NEW YORK STATE OF OPPORTUNITY. Department of Health

Health and Recovery Plan (HARP) Subpopulation

Value Based Payment Recommendations Report

Behavioral Health Clinical Advisory Group

April 19, 2016

Introduction

Delivery System Reform Incentive Payment (DSRIP) Program & Value Based Payment (VBP) Overview

New York State (NYS) DSRIP aims to fundamentally restructure New York State's (NYS) health care delivery system, reducing avoidable hospital use by 25%, and improving the financial sustainability of NYS' safety net.

To further stimulate and sustain this delivery reform, at least 80-90% of all payments made from Managed Care Organizations (MCO) to providers will be captured within VBP arrangements in 2020. The goal of converting to VBP arrangements is to develop a sustainable system, which incentivizes value over volume. The Centers for Medicare & Medicaid Services (CMS) has approved the State's multi-year VBP Roadmap, which details the Menu of Options and different Levels of VBP the MCOs and providers can select.

Behavioral Health Clinical Advisory Group (CAG)

CAG Overview

For all of the VBP arrangements, Clinical Advisory Groups (CAG) have been convened. CAGs are comprised of leading experts and key stakeholders throughout NYS health care delivery system, including: providers, medical centers, universities, State agencies, medical societies and clinical experts from health plans spanning NYS's upstate and downstate regions.

The Behavioral Health CAG held a series of meetings throughout the State on the Health and Recovery Plan (HARP) subpopulation, Depression and Bipolar Disorder episodes.[1] Specifically the CAG discussed key components of the Behavioral Health VBP arrangements, including subpopulation and bundle definitions, risk adjustment, and the behavioral health quality measures. This report focuses on the HARP subpopulation. HARP is a specialized managed care program for adult individuals with Severe Mental Illness (SMI) or Substance Use Disorder (SUD) that began its rollout in New York State on October 1, 2015.

Recommendation Report Overview & Components

The following report contains two key components:

1. **HARP Playbook**: The playbook provides a definition of the HARP subpopulation and presents a selection of descriptive data views that were presented to the CAG.

2. **HARP Quality Measure Summary**: The quality measure summary provides a description of the criteria used to determine relevancy, categorization and prioritization of outcome measures, and a listing of the recommended outcome measures.

[1] The recommendations regarding these two episodes will be presented in a separate document.

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Behavioral Health Health and Recovery Plan (HARP) Playbook

Definition of the HARP subpopulation

April 2016

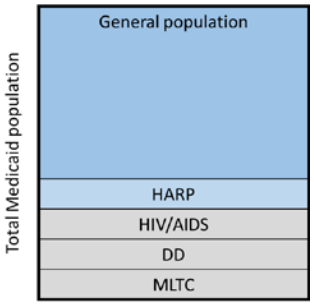
NYS Medicaid Value Based Payment

Playbook Overview – Health and Recovery Plan (HARP)

New York State's Value Based Payment (VBP) Roadmap[2] describes how the State will transition 80-90% of all payments from Managed Care Organizations to providers from Fee for Service (FFS) to Value Based Payments.

For this purpose, the total Medicaid population is divided into five subpopulations:

- Members in Health and Recovery Plans (HARP)
- Members with HIV/AIDS
- Members with developmental disabilities
- Members in Managed Long Term Care plans (MLTC)
- All other members, the general population



This document will focus on Medicaid members in the Health and Recovery Plans (HARP) subpopulation.

The table below gives an overview of this playbook.

Section	Short Description
Description of Subpopulation	Description of the HARP subpopulation
Attachment A: Glossary	Listing of all important definitions
Attachment B: Impression of the Data Available	Data overview of the HARP subpopulation

[2] https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/vbp_roadmap_final.pdf.

Definition of Subpopulation – Health and Recovery Plan (HARP)

The HARP subpopulation targets Medicaid-only members who are eligible for a Health and Recovery plan. Adults enrolled in Medicaid and 21 years or older with select Serious Mental Illness (SMI) and/or serious Substance Use Disorder (SUD) diagnoses having serious behavioral health issues are eligible to enroll in HARP Plans. Those plans are not open for dual eligible members (receiving both Medicaid and Medicare benefits).

The subpopulation definition will thus be identical to the inclusion criteria used for the HARP plans as defined in the New York Request for Qualifications (RFQ) for Behavioral Health Benefit Administration: Managed Care Organizations and Health and Recovery Plans developed by the NYS Office of Mental Health (OMH) and Office of Alcoholism and Substance Abuse Services (OASAS).[3]

HARP enrollment will be open to Medicaid members with serious mental illness and/or substance use disorders. Individuals identified as HARP eligible must be offered care management through State-designated Health Homes. HARP enrollment of eligible individuals began in New York City in October 2015, and an estimated 45,000 individuals will be enrolled in NYC HARPs as of 2016. Enrollment of eligible individuals in the rest of NYS will begin in July 2016. Going forward, HARP eligible members will be identified by the State on an ongoing basis and shared with the HARP Plans, which will make assignments to Health Homes. Individuals can also be referred to HARP plans. HARP members will be assessed for Behavioral Health Home and Community Based Services (BH HCBS) eligibility using a BH HCBS eligibility tool that contains items from the NYS Community Mental Health Suite of the interRAI Functional Assessment. The eligibility assessment tool will determine if an individual is eligible for Tier 1 or Tier 2 BH HCBS. Tier I services include employment, education and peer supports services. Tier 2 includes the full array of BH HCBS.

Likewise, the scope of care services included in this VBP arrangement is identical to the scope of services covered by the HARP plans (including the enhanced benefit package BH HCBS).

For analysis purposes, a list of eligible members was provided by New York State Office of Mental Health (NYS OMH).

The HARP population has only recently started to move into managed care, beginning from 10/1/2015. Health homes are intended to play a key coordinating role in this care. As a default, they will also drive the attribution for HARP subpopulation VBP contractors (this means that those patients that are assigned to a health home are attributed to the VBP contractor that health home is linked to (if any).

Approx. 7% of the Medicaid-only HARP population has HIV/AIDS, and thus would also be eligible for the HIV/AIDS subpopulation. As individuals cannot be part of two VBP subpopulation arrangements at the same time, the MCO ultimately decides to which subpopulation the individual is attributed.

