatient visit, an intensive outpatient encounter or a partial hospitalization for mental illness.

2. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence. The percentage of ED visits for members 13 years of age and older with a primary diagnosis of alcohol and other drug (AOD) dependence, who had an outpatient visit, an intensive outpatient encounter or a partial hospitalization for AOD.

Thoughts on A Measurement Framework from OASAS' "Finding and Managing Value from Managing SUD"

Functioning
- Social Connectedness
- Housing (stability)
- Employment and Education
- Personal Relationships
- Resources/Support
- CJ Status
- Activities of Daily Living (ADL)



Treatment
- Continuity of Care
- Medication Assisted Treatment
- Continuing Engagement in Treatment
- Network for the Improvement of Addiction Treatment

Symptom Burden
- ED/IP Visits
- Assessment of SUD (Severity, etc.)
- Craving
- Lab Tests
- Physical Health
- SBIRT
- Assessment of comorbidity
- Distress (level of)

Patient-Centered
- Quality of Life
- Satisfaction with Treatment
- Therapeutic Alliance
- Patient Activation

Recovery
- Abstinence
- Relapse
- Speed to Recovery

Substance Use Disorder Quality Measure – **Review and Selection**

Substance Use Disorder

Topic	#	Quality Measure	Type of Measure	DSRIP	QARR/HEDIS	Suggested by OHM/OASAS	CMS	NQF	NCQA	Availability		CAG categorization
										Medicaid Claims Data	Clinical Data	
Continuing Engagement in Treatment	1	Expansion of IET to Continuing Engagement in Treatment (CET)	Process			X				Yes	No	
	2	Identification Alcohol & Drug Services (IAD)	Process			X				Yes	No	
	3	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	Process			X		X		Yes	Yes	
	4	Initiation of MAT for Opioid Dependence	Process			X				Yes	No	
	5	Percent of discharges (from any level of SUD care) followed by a lower level SUD service within 14 days (rolled up COC)	Process			X				Yes	No	

Substance Use Disorder Quality Measure – **Review and Selection**

Substance Use Disorder

Topic	#	Quality Measure	Type of Measure	DSRIP	QARR/HEDIS	Suggested by OHM/OASAS	CMS	NQF	NCQA	Availability		CAG categorization
										Medicaid Claims Data	Clinical Data	
Continuing Engagement in Treatment	6	Utilization of MAT for Opioid Dependence	Process			X				Yes	No	
	7	Initiation of MAT for Alcohol Dependence	Process			X				Yes	No	
	8	Utilization of MAT for Alcohol Dependence	Process			X				Yes	No	
	9	Connectivity to Primary Care	Process			X				Yes	No	
	10	Connection to Community Recovery Supports	Process			X				No	Yes	

Substance Use Disorder Quality Measure – **Review and Selection**

Substance Use Disorder

Topic	#	Quality Measure	Type of Measure	DSRIP	QARR/HEDIS	Suggested by OHM/OASAS	CMS	NQF	NCQA	Availability		CAG categorization
										Medicaid Claims Data	Clinical Data	
Continuing Engagement in Treatment	11	Measures from MRT/Behavioral Health Medicaid Managed Care Phase I (BHO 1): Continuity of Care (CoC) from Detox or Inpatient Rehab to a lower level of SUD treatment (within 14 days).	Process			X				No	Yes	
	12	Proposed Refinement of Measures (with OQPS/OMH) for MRT/Behavioral Health Medicaid Managed Care Phase II (BHO 2): Continuity of Care (CoC) measures to include residential and all OASAS treatment modalities.	Process			X				No	Yes	
	13	Proposed Pay-for-Reporting measure: To support decreases in inpatient crisis (detox) with corresponding uptake in ancillary withdrawal services.	Process			X				No	Yes	

