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

A White Paper

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The National Committee for Quality Assurance (NCQA)

In Brief

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

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

Findings

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

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

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

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

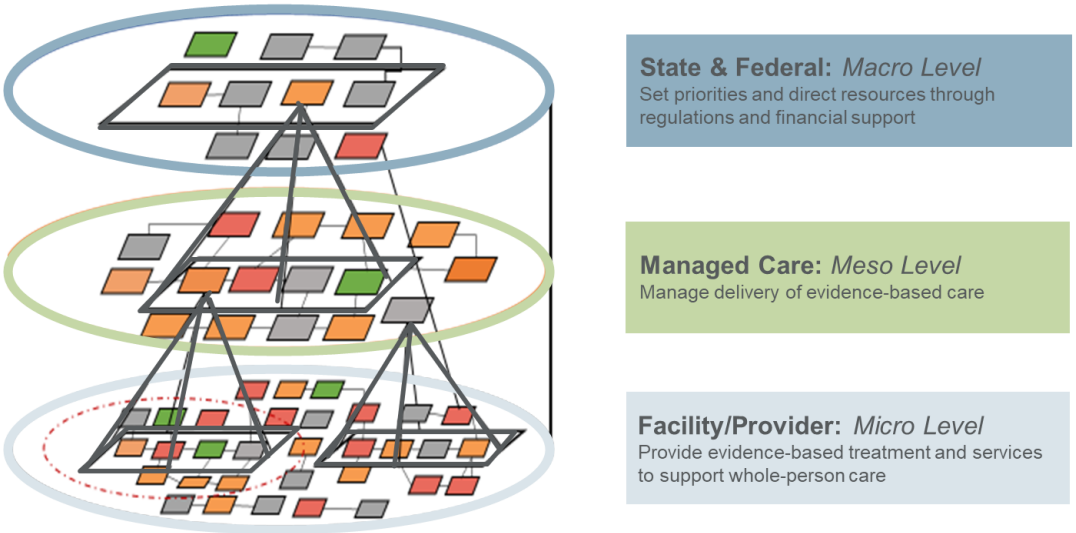
Meaningful Aspects of BH Care Quality, by Delivery System Level

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

Recommendations

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

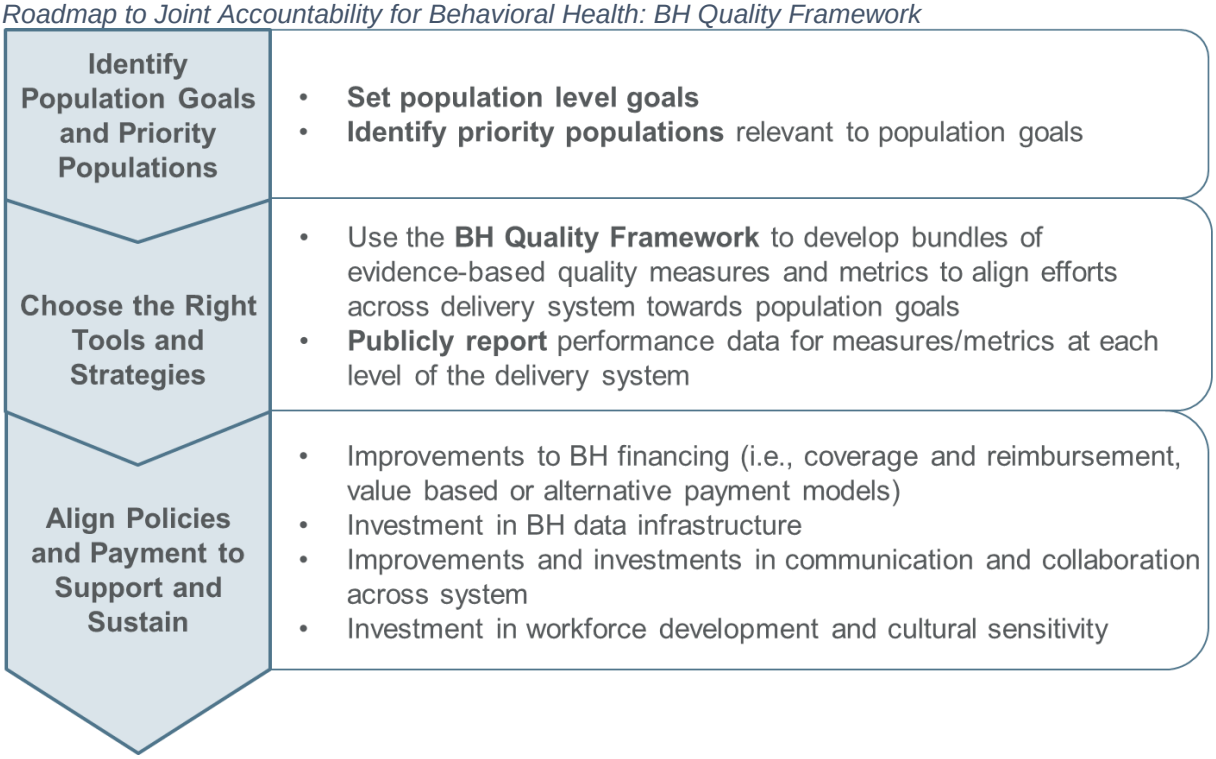
BH Quality Framework: Approach for Aligning Measures Across Levels of a Delivery System