[3] https://www.omh.ny.gov/omhweb/bho/final-rfq.pdf

Attachment A: Glossary

- **Delivery System Reform Incentive Payments (DSRIP):** A five-year program that reinvests up to $6.42B in Medicaid savings in groups of NYS healthcare organizations to reduce hospitalizations, reduce emergency room visits, and improve outcomes. The goal of DSRIP is to move provider Medicaid payments from Fee-for-Service ("FFS") to Value-Based Payments ("VBP").
- **Fee for Service (FFS):** The prevailing payment model where physicians and other state agency licensed/certified providers are paid for each service rendered. Proven to incentivize volume over value.
- **Medicaid Redesign Team (MRT):** Medicaid Redesign Team (MRT) is a State team organized by Governor Cuomo to find savings in the long-term. The MRT estimates to generate $17.1 B in federal Medicaid savings over a period of five years, which enabled the State to obtain an 1115 Waiver to reinvest half into delivery system reform programs.[4]
- **Value Based Payment (VBP):** VBP is a sophisticated payment mechanism design to incentivize physicians to provide more value and better outcomes while reducing costs.
- **VBP Roadmap:** To ensure the long-term sustainability of the improvements made possible by the DSRIP investments in the waiver, the Terms and Conditions (T&Cs) (§ 39) require the State to submit a multiyear Roadmap for comprehensive Medicaid payment reform including how the State will amend its contracts with Managed Care Organizations (MCOs).

[4] https://www.health.ny.gov/health_care/medicaid/redesign/docs/2012-08-06_waiver_amendment_request.pdf

Attachment B: Available Data Impression5

Subpopulation: HARP (Medicaid Only)

General Characteristics

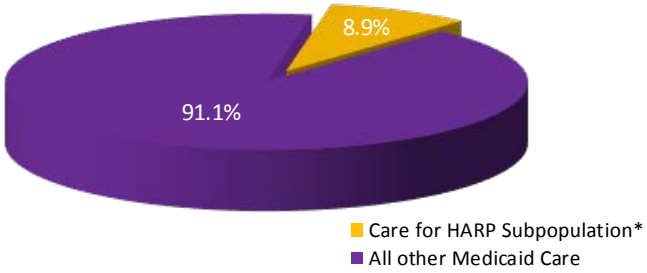
Source: Medicaid Data Claims January 1st, 2014 - December 31st, 2014 (CY2014)

Disclaimer: No rights can be derived from these graphs. At the moment of publishing the data cleansing was incomplete and the prices not yet standardized. Validation ongoing.

Annual Member Volume	Annual HARP Medicaid Costs	Annual Cost Per Member
115K	**$2.24B**	**$20,518**

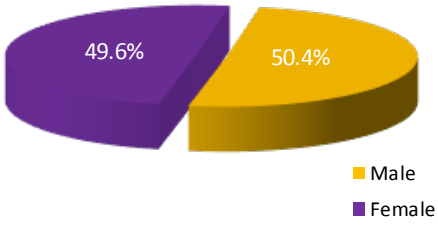
Annual HARP Spending

Total Annual Medicaid Costs: $25B

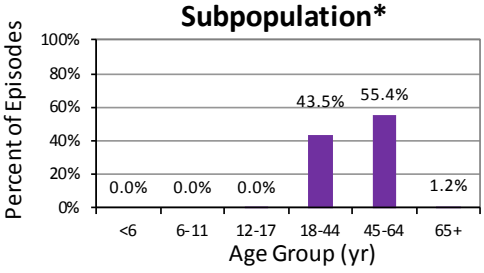


**Represents all Medicaid claims for healthcare services for HARP members across all provider types.*

Gender Distribution of HARP Subpopulation



Age Distribution of HARP Subpopulation*



**Age on January 1st, 2014*

[5] HARP population is based on OMH list of HARP enrolled and HARP eligible members as of April 2016. Annual HARP Medicaid Costs include all Medicaid claims associated with the aforementioned identified members for CY2014. Average annualized costs are calculated by total costs divided by member months x 12 months.

Subpopulation: HARP (Medicaid Only)

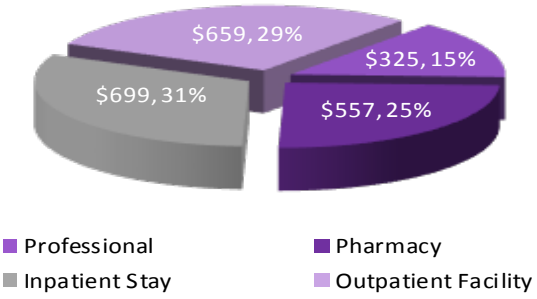
Cost Breakdown

Source: Medicaid Data Claims January 1st, 2014 - December 31st, 2014 (CY2014)

Disclaimer: No rights can be derived from these graphs. At the moment of publishing the data cleansing was incomplete and the prices not yet standardized. Validation ongoing.

Annual Dollar Allocation (in Millions)

Total Annual Amount: $2.24B

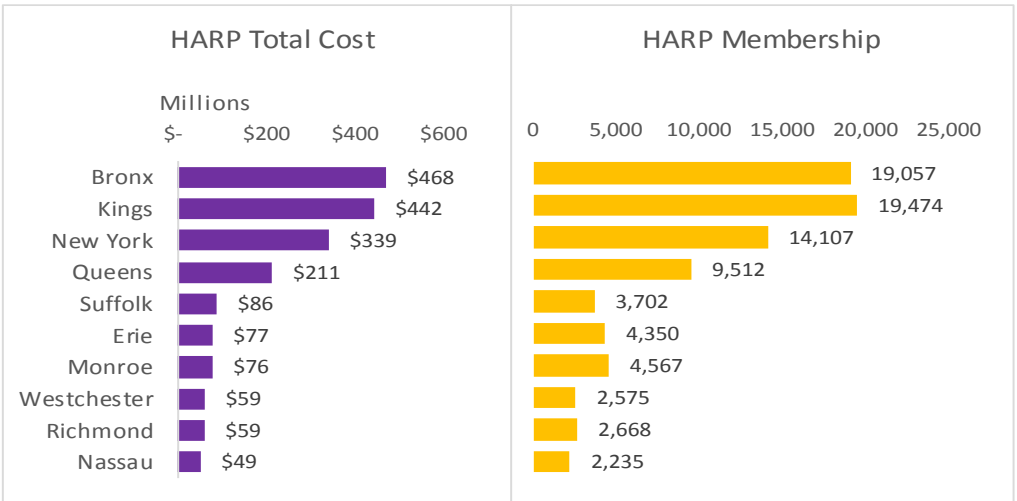


Variations in Costs per County

Source: Medicaid Data Claims January 1st, 2014 - December 31st, 2014 (CY2014)

Disclaimer: No rights can be derived from these graphs. At the moment of publishing the data cleansing was incomplete and the prices not yet standardized.