Substance Use Disorder Quality Measure – **Review and Selection**

Substance Use Disorder

Topic	#	Quality Measure	Type of Measure	DSRIP	QARR/HEDIS	Suggested by OHM/OASAS	CMS	NQF	NCQA	Availability		CAG categorization
										Medicaid Claims Data	Clinical Data	
Continuing Engagement in Treatment	14	1-Week Retention Rate for Chemical Dependency Treatment	Process							No	Yes	
	15	1-Month Retention Rate for Chemical Dependency Treatment	Process							No	Yes	
	16	3-Month Retention Rate for Chemical Dependency Treatment	Process							No	Yes	
	17	6-Month Retention Rate for Chemical Dependency Treatment	Process							No	Yes	
	18	1-Year Retention Rate for Chemical Dependency Treatment	Process							No	Yes	
	19	Program Completion for Chemical Dependency Treatment	Process							No	Yes	
	20	Completion of Treatment for Substance Abuse	Process							No	Yes	
	21	Completion of Treatment for Substance Abuse (Child/Adolescents)	Process							No	Yes	

Substance Use Disorder Quality Measure – **Review and Selection**

Substance Use Disorder

Topic	#	Quality Measure	Type of Measure	DSRIP	QARR/HEDIS	Suggested by OHM/OASAS	CMS	NQF	NCQA	Availability		CAG categorization
										Medicaid Claims Data	Clinical Data	
Treatment (Medication Assisted)	21	Opioid and Alcohol parameters: Number of individuals with at least one prescription for appropriate pharmacotherapy at any time during the measurement year.	Process			X				Yes	Yes	
	22	Initiation measure: Opioid Parameters: Number of individuals who initiate pharmacotherapy with at least one prescription for an opioid treatment medication within 30 days following index visit with a diagnosis of opioid dependence.	Process			X				Yes	Yes	
	23	Initiation measure: Alcohol Parameter: Number of individuals who initiate pharmacotherapy with at least one prescription for an alcohol treatment medication within 30 days following index visit with a diagnosis of alcohol dependence.	Process			X				Yes	Yes	

Substance Use Disorder Quality Measure – **Review and Selection**

Substance Use Disorder

Topic	#	Quality Measure	Type of Measure	DSRIP	QARR/HEDIS	Suggested by OHM/OASAS	CMS	NQF	NCQA	Availability		CAG categorization
										Medicaid Claims Data	Clinical Data	
Treatment	24	Counseling Regarding Psychosocial and Pharmacologic Treatment Options for Opioid Addiction	Process							No	Yes	
	25	60-day Continuation of Substance Abuse Treatment	Process							No	Yes	
	26	Maintenance Pharmacotherapy for Substance Abuse	Process							No	Yes	

Substance Use Disorder Quality Measure – **Review and Selection**

Substance Use Disorder

Topic	#	Quality Measure	Type of Measure	DSRIP	QARR/HEDIS	Suggested by OHM/OASAS	CMS	NQF	NCQA	Availability		CAG categorization
										Medicaid Claims Data	Clinical Data	
Recovery	27	Ambulatory Follow-up Attended within 30 Days of Discharge Substance Abuse	Process							No	Yes	
	28	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence	Process						X	Yes	No	
	29	Outpatient Follow-up after Initial Substance-Related Visit (2 or more visits)	Process							No	Yes	
	30	Multiple Outpatient Visits after Substance-Related Hospitalization	Process							No	Yes	
	31	Outpatient Visit within 3 Days of Discharge (Substance Abuse)	Process							No	Yes	
	32	Availability of Alcohol Counseling and Education	Process							No	Yes	
	33	Chemical Dependency Utilization- % of Members Receiving Inpatient, Day/Night Care & Ambulatory Services	Process						X	No	Yes	

Substance Use Disorder Quality Measure – **Review and Selection**

Substance Use Disorder

Topic	#	Quality Measure	Type of Measure	DSRIP	QARR/HEDIS	Suggested by OHM/OASAS	CMS	NQF	NCQA	Availability		CAG categorization
										Medicaid Claims Data	Clinical Data	
Recovery	34	14-Day Follow-up after Initiating Substance-related Treatment	Process							No	Yes	
	35	Readmission Rates for Chemical Dependency	Process						X	No	Yes	
	36	Substance Abuse Treatment Following Detoxification	Process							No	Yes	

Substance Use Disorder Quality Measure – **Review and Selection**

Substance Use Disorder

Topic	#	Quality Measure	Type of Measure	DSRIP	QARR/HEDIS	Suggested by OHM/OASAS	CMS	NQF	NCQA	Availability		CAG categorization
										Medicaid Claims Data	Clinical Data	
Symptom Burden	37	Substance Use Screening and Intervention Composite	Process					X		No	Yes	
	38	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	Process					X		No	Yes	
	39	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	Process					X		No	Yes	

Substance Use Disorder Quality Measure – **Review and Selection**

Substance Use Disorder

Topic	#	Quality Measure	Type of Measure	DSRIP	QARR/HEDIS	Suggested by OHM/OASAS	CMS	NQF	NCQA	Availability		CAG categorization
										Medicaid Claims Data	Clinical Data	
Screening	40	GAD-7	Outcome			X				No	Yes	
	41	PHQ-9	Outcome			X				No	Yes	
	42	Screening for MH/PH Disorder	Process			X				No	Yes	

Substance Use Disorder Quality Measure – **Review and Selection**

Substance Use Disorder

Topic	#	Quality Measure	Type of Measure	DSRIP	QARR/HEDIS	Suggested by OHM/OASAS	CMS	NQF	NCQA	Availability		CAG categorization
										Medicaid Claims Data	Clinical Data	
Functioning	43	Functional Outcome Assessment	Process				X			No	Yes	
	44	Substantial Decline in 3 or more Activities of Daily Living	Process				X			No	Yes	
	45	Improvement / Stability in Activities of Daily Living (ADL) Functioning	Process							No	Yes	

Substance Use Disorder Quality Measure – **Review and Selection**

Substance Use Disorder

#	Quality Measure	Type of Measure	DSRIP	QARR/HEDIS	Suggested by OHM/OASAS	CMS	NQF	NCQA	Availability		CAG categorization
									Medicaid Claims Data	Clinical Data	
46	SUB-1 Alcohol Use Screening	Process					X		Yes	Yes	
47	SUB-2 Alcohol Use Brief Intervention Provided or Offered SUB-2a Alcohol Use Brief Intervention	Process					X		Yes	Yes	
48	SUB-3 Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge SUB-3a Alcohol & Other Drug Use Disorder Treatment at Discharge	Process					X		Yes	Yes	
49	Risky Behavior Assessment or Counseling by Age 13 Years	Process					X	X	Yes	Yes	
50	Risky Behavior Assessment or Counseling by Age 18 Years	Process					X	X	Yes	Yes	

Substance Use Disorder Quality Measure – **Review and Selection**

Substance Use Disorder

#	Quality Measure	Type of Measure	DSRIP	QARR/HEDIS	Suggested by OHM/OASAS	CMS	NQF	NCQA	Availability		CAG categorization
									Medicaid Claims Data	Clinical Data	
51	Adult Current Smoking Prevalence	Process					X		No	Yes	
52	Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence	Process					X	X	Yes	No	
53	Promoting Healthy Development Survey (PHDS)	Process					X		No	Yes	

Substance Use Disorder Quality Measure – **Review and Selection**

Substance Use Disorder

#	Quality Measure	Type of Measure	DSRIP	QARR/HEDIS	Suggested by OHM/OASAS	CMS	NQF	NCQA	Availability		CAG categorization
									Medicaid Claims Data	Clinical Data	
54	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up (SUD Link: Alcohol – Glucose intolerance)	Process		X		X	X		Yes	Yes	
55	Blood Pressure Control (<140/90 mm Hg) (SUD Link: Alcohol, cocaine, amphetamine use – raised BP)	Process		X			X	X	Yes	Yes	
56	Prenatal & Postpartum Care (PPC) (SUD Link: SUD impact on pregnancy and postpartum care)	Process		X			X	X	Yes	Yes	

Thank you!