HARP Population Total Payments & Membership for Top 10 Counties (by Total Cost)



NEW YORK STATE OF OPPORTUNITY. Department of Health

Behavioral Health Health and Recovery Plan (HARP) Quality Measure Summary

April 2016

NYS Medicaid Value Based Payment

Behavioral Health (HARP)
Clinical Advisory Group (CAG)
Outcome Measure Recommendations

Introduction

Over the course of two meetings, the Behavioral Health CAG has reviewed, discussed and provided feedback on the proposed Health and Recovery Program (HARP) subpopulation analysis to be used to inform value based payment contracting for VBP Levels 1-3.

A key element of these discussions was the review of current, existing and new outcome measures used to measure quality related to the HARP subpopulation. This document summarizes the discussion of the CAG and their categorization of outcome measures.[6]

HARP Population[7]

The HARP population is a list of members maintained by the New York State Office of Mental Health (OMH) and the New York State Office of Alcoholism and Substance Abuse Services (OASAS). Individuals are eligible for HARP designation if they are an adult Medicaid member 21 years or older and who are eligible for mainstream managed care and meet one of the following criteria:

1. Have target criteria or risk factors as defined by the OMH and OASAS[8], or
2. Be identified by an individual's case review or completion of a HARP eligibility screen.

The most common diagnoses within this subpopulation include bipolar disorder, depression, schizophrenia and substance use. HARPs contract with Health Homes (HH) to develop a person-centered care plan and provide care management for all services within the care plan—which includes access to Behavioral Health Home and Community Based Services (BH HCBS).

Unfortunately, HARP members often suffer from illnesses that are ineffectively treated, including chronic health conditions such as diabetes, hypertension, and other diseases. For example, 20% of HARP members discharged from general hospital psychiatric units are readmitted within 30 days, often to different hospitals; and mental health specialists see only approximately 20% of adults with mental diseases and disorders. In addition, only 31% of spending

[6] The following sources were used to establish the list of measures to evaluate existing DSRIP/QARR measures; AHRQ PQI/IQI/PSI/PDI measures; CMS Medicaid Core set measures; other existing statewide measures; NQF endorsed measures; measures suggested by the CAG.

[7] Please see BH CAG #1 Presentation for more detailed analysis

[8] See https://www.omh.ny.gov/omhweb/bho/final-rfq.pdf regarding the full list of criteria and risk factors

for HARP members spending is for mental diseases and disorders (largely bipolar disorder and depression) indicating that a more holistic approach to treatment may be warranted. Lastly, there is significant overlap among the HARP subpopulation and the HIV/AIDS, developmentally disabled and Managed Long Term Care populations.

Many of these individuals experience poor health outcomes. For example, persons suffering from SMI have a life expectancy of about 25 years less than the general population.[9] Furthermore, persons with SMI are at risk of homelessness, chronic unemployment, and incarceration. Untreated SUD adds to these risks and complicates care management.

Criteria used to consider relevance:[10]

NY STATE HARP FOCUS

Key values of behavioral health transformation
i.e., measures are person-centered, recovery-oriented, integrated, data-driven and evidence-based

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). Outcomes for BH should encompass not only health outcomes (symptom burden) but also outcomes related to functional dimensions and recovery.

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

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 Patient Quality and Safety (OQPS), endorsed by the National Quality Forum (NQF), Healthcare Effectiveness Data and Information Set (HEDIS) measures and/or measures owned by organizations such as the National Committee for Quality Assurance.

Outcome measures are adequately risk-adjusted
Measures without adequate risk adjustment make it impossible to compare outcomes between providers.

FEASIBILITY

Claims-based measures are preferred over non-claims based measures (clinical data, surveys)
I.e. ease of data collection data is important and measure information should not add unnecessary burden for data collection

When clinical data or surveys are required, existing sources must be available

[9] Reference needed
[10] After the Measurement Evaluation Criteria established by the National Quality Forum (NQF), http://www.qualityforum.org/uploadedFiles/Quality_Forum/Measuring_Performance/Consensus_Development_Process%E2%80%99s_Principle/EvalCriteria2008-08-28Final.pdf

I.e. the link between the Medicaid claims data and this clinical registry is already established or data elements are available in a standardized way from a majority of EHRs.

Data sources preferably are patient-level data
Measures that require random samples (e.g. sampling patient records or using surveys) are less ideal because they do not allow drill-down to patient level and/or adequate risk-adjustment, and may add to the burden of data collection. An exception is made for such measures that are part of DSRIP/QARR.

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).

Categorizing and Prioritizing Outcome Measures

Based on the above criteria, the CAG discussed the outcome measures in the framework of three categories:

- **Category 1** – Category 1 is comprised of approved process and outcome measures that are felt to be clinically relevant, reliable and valid, and feasible.
- **Category 2** – The Category 2 outcome measures discussed below are clinically relevant and central to the transformational goals of the HARP program. These measures document social and functional outcomes as well as access to behavioral health rehabilitation and recovery-oriented services. Ensuring access to these services is a critical element of the HARP model and a national priority related to recent federal mental health and substance use disorder parity legislation. Category 2 measures must be reported in VBP pilot arrangements, but because many of these measures have not been sufficiently tested for reliability and validity, they will not be included in HARP pilot contractually specified incentive payment arrangements in the first year. Instead, Category 2 measures will be reported and reviewed as described below.
- **Category 3** – Category 3 measures were decided to be insufficiently relevant, valid, reliable and/or feasible.