For more BH VBP Information:

https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/clinical_advisory_group.htm

NEW YORK STATE | Department of Health | Medicaid Redesign Team

Appendix

Measure Name	Measure Description/Rationale	Measure Steward/ Developer
Expansion of IET to Continuing Engagement in Treatment (CET)	OASAS defined measure: Fully defined and ready for general implementation	OASAS
Identification Alcohol & Drug Services (IAD)	OASAS defined measure: Fully defined and ready for general implementation	OASAS
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	OASAS defined measure: Fully defined and ready for general implementation	OASAS
Initiation of MAT for Opioid Dependence	OASAS defined measure: Fully defined and ready for general implementation	OASAS
Percent of discharges (from any level of SUD care) followed by a lower level SUD service within 14 days (rolled up COC)	OASAS defined measure: Fully defined and ready for general implementation	OASAS
Utilization of MAT for Opioid Dependence	OASAS defined measure: Ready for pilot testing	OASAS
Initiation of MAT for Alcohol Dependence	OASAS defined measure: Ready for pilot testing	OASAS
Utilization of MAT for Alcohol Dependence	OASAS defined measure: Fully defined and ready for general implementation	OASAS
Connectivity to Primary Care	OASAS defined measure: Ready for pilot testing	OASAS
Connection to Community Recovery Supports	OASAS defined measure: under development	OASAS

Measure Name	Measure Description/Rationale	Measure Steward/ Developer
Measures from MRT/Behavioral Health Medicaid Managed Care Phase I (BHO 1): Continuity of Care (CoC) from Detox or Inpatient Rehab to a lower level of SUD treatment (within 14 days).	OASAS defined measure	OASAS
Proposed Refinement of Measures (with OQPS/OMH) for MRT/Behavioral Health Medicaid Managed Care Phase II (BHO 2): Continuity of Care (CoC) measures to include residential and all OASAS treatment modalities.	OASAS defined measure	OASAS
Proposed Pay-for-Reporting measure: To support decreases in inpatient crisis (detox) with corresponding uptake in ancillary withdrawal services.	OASAS defined measure	OASAS

Measure Name	Measure Description/Rationale	Measure Steward/ Developer
1-Week Retention Rate for Chemical Dependency Treatment	Many individuals with substance use disorders leave treatment prematurely. Although limited by confounding with other patient characteristics, research suggests that patients who leave prior to completing a prescribed treatment course have a greater likelihood of relapse and lower levels of functioning than those who complete the course. While clinicians have limited influence in regard to patient engagement in treatment, strategies have been proposed to engage and motivate individuals at risk for early dropout.	NY State Office of Alcoholism and Substance Abuse Services CQAIMH
1-Month Retention Rate for Chemical Dependency Treatment		
3-Month Retention Rate for Chemical Dependency Treatment		
6-Month Retention Rate for Chemical Dependency Treatment		
1-Year Retention Rate for Chemical Dependency Treatment		
Program Completion for Chemical Dependency Treatment		
Completion of Treatment for Substance Abuse		Texas Commission on Alcohol and Drug Abuse
Completion of Treatment for Substance Abuse (Child/Adolescents)		Texas Commission on Alcohol and Drug Abuse

Measure Name	Measure Description/Rationale	Measure Steward/ Developer
Opioid and Alcohol parameters: Number of individuals with at least one prescription for appropriate pharmacotherapy at any time during the measurement year.	OASAS defined measure	OASAS
Initiation measure: Opioid Parameters: Number of individuals who initiate pharmacotherapy with at least one prescription for an opioid treatment medication within 30 days following index visit with a diagnosis of opioid dependence.	OASAS defined measure	OASAS
Initiation measure: Alcohol Parameter: Number of individuals who initiate pharmacotherapy with at least one prescription for an alcohol treatment medication within 30 days following index visit with a diagnosis of alcohol dependence.	OASAS defined measure	OASAS

Measure Name	Measure Description/Rationale	Measure Steward/ Developer
Counseling Regarding Psychosocial and Pharmacologic Treatment Options for Opioid Addiction	Percentage of patients aged 18 years and older with a diagnosis of current opioid addiction who were counseled regarding psychosocial AND pharmacologic treatment options for opioid addiction within the 12 month reporting period	AMA-PCPI
60-day Continuation of Substance Abuse Treatment	Many individuals with substance abuse disorders leave treatment prematurely. Although limited by confounding with other patient characteristics, research suggests that termination of substance abuse treatment prior to completing a prescribed course is associated with a greater likelihood of relapse than patients completing the course. Studies also show that individuals who complete substance abuse programs are more likely to experience positive outcomes (e.g., abstinence, employment, fewer psychological problems) than patients who failed to return following intake. While clinicians have limited influence in regard to patient continuation in treatment, strategies have been proposed to engage and motivate individuals at risk for early dropout. This measure is part of a set of measures proposed for testing and has not been adopted by the developing organization.	American Managed Behavioral Healthcare Association
Maintenance Pharmacotherapy for Substance Abuse	Research evidence indicates that psychopharmacologic agents are helpful adjuncts in maintaining abstinence from opioids and alcohol in individuals with substance-related disorders, although outcomes vary depending on the particular medication. Substances such as methadone, buprenorphine, naltrexone, and disfulram either block effects associated with the abused agent or cause the abused substance to be less tolerable. Although there is little data on utilization of most of these drugs, several are believed to be underused	American Psychiatric Association

Measure Name	Measure Description/Rationale	Measure Steward/ Developer
Ambulatory Follow-up Attended within 30 Days of Discharge Substance Abuse	Hospitalization for substance abuse generally occurs when a person is at risk of serious physical or psychiatric complications resulting from abuse, dependence, or withdrawal. Continuing treatment after inpatient discharge is typically necessary to address ongoing problems and decrease the likelihood of relapse. The American Psychiatric Association's practice guidelines for treatment of substance abuse disorders indicates that frequency of relapse monitoring should be intensified during transitions from higher to lower levels of care. Research evidence shows that the duration, frequency, and intensity of treatment are positively related to treatment outcomes but, studies have not specifically examined the utilization evaluated by this measure.	American Managed Behavioral Healthcare Association
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence	The percentage of discharges for patients 18 years of age and older who had a visit to the emergency department with a primary diagnosis of mental health or alcohol or other drug dependence during the measurement year AND who had a follow-up visit with any provider with a corresponding primary diagnosis of mental health or alcohol or other drug dependence within 7- and 30-days of discharge.	NCQA
Outpatient Follow-up after Initial Substance-Related Visit (2 or more visits)	Alcohol and drug abuse and dependence is prevalent and associated with reduced social functioning, work productivity, poorer health status, and higher medical costs. Effective treatments are available, however, many individuals with substance-use disorders (SUD) leave treatment prematurely. Though confounded by other patient characteristics, observational studies suggest that these patients are subsequently at greater risk for relapse than those who complete a prescribed treatment course. While clinicians have limited influence in regard to patient engagement in treatment, strategies have been proposed to engage and motivate individuals at risk for early dropout.	Department of Veterans Affairs- Palo Alto Health Care System

Measure Name	Measure Description/Rationale	Measure Steward/ Developer
Multiple Outpatient Visits after Substance-Related Hospitalization	Hospitalization for substance abuse generally occurs when a person is at risk of serious physical or psychiatric complications resulting from abuse, dependence, or withdrawal. Continuing treatment after inpatient discharge is typically necessary to address ongoing problems and decrease the likelihood of relapse. The American Psychiatric Association's practice guidelines for treatment of substance abuse disorders indicates that frequncy of relapse monitoring should be intensified during transitions from higher to lower levels of care. Research evidence shows that the duration, frequency, and intensity of treatment are positively related to treatment outcomes.	Department of Veterans Affairs-Palo Alto Health Care System
Outpatient Visit within 3 Days of Discharge (Substance Abuse)	Hospitalization for substance abuse generally occurs when a person is at risk of serious physical or psychiatric complications resulting from abuse, dependence, or withdrawal. Continuing treatment after inpatient discharge is typically necessary to address ongoing problems and decrease the likelihood of relapse. The American Psychiatric Association's practice guidelines for treatment of substance abuse disorders indicates that frequency of relapse monitoring should be intensified during transitions from higher to lower levels of care. Research evidence shows that the duration, frequency, and intensity of treatment are positively related to treatment outcomes but, studies have not specifically examined the utilization evaluated by this measure.	Department of Veterans Affairs-Palo Alto Health Care System