The CAG will be re-assembled on a yearly basis during at least 2016 and 2017 to review and revise Category 1 (if necessary) and 2 measures based upon experiences in NYS as well as newly available information from national endorsing entities.

The successful implementation and execution of the HARP VBP arrangement, consistent with HARP VBP quality measures, will result in the realization of shared savings for providers and plans contracting at levels one through three. Leveraging shared savings to continue investing in the BH/SUD care infrastructure is the only way to structurally achieve the outcomes and efficiencies that are key to sustainable success in this VBP arrangement. At least a part of the shared savings may be used to strengthen the BH/SUD care infrastructure. The proportion of the shared savings to be invested is dependent on a myriad of factors including process and outcome measures as well as the current state of the BH/SUD care infrastructure and the nature of the savings realized. Process and outcome measures that drive shared savings will also drive investment, which is why it is critical that a robust set of behavioral health measures centered on ambulatory and community-based services and their linkages be reported in VBP HARP pilots.

During the 2016 (and possibly 2017) pilot implementation period, value-base agreements targeting HARP members should include performance/incentive payments related to Category 1 measures. HARP pilot contracts must also include requirements for reporting specific category 2 measures. Given the complexity of the NYS behavioral health care-in and the novel and innovative features of the HARP model, representatives from DOH, OASAS, OMH, and KPMG will comprise an advisory group to work with managed care plans and provider networks developing and implementing pilot HARP VBP arrangements. The Behavioral Health CAG will serve as the foundation for the advisory group. Further details about the role and position of this advisory group are forthcoming.

Overview of CAG Outcome Measure Discussion

As a starting point, the CAG was presented with an overview of measures derived from DSRIP, the NYS QARR measures set, CMS Medicaid Core Set (Behavioral Performance Measures Set) and NQF Endorsed Measures.

As the CAG reviewed the outcome measures by theme, a number of conclusions emerged. First, it was discussed that for screening measures the CAG would like to make more integrated measures that allows those with Serious Mental Illness (SMI) to be screened for Substance Use Disorder (SUD) and those with SUD to be screened for SMI. These measures would be further developed during the HARP pilot process.

Additionally, it was felt that nearly all the measures that related to physical health and management of symptoms with medication measures were important due to the fully integrated HARP plan benefit structure.

The group was especially interested in looking at access to BH HCBS and rehabilitation services. They would like to assure PPR and PPV measures that pertain to the HARP population as well as PPR and PPV measures that specify BH and SUD related avoidable events. The CAG recommends tracking of metrics related to Health Home enrollment and dis-enrollment.

As noted above, the CAG strongly endorses measurement of recovery and functioning in multiple domains including employment, education, housing/homelessness, criminal justice, social connectedness and self-help group participation. All HARP enrollees will be screened annually using the interRAI tool, which will collect data on these social and functional domains. The advisory group recommends that HARP VBP pilots consider incentive payments for number and timeliness of completed interRAI screens. Other pilot initiatives are underway in NYS to link administrative data from criminal justice and behavioral health systems, which will create further potential data sources for Category 2 measures. The HARP VBP pilots will provide important opportunities to examine the role and impact of Category 2 measures as described above. Once the Pilots are able to investigate and test the quality measures, the BH CAG will be reconvened to discuss and reassess the categorization and prioritization of the HARP subpopulation quality measures.

BH HARP CAG Recommended Outcome Measures – Category 1 and 2

The categorization below does not reflect the priorities of the CAG but primarily the fact that the most relevant measures will require additional attention during the pilot phase.

	#	Measure	Measure Steward/Source
Category 1	1	Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence*	National Committee for Quality Assurance
	2	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	National Committee for Quality Assurance
	3	Diabetes Monitoring for People With Diabetes and Schizophrenia	National Committee for Quality Assurance
	4	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Testing*	National Committee for Quality Assurance
	5	Diabetes Care for People with Serious Mental Illness: Medical Attention for Nephropathy*	National Committee for Quality Assurance
	6	Diabetes Care for People with Serious Mental Illness: Blood Pressure Control (<140/90 mm Hg)*	National Committee for Quality Assurance
	7	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)*	National Committee for Quality Assurance
	8	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Control (<8.0%)*	National Committee for Quality Assurance
	9	Diabetes Care for People with Serious Mental Illness: Eye Exam*	National Committee for Quality Assurance
	10	Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	National Committee for Quality Assurance
	11	Controlling High Blood Pressure for People with Serious Mental Illness*	National Committee for Quality Assurance
	12	Body Mass Index Screening and Follow-Up for People with Serious Mental Illness*	National Committee for Quality Assurance
	13	Antidepressant Medication Management	National Committee for Quality Assurance
	14	Adherence to Antipsychotic Medications for Individuals With Schizophrenia	National Committee for Quality Assurance
	15	SUD pharmacotherapy for alcohol and opioid dependence	New York State Office of Mental Health / Office of Alcoholism and Substance Abuse Services
	16	Follow-up After Hospitalizations for Mental Illnesses (within 7 and 30 days)*	National Committee for Quality Assurance

	17	Percentage of patients within the HARP subpopulation that have a potentially avoidable complication during a calendar year.	HCI3/Bridges to Excellence
	18	Identification of Alcohol and Other Drug Services[X]	National Committee for Quality Assurance
	19	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment[X]	National Committee for Quality Assurance
	20	HH assigned/referred members in outreach or enrollment[X]	DSRIP
	21	HH members in outreach/enrollment who were enrolled in measurement year[X]	DSRIP
Category 1-2	22	% enrollment in HH (specified by ethnicity and potential other subpopulations)[11]	New Proposal by CAG
Category 2	23	SBIRT Screening	New York State Office of Mental Health / Office of Alcoholism and Substance Abuse Services
	24	Depression Utilization of the PHQ-9 Tool*	MN Community Measurement
	25	Multidimensional Mental Health Screening Assessment*	M3 Information LLC
	26	Major Depressive Disorder (MDD): Diagnostic Evaluation	AMA Physician Consortium for Performance Improvement
	27	Major Depressive Disorder (MDD): Suicide Risk Assessment	AMA Physician Consortium for Performance Improvement
	28	Substance Use Screening and Intervention Composite*	American Society of Addiction Medicine
	29	Alcohol Screening and Follow-up for People with Serious Mental Illness*	National Committee for Quality Assurance
	30	Medical Assistance With Smoking and Tobacco Use Cessation	National Committee for Quality Assurance
	31	Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use	Substance Abuse and Mental Health Services Administration
	32	Potentially preventable ED visits (PPV) (for persons with BH diagnosis)	3M
	33	Readmission to mental health inpatient care within 30 days of discharge	New York State Office of Mental Health / Office of Alcoholism and Substance Abuse Services
	34	Mental Health Utilization	National Committee for Quality Assurance