Measure Name	Measure Description/Rationale	Measure Steward/ Developer
Availability of Alcohol Counseling and Education	Brief interventions by the primary care clinicians have been found to reduce alcohol abuse in randomized controlled trials. Interventions include motivational counseling, advice, education and contracting information, and use of drinking diaries. However, a recent national survey found that many primary care clinicians do not routinely offer interventions to problem drinkers.	Foundation for Accountability
Chemical Dependency Utilization- % of Members Receiving Inpatient, Day/Night Care & Ambulatory Services	Many managed care organizations and health plans use utilization management techniques to determine access to substance abuse services. Because financial incentives typically favor limiting service utilization, there is an interest in monitoring access to care. Researchers and accrediting organizations have used penetration rates (i.e., the proportion of plan beneficiaries using substance abuse services over a specified period) as a crude indicator of access. At present, little is known about what would be an "appropriate" penetration rate or how this rate should be adjusted for characteristics of beneficiary populations.	NCQA

Measure Name	Measure Description/Rationale	Measure Steward/ Developer
14-Day Follow-up after Initiating Substance-related Treatment	Hospitalization for substance abuse generally occurs when a person is at risk of serious physical or psychiatric complications resulting from abuse, dependence, or withdrawal. Continuing treatment after inpatient discharge is typically necessary to address ongoing problems and decrease the likelihood of relapse. The American Psychiatric Association's practice guidelines for treatment of substance abuse disorders indicates that frequency of relapse monitoring should be intensified during transitions from higher to lower levels of care. Research evidence shows that the duration, frequency, and intensity of treatment are positively related to treatment outcomes but, studies have not specifically examined the utilization evaluated by this measure	Washington Circle Group
Readmission Rates for Chemical Dependency	Hospital readmission rates are widely used as a proxy for illness relapse or complications stemming from a previous hospitalization. Some anecdotal reports support the use of readmission rates in quality improvement activities, and have led to improved discharge planning and linkages between inpatient and outpatient care. However, quantitative analyses have failed to find a relationship between mental health and substance abuse treatment readmission rates and other measures of quality.	NCQA
Substance Abuse Treatment Following Detoxification	While detoxification treatment is an effective medical intervention used to manage an individual safely through the process of acute withdrawal, it is not designed to address the long-standing psychological, social, and behavioral problems associated with alcohol and drug disorders. Ideally, detoxification should be followed by rehabilitative services that include education, counseling, peer support, and other services.	Washington Circle Group

Measure Name	Measure Description/Rationale	Measure Steward/ Developer
Substance Use Screening and Intervention Composite	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.	American Society of Addiction Medicine
Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	Percentage of patients aged 18 years and older who were screened at least once within the last 24 months for unhealthy alcohol use using a systematic screening method AND who received brief counseling if identified as an unhealthy alcohol user.	AMA-convened Physician Consortium for Performance Improvement
Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	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.	AMA-convened Physician Consortium for Performance Improvement
GAD-7	Choose the one description for each item that best describes how many days you have been bothered by each of the following over the past 2 weeks: -Feeling nervous, anxious, or on edge -Unable to stop worrying -Worrying too much about different things -Problems relaxing -Feeling restless or unable to sit still -Feeling irritable or easily annoyed -Being afraid that something awful might happen	Substance Abuse and Mental Health Services Administration

Measure Name	Measure Description/Rationale	Measure Steward/ Developer
PHQ-9	The PHQ-9 is a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression: • The PHQ-9 incorporates DSM-IV depression diagnostic criteria with other leading major depressive symptoms into a brief self-report tool. • The tool rates the frequency of the symptoms which factors into the scoring severity index. • Question 9 on the PHQ-9 screens for the presence and duration of suicide ideation. • A follow up, non-scored question on the PHQ-9 screens and assigns weight to the degree to which depressive problems have affected the patient's level of function.	Center for Quality Assessment and Improvement in Mental Health (CQAIMH)
Screening for MH/PH Disorder	OASAS defined measure: Need to determine appropriateness of screening tools for SUD populations	OASAS

Measure Name	Measure Description/Rationale	Measure Steward/ Developer
Functional Outcome Assessment	Percentage of visits for patients aged 18 years and older with documentation of a current functional outcome assessment using a standardized functional outcome assessment tool on the date of the encounter AND documentation of a care plan based on identified functional outcome deficiencies on the date of the identified deficiencies.	CMS
Substantial Decline in 3 or more Activities of Daily Living	Percentage of home health episodes of care during which the patient became substantially more dependent in at least three out of five activities of daily living.	CMS
Improvement / Stability in Activities of Daily Living (ADL) Functioning	Participants who remained stable or improved in ADL functioning between previous assessment and most recent assessment.	NYS State-specified measure under FIDA I/DD
SUB-1 Alcohol Use Screening	Hospitalized patients 18 years of age and older who are screened within the first three days of admission using a validated screening questionnaire for unhealthy alcohol use.	The Joint Commission
SUB-2 Alcohol Use Brief Intervention Provided or Offered SUB-2a Alcohol Use Brief Intervention	The measure is reported as an overall rate which includes all hospitalized patients 18 years of age and older to whom a brief intervention was provided, or offered and refused, and a second rate, a subset of the first, which includes only those patients who received a brief intervention.	The Joint Commission
SUB-3 Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge SUB-3a Alcohol & Other Drug Use Disorder Treatment at Discharge	The measure is reported as an overall rate which includes all hospitalized patients 18 years of age and older to whom alcohol or drug use disorder treatment was provided, or offered and refused, at the time of hospital discharge, and a second rate, a subset of the first, which includes only those patients who received alcohol or drug use disorder treatment at discharge.	The Joint Commission

Measure Name	Measure Description/Rationale	Measure Steward/ Developer
Risky Behavior Assessment or Counseling by Age 13 Years	The percentage of children with documentation of a risk assessment or counseling for risky behaviors by 13 years of age. Four rates are reported: Risk Assessment or Counseling for Alcohol Use, Risk Assessment or Counseling for Tobacco Use, Risk Assessment or Counseling for Other Substance Use, Risk Assessment or Counseling for Sexual Activity.	NCQA
Risky Behavior Assessment or Counseling by Age 18 Years	The percentage of adolescents with documentation of assessment or counseling for risky behavior by the age of 18 years. Four rates are reported: Risk Assessment or Counseling for Alcohol Use, Risk Assessment or Counseling for Tobacco Use, Risk Assessment or Counseling for Other Substance Use, and Risk Assessment or Counseling for Sexual Activity.	NCQA

Measure Name	Measure Description/Rationale	Measure Steward/ Developer
Adult Current Smoking Prevalence	Percentage of adult (age 18 and older) U.S. population that currently smoke.	Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion
Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence	The percentage of discharges for patients 18 years of age and older who had a visit to the emergency department with a primary diagnosis of mental health or alcohol or other drug dependence during the measurement year AND who had a follow-up visit with any provider with a corresponding primary diagnosis of mental health or alcohol or other drug dependence within 7- and 30-days of discharge.	NCQA
Promoting Healthy Development Survey (PHDS)	The Promoting Healthy Development Survey (PHDS) assesses national recommendations for preventive and developmental services for young children such as those included in the Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents—Third Edition. The PHDS is a survey of parents or guardians of children 3-48 months of age.	Oregon Health & Science University
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up (SUD Link: Alcohol – Glucose intolerance)	Percentage of patients aged 18 years and older with a documented BMI during the current encounter or during the previous six months AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter. Normal Parameters: Age 65 years and older BMI > or = 23 and < 30 Age 18 – 64 years BMI > or = 18.5 and < 25	CMS

Measure Name	Measure Description/Rationale	Measure Steward/ Developer
Blood Pressure Control (<140/90 mm Hg) (SUD Link: Alcohol, cocaine, amphetamine use – raised BP)	The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent blood pressure level taken during the measurement year is <140/90 mm Hg.	NCQA
Prenatal & Postpartum Care (PPC) (SUD Link: SUD impact on pregnancy and postpartum care)	The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care. • Rate 1: Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit as a patient of the organization in the first trimester or within 42 days of enrollment in the organization. • Rate 2: Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.	NCQA