[11] This measure has been identified as new because it is a variation of measure #21. However, it includes the subpopulation angle, which requires development.

	35	Outpatient Engagement	Behavioral Health Organization (BHO) I
	36	Timely filling of appropriate medication prescriptions post discharge	Behavioral Health Organization (BHO) I
	37	Percentage of SUD Detox Discharges Followed by a Lower Level SUD Service within 14 Days	Behavioral Health Organization (BHO) I
	38	Percentage of SUD Rehabilitation Discharges Followed by a Lower Level SUD Service within 14 Days	Behavioral Health Organization (BHO) I
	39	Percentage of SUD Detox or Rehabilitation Discharges where a Prescription for an Anti-Addiction Medication was Filled within 30 Days	Behavioral Health Organization (BHO) I
	40	% of members with case conference	New Proposal by CAG
	41	HH Disenrollment	New Proposal by CAG
	42	Depression Remission (at Twelve or Six Months)*	MN Community Measurement
	43	The % of members currently employed	New York State Office of Mental Health / Office of Alcoholism and Substance Abuse Services
	44	The % of members employed at least 35 hours per week in the past month	New York State Office of Mental Health / Office of Alcoholism and Substance Abuse Services
	45	The % of members employed at or above the minimum wage	New York State Office of Mental Health / Office of Alcoholism and Substance Abuse Services
	46	The % of members currently enrolled in a formal education program	New York State Office of Mental Health / Office of Alcoholism and Substance Abuse Services
	47	The % of members who are homeless	New York State Office of Mental Health / Office of Alcoholism and Substance Abuse Services
	48	The % of members with residential instability in the past two years	New York State Office of Mental Health / Office of Alcoholism and Substance Abuse Services
	49	The % of members who were arrested within the past 30 days	New York State Office of Mental Health / Office of Alcoholism and Substance Abuse Services
	50	The % of members who were arrested within the past year	New York State Office of Mental Health / Office of Alcoholism and Substance Abuse Services
	51	The % of members who were incarcerated within the past 30 days	New York State Office of Mental Health / Office of Alcoholism and Substance Abuse Services

	52	The % of members who were incarcerated within the past year	New York State Office of Mental Health / Office of Alcoholism and Substance Abuse Services
	53	The % of members with social interaction in the past week	New York State Office of Mental Health / Office of Alcoholism and Substance Abuse Services
	54	The % of members with one or more social strengths	New York State Office of Mental Health / Office of Alcoholism and Substance Abuse Services
	55	The % of members who attended a self-help or peer group in the past 30 days	New York State Office of Mental Health / Office of Alcoholism and Substance Abuse Services

*NQF Endorsed

[X] Measures were added after the CAG to reflect initiatives underway in BHO I and DSRIP, and therefore are not listed below with CAG comments. Please see Appendix B for measure definition.

CAG Categorization and Discussion of Measures

	Topic	#	Quality Measure (* = NQF Endorsed)	Type of Measure	Measure Steward/ Source*	QARR	HEDIS	DSRIP	Available Data		Quality Measure Categorization & Notes	
									Medicaid Claims Data	Clinical data	Category	Notes
Screening and assessment	Behavioral health screening	1	Screening for Clinical Depression	Process	CMS NQF 0418 (adult)			X	YES	YES	3	-This may not be relevant for some of the HARP population; also, there is a comprehensive assessment before members are entered into the HARP program as part of the required design.
		2	SBIRT Screening	Process	QARR Measure Suggested by OMH/ OASAS				YES	YES	2	-The CAG would like to develop more integrated measures that allows those with Serious Mental Illness (SMI) to be screened for Substance Use Disorder (SUD) and those with SUD to be screened for SMI. This will be further developed during the HARP pilot process.
		3	Depression Utilization of the PHQ-9 Tool*	Process	NQF 07102 MN Community Measurement				NO	YES	2	-The CAG would like to develop more integrated measures that allows those with Serious Mental Illness (SMI) to be screened for Substance Use Disorder (SUD) and those with SUD to be screened for SMI. This will be further developed during the HARP pilot process
		4	Multidimensional Mental Health Screening Assessment*	Process	M3 Information LLC				NO	YES	2	-The CAG would like to develop more integrated measures that allows those with Serious Mental Illness (SMI) to be screened for Substance Use Disorder (SUD) and those with SUD to be screened for SMI. This will be further developed during the HARP pilot process
		5	Major Depressive Disorder (MDD): Diagnostic Evaluation	Process	AMA-PCPI NQF 0103				YES	NO	2	-The CAG would like to develop more integrated measures that allows those with Serious Mental Illness (SMI) to be screened for Substance Use Disorder (SUD) and those with SUD to be screened for SMI. This will be further developed during the HARP pilot process
		6	Major Depressive Disorder (MDD): Suicide Risk Assessment	Process	AMA-PCPI NQF 0104				YES	NO	2	-The CAG would like to develop more integrated measures that allows those with Serious Mental Illness (SMI) to be screened for Substance Use Disorder (SUD) and those with SUD to be screened for SMI. This will be further developed during the HARP pilot process

	Topic	#	Quality Measure (* = NQF Endorsed)	Type of Measure	Measure Steward/ Source*	QARR	HEDIS	DSRIP	Available Data		Quality Measure Categorization & Notes	
									Medicaid Claims Data	Clinical data	Category	Notes
	Substance use screening	7	Substance Use Screening and Intervention Composite*	Process	American Society of Addiction Medicine				NO	YES	2	-The CAG would like to develop more integrated measures that allows those with Serious Mental Illness (SMI) to be screened for Substance Use Disorder (SUD) and those with SUD to be screened for SMI. This will be further developed during the HARP pilot process
		8	Alcohol Screening and Follow-up for People with Serious Mental Illness*	Process	National Committee for Quality Assurance				YES	YES	2	-The CAG would like to develop more integrated measures that allows those with Serious Mental Illness (SMI) to be screened for Substance Use Disorder (SUD) and those with SUD to be screened for SMI. This will be further developed during the HARP pilot process
		9	Medical Assistance With Smoking and Tobacco Use Cessation	Process	HEDIS				YES	YES	2	-The CAG would like to develop more integrated measures that allows those with Serious Mental Illness (SMI) to be screened for Substance Use Disorder (SUD) and those with SUD to be screened for SMI. This will be further developed during the HARP pilot process
		10	Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence*	Process	National Committee for Quality Assurance				YES	YES	1	-In addition to building a composite screening tool (for SMI for those with SUD and vice versa), this is also an important measure.
		11	Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use	Process	NQF 0110				YES	NO	2	-The CAG would like to develop more integrated measures that allows those with Serious Mental Illness (SMI) to be screened for Substance Use Disorder (SUD) and those with SUD to be screened for SMI. This will be further developed during the HARP pilot process
Connection to Physical Health	Diabetes related measures	12	Diabetes Screening for People With Schizophrenia or Bipolar Disorder	Process	HEDIS		X	X	YES	NO	1	- This measure scores high on all criteria.

	Topic	#	Quality Measure (* = NQF Endorsed)	Type of Measure	Measure Steward/ Source*	QARR	HEDIS	DSRIP	Available Data		Quality Measure Categorization & Notes	
									Medicaid Claims Data	Clinical data	Category	Notes
			Who Are Using Antipsychotic Medications									
		13	Diabetes Monitoring for People With Diabetes and Schizophrenia	Process	HEDIS		X	X	YES	NO	1	-This measure scores high on all criteria.
		14	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Testing*	Process	National Committee for Quality Assurance				YES	YES	1	-The measure scores high on all criteria.
		15	Diabetes Care for People with Serious Mental Illness: Medical Attention for Nephropathy*	Process	National Committee for Quality Assurance				YES	YES	1	-The measure scores high on all criteria.
		16	Diabetes Care for People with Serious Mental Illness: Blood Pressure Control (<140/90 mm Hg)*	Process	National Committee for Quality Assurance				YES	YES	1	-The measure scores high on all criteria.
		17	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)*	Process	National Committee for Quality Assurance				YES	YES	1	-The measure scores high on all criteria.

	Topic	#	Quality Measure (* = NQF Endorsed)	Type of Measure	Measure Steward/ Source*	QARR	HEDIS	DSRIP	Available Data		Quality Measure Categorization & Notes	
									Medicaid Claims Data	Clinical data	Category	Notes
	Other measures	18	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Control (<8.0%)*	Process	National Committee for Quality Assurance				YES	YES	1	-The measure scores high on all criteria.
		19	Diabetes Care for People with Serious Mental Illness: Eye Exam*	Process	National Committee for Quality Assurance				YES	YES	1	-The measure scores high on all criteria.
		20	Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	Process	HEDIS		X	X	YES	NO	1	-The measure scores high on all criteria.
		21	Controlling High Blood Pressure for People with Serious Mental Illness*	Process	National Committee for Quality Assurance				YES	YES	1	-The measure scores high on all criteria.
		22	Body Mass Index Screening and Follow-Up for People with Serious Mental Illness*	Process	National Committee for Quality Assurance				YES	YES	1	-The measure scores high on all criteria.
Management of Symptoms with Medication		23	Antidepressant Medication Management	Process	HEDIS		X	X	YES	YES	1	-The measure scores high on all criteria.
		24	Adherence to Antipsychotic Medications for	Process	HEDIS		X	X	YES	YES	1	-The measure scores high on all criteria.

	Topic	#	Quality Measure (* = NQF Endorsed)	Type of Measure	Measure Steward/ Source*	QARR	HEDIS	DSRIP	Available Data		Quality Measure Categorization & Notes	
									Medicaid Claims Data	Clinical data	Category	Notes
			Individuals With Schizophrenia									
		25	SUD pharmacotherapy for alcohol and opioid dependence	Process	QARR Measure Suggested by OMH/ OASAS				YES	YES	1	-The measure scores high on all criteria.
Access and (inappropriate) Hospital Use		26	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Process	HEDIS		X	X	YES	NO	3	-This is key for mainstream plans, but is not significantly relevant for the HARP population.
		27	Potentially preventable ED visits (PPV) (for persons with BH diagnosis)	Outcome	3M			X	YES	NO	2	-This is a 3M measure. It is not an endorsed measure. This is not just for behavioral health ER visit; this is for all ER visits. This measure will be interesting to track once pilot data can be used and also to see how meaningful it is when specified to the BH/SUD population as well as when 'narrowed' to those ED visits that are BH/SUD related..
		28	Potentially preventable readmissions (PPR) for SNF patients	Outcome	3M			X	YES	NO	3	-Not relevant for this population.
		29	Readmission to mental health inpatient care within 30 days of discharge	Outcome	QARR Measure Suggested by OMH/ OASAS				YES	YES	2	-This has not been developed yet it is a QARR measure suggested by OMH/OASAS. -NY State is working on looking at PPR for subset populations, however there is not yet one for BH. This is easily created; yet its validity would have to be investigated. -OMH would like PPR and PPV drilldown into behavioral health. This has yet to be developed by 3M. As above, another specification is to focus on those readmissions that have a BH/SUD condition as a primary diagnosis.

	Topic	#	Quality Measure (* = NQF Endorsed)	Type of Measure	Measure Steward/ Source*	QARR	HEDIS	DSRIP	Available Data		Quality Measure Categorization & Notes	
									Medicaid Claims Data	Clinical data	Category	Notes
		30	Mental Health Utilization	Process	HEDIS		X		YES	NO	2	-This measure may not be as refined as the CAG would like to capture use patterns. -Ultimately, OMH wants access for this population, so tracking access to Home and Community Based Services (BH HCBS) and rehabilitation services is key.
		31	Follow-up After Hospitalizations for Mental Illnesses (within 7 and 30 days)*	Process	HEDIS National Committee for Quality Assurance		X	X	YES	YES	1	-The CAG agrees this is a category 1 measure. -This is specifically linked to inpatient stays, compared to #33 "Outpatient Stays" is a more general measure (e.g., how many visits did you have within X days, etc.)
		32	Percent of Long Stay Residents who have Depressive Symptoms	Outcome	CMS			X	YES	YES	3	-Long stay residents are not part of the HARP population
		33	Outpatient Engagement	Outcome	QARR Measure Suggested by OMH/ OASAS				YES	YES	2	-Not necessarily endorsed and validated measures, however a very important measure that will require pilot work to implement.
		34	Admission to lower level care within 14 days of discharge from inpatient rehab or detox treatment	Outcome	QARR Measure Suggested by OMH/ OASAS				YES	YES	2	-OMH indicated this measure would need work to be operationalized. - Please see the following measure in Appendix B for definition that is more precise. "Percentage of SUD Detox Discharges Followed by a Lower Level SUD Service within 14 Days."
		35	% enrollment in HH (specified by ethnicity and potential other subpopulations)	Process	CAG/DOH				NO	YES	1-2	-Data is available. This is a key DOH, OMH and OASAS policy. The additional specification per ethnicity etc. is a key issue added by the CAG ('penetration') - Please see the following measure in Appendix B for more precise definition of Health Home enrollment. "HH members in outreach/enrollment who were enrolled in measurement year." However,

	Topic	#	Quality Measure (* = NQF Endorsed)	Type of Measure	Measure Steward/ Source*	QARR	HEDIS	DSRIP	Available Data		Quality Measure Categorization & Notes	
									Medicaid Claims Data	Clinical data	Category	Notes
												this measure does not take into account ethnicity and other subpopulation overlap. This measure to be explored in the pilot.
		36	% of members with case conference	Process	CAG				NO	YES	2	-This would be available in the HH data. It is deemed to be important to stimulate interdisciplinary teamwork
		37	HH Disenrollment	Process	CAG				NO	YES	2	-High HH Disenrollment numbers is considered to be a sign of suboptimal patient engagement.
Recovery/Function Improvement		38	Depression Remission (at Twelve or Six Months)*	Outcome	NQF 0710 MN Community Measure-ment				NO	YES	2	-May not be feasible, feasible measure without adequate patient-level clinical measurement. Important outcome measure.
	Employment	39	The % of members currently employed	Outcome	OMH/OASAS Specific HARP Measures				NO	NO	2	-All measures in this subset (39- 51) are considered key for this population. -Data for these indicators will be collected through the interRAI instrument, which HARP providers have to use at the individual patient level. -The interRAI tool offers a unique way to obtain insight in key social determinants & outcomes for this subpopulation. -Linking this dataset to the MDW to allow for integrating these outcomes with the claims data should be a high priority. -Finally, for all the measures in this category, it was argued that at year 1 of participation in a HARP VBP arrangement (at least in 2016 and 2017), this measure would focus on % of patients with adequate interRAI data. Subsequently (or in parallel), a baseline would be established. Only after that, improvement on this baseline could become the key outcome. -Testing and improving the validity and reliability of these measures will only become possible once a baseline is established.

	Topic	#	Quality Measure (* = NQF Endorsed)	Type of Measure	Measure Steward/ Source*	QARR	HEDIS	DSRIP	Available Data		Quality Measure Categorization & Notes	
									Medicaid Claims Data	Clinical data	Category	Notes
		40	The % of members employed at least 35 hours per week in the past month	Outcome	OMH/OASAS Specific HARP Measures						2	
		41	The % of members employed at or above the minimum wage	Outcome	OMH/OASAS Specific HARP Measures						2	
	Education	42	The % of members currently enrolled in a formal education program	Outcome	OMH/OASAS Specific HARP Measures				NO	NO	2	
	Housing	43	The % of members who are homeless	Outcome	OMH/OASAS Specific HARP Measures				NO	NO	2	
		44	The % of members with residential instability in the past two years	Outcome	OMH/OASAS Specific HARP Measures						2	
	Criminal Justice	45	The % of members who were arrested within the past 30 days	Outcome	OMH/OASAS Specific HARP Measures				NO	NO	2	-The chance that tools like InterRai give reliable insights into this type of data is low. -The CAG strongly suggest to attempt to realize a connection to the criminal justice system. Maimonides has already realized this connection, for example
		46	The % of members who were arrested within the past year	Outcome	OMH/OASAS Specific HARP Measures						2	
		47	The % of members who were incarcerated	Outcome	OMH/OASAS Specific HARP Measures						2	

	Topic	#	Quality Measure (* = NQF Endorsed)	Type of Measure	Measure Steward/ Source*	QARR	HEDIS	DSRIP	Available Data		Quality Measure Categorization & Notes	
									Medicaid Claims Data	Clinical data	Category	Notes
			within the past 30 days									
		48	The % of members who were incarcerated within the past year	Outcome	OMH/OASAS Specific HARP Measures						2	
	Social Connectedness	49	The % of members with social interaction in the past week	Outcome	OMH/OASAS Specific HARP Measures				NO	NO	2	
		50	The % of members with one or more social strengths	Outcome	OMH/OASAS Specific HARP Measures						2	
	Self-Help Group Participation	51	The % of members who attended a self-help or peer group in the past 30 days	Outcome	OMH/OASAS Specific HARP Measures				NO	NO	2	
	Outcomes of Care	52	Proportion of patients in the HARP subpopulation that have a potentially avoidable complication during a calendar year*	Outcome	Health Care Incentives Improvement Institute				YES	NO	2	

Appendix A:

Meeting Schedule

	Date	Agenda
CAG #1	8/12/2015	• Clinical Advisory Group- Roles and Responsibilities • Introduction to Value Based Payment • HARP population definition and analysis • Introduction to outcome measures
CAG #2	9/15/15	• Recap first meeting • HARP Population Quality Measures •
CAG #3	10/6/2015	• Bundles – Understanding the Approach • Depression Bundle – Current State • Bipolar Disorder Bundle • Bipolar Disorder Outcome Measures
CAG #4	TBD	• Depression Bundle Definition and Quality Measures

Appendix B:

Additional Quality Measures from HEDIS/QARR, DSRIP, and BHO I

Quality Measure	Measure Steward	Proposed Data Source	Numerator	Denominator
Identification of alcohol and other drug services: summary of the number and percentage of members with an alcohol and other drug (AOD) claim who received the following chemical dependency services during the measurement year: any service, inpatient, intensive outpatient or partial hospitalization, and outpatient or ED.[12]	HEDIS/QARR	Claims Data	Members who received inpatient, intensive outpatient, partial hospitalization, outpatient and emergency department (ED) chemical dependency services (see the related "Numerator Inclusions/Exclusions" field)	For commercial, Medicaid, and Medicare product lines, all member months during the measurement year for members with the chemical dependency benefit, stratified by age and sex
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment [13]	HEDIS/QARR	Claims Data	Numerator 1: Patients who initiated treatment within 14 days of the diagnosis Numerator 2: Patients who initiated treatment and who had two or more	Patients age 13 years of age and older who were diagnosed with a new episode of alcohol or drug dependency during a visit in the first 11 months of the measurement period

[12] http://www.qualitymeasures.ahrq.gov/content.aspx?id=48735
[13] https://ecqi.healthit.gov/system/files/ecqm/2014/EP/measures/CMS137v4_1.html

			additional services with an AOD diagnosis within 30 days of the initiation visit	
Health Home assigned/referred members in outreach or enrollment[14]	DSRIP	Claims Data	Number of referred and assigned HH eligible members with at least one outreach or enrollment segment during the measurement year	Total number of referred and assigned HH eligible members in the Health Home Tracking System during the measurement year
HH members in outreach/enrollment who were enrolled in measurement year[15]	DSRIP	Claims Data	Number of HH members with at least one enrollment segment in the Health Home Tracking System during the measurement year	Total number HH eligible members with at least one outreach or enrollment segment of in the Health Home Tracking System during the measurement year
Timely filling of appropriate medication prescriptions post discharge (30 days and 100 days) • **Psychotropic Medication Fill After MH Discharge** • **Antipsychotic Medication Fill After a MH Discharge for a Psychotic Disorder Diagnosis**	BHO I	OMH/OASAS	Please see: Section VII and VIII https://www.omh.ny.gov/omhweb/special-projects/dsrip/docs/bho-reference.pdf	Please see: Section VII and VIII https://www.omh.ny.gov/omhweb/special-projects/dsrip/docs/bho-reference.pdf

[14] https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/dsrip_specif_report_manual.pdf

[15] https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/dsrip_specif_report_manual.pdf

• **Mood Stabilizer/Antidepressant Medication Fill After a MH Discharge for a Mood Disorder Diagnosis** • **Anti-Addiction Medication Fill After an SUD Discharge** • **Mood-Disorder/Antidepressant Medication Fill After an SUD Discharge With a Co-occurring Diagnosis for SUD and Mood Disorder**				
Percentage of SUD Detox Discharges Followed by a Lower Level SUD Service within 14 Days[16]	BHO I	OMH/OASAS	The numerator includes the number of discharges from the denominator that had non crisis services within 14 days post discharge from inpatient detoxification. • Non crisis services include Inpatient rehabilitation, Residential rehabilitation services, CD/Alcohol Outpatient Clinic, and CD/Alcohol Outpatient Rehabilitation and MMTP services. • Only discharges where the outpatient service visit occurred as the next	The denominator includes discharges from inpatient detoxification. • Discharges for recipients with continuous Medicaid eligibility of 30 days or more after discharge are included. • Only recipients age 18 and over are included. • Discharges for recipients who are Medicare-eligible are excluded.

[16] https://www.omh.ny.gov/omhweb/special-projects/dsrip/docs/bho-reference.pdf

			immediate service post discharge is counted towards the numerator.	
Percentage of SUD Rehabilitation Discharges Followed by a Lower Level SUD Service within 14 Days[17]	BHO I	OMH/OASAS	The numerator includes the number of discharges from the denominator that had non-crisis services within 14 days post discharge from inpatient rehabilitation. • Non crisis services include Residential rehabilitation services, CD/Alcohol Outpatient Clinic, CD/Alcohol Outpatient Rehabilitation and MMTP services. • Also included are ACT services, PROS and RTF services. • Only discharges where the outpatient service visit occurred as the next immediate service post discharge is counted towards the numerator.	The denominator contains discharges from inpatient rehabilitation. • Discharges for recipients with continuous Medicaid eligibility of 30 days or more after discharge are included. • Only recipients age 18 and over are included. • Discharges for recipients who are Medicare-eligible are excluded.
Percentage of SUD Detox or Rehabilitation Discharges where a Prescription for an Anti-Addiction Medication was Filled within 30 Days and a Second Such Prescription	BHO I	OMH/OASAS	The numerator includes the number of discharges from the denominator where the patient discharged had a second anti-addiction drug fill within 100 days of discharge.	The denominator includes the number of discharges to the community from inpatient detoxification and inpatient rehabilitation identified on claims data where the discharged patient filled an

[17] https://www.omh.ny.gov/omhweb/special-projects/dsrip/docs/bho-reference.pdf

was Filled within 100 Days[18]				anti-addiction prescription within 30 days of discharge. • Discharges for recipients with continuous Medicaid eligibility of 100 days or more after discharge are included. • An inpatient detoxification service followed by an inpatient rehabilitation service within 14 days counts as one inpatient stay in the denominator. • Only recipients age 18 and over are included. • Discharges for recipients who are Medicare-eligible are excluded.

[18] https://www.omh.ny.gov/omhweb/special-projects/dsrip/docs/bho-reference.pdf