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

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

Roadmap to Joint Accountability for Behavioral Health: BH Quality Framework



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

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

Acknowledgments

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Contents

Section 1: The Challenge of Measuring BH Care Quality

State of behavioral health care in the United States

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

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

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

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

Tackling BH to manage health care costs

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

Role of quality measurement

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

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

underserved populations with BH needs. Unfortunately, investment in BH quality measurement has lagged behind investment in other areas of health, adding to existing challenges to improve BH care quality.[18] There is a clear need for investing resources in evaluating, implementing, and developing a meaningful and coordinated set of measures to drive improvements in BH care quality and outcomes.[17,18]

Calls for a behavioral health care delivery framework

The current fragmented and inequitable state of BH care delivery and management calls for a measurement framework that can be guide and hold entities jointly accountable for improving care access and outcomes for individuals with BH conditions.

To guide development of such a framework, the National Committee for Quality Assurance (NCQA) employed a mixed-methods approach to evaluate the current BH quality measurement landscape and gain a better understanding of the needs and challenges of entities that are responsible for BH care across the delivery system. Specifically, this report provides a synthesis of insights gained from:

1. An **environmental scan and gap analysis** of BH measures and metrics used in active federal programs.
2. **Key stakeholder interviews** about the current use of quality measures for the delivery, management, and improvement of care for populations with BH needs.

The sections below provide an overview of the findings from this work, as well as the resulting recommendation and accompanying roadmap for use of a BH Quality Framework to achieve joint accountability across entities responsible for serving individuals with BH needs.

Section 2: Environmental Scan

Federal agencies are engaged in both funding and subsequent oversight of a large proportion of BH care delivery through direct contracting, accountability programs, demonstration programs, and accreditations. To better understand how the quality of BH care and management is evaluated by federal agencies, our environmental scan and gap analysis focused on BH quality measures used in Federal Reporting Programs *(see callout box for definition)*.

Through a web-based search of all federal agency sites, conducted in October 2020, NCQA identified 86 Federal Reporting Programs. Of these, we analyzed 39 active programs that were national in scope and included standardized reporting requirements for assessing care quality (see *Appendix A* for details). Among these programs, 6 focused on BH care (e.g., Section 1115 SUD Demonstration program), 27 focused on general medical care (e.g., Medicare Shared Savings Program), and the remaining 6 focused on integrated BH and medical care, hereafter called “behavioral health integration (BHI)” (e.g., Certified Community Behavioral Health Clinic program).

What is a Federal Reporting Program?

Initiatives funded through federal agencies (e.g., Centers for Medicare & Medicaid Services) that disperse funds to entities operating in the health delivery system to incentivize improvements in care delivery, management, or quality. These initiatives can take the form of active demonstrations, value or alternative based payment initiatives, accreditations, or certifications. For more information on our selection criteria and the programs identified, see *Appendix A*.

To characterize the reporting requirements used by federal programs to assess care quality, NCQA categorized and defined measures as standardized quality measures, nonstandardized quality measures, and metrics (*see callout box for definitions*). Standardized quality measures, which have been inventoried through the National Quality Forum (NQF) endorsement process[19] or included in the Centers for Medicare & Medicaid Services Measures Inventory Tool (CMIT),[20] were further categorized into three domains: BH, PH, and cross-cutting. The "cross-cutting" measure designation included concepts such as family or patient perceptions of care, care continuity and coordination, patient safety, and social determinants of health.

Defining data used in Federal Reporting Programs

Standardized quality measures: Data used to quantify and compare the quality of health care in a standardized and structured way. In this study, standardized quality measures have undergone testing and have been endorsed by NQF or have met criteria for inclusion in the CMIT. They include specifications that allow comparison across entities or programs.

Nonstandardized quality measures: Data used to quantify and compare the quality of health care in a structured way. Data are not NQF-endorsed or included in CMIT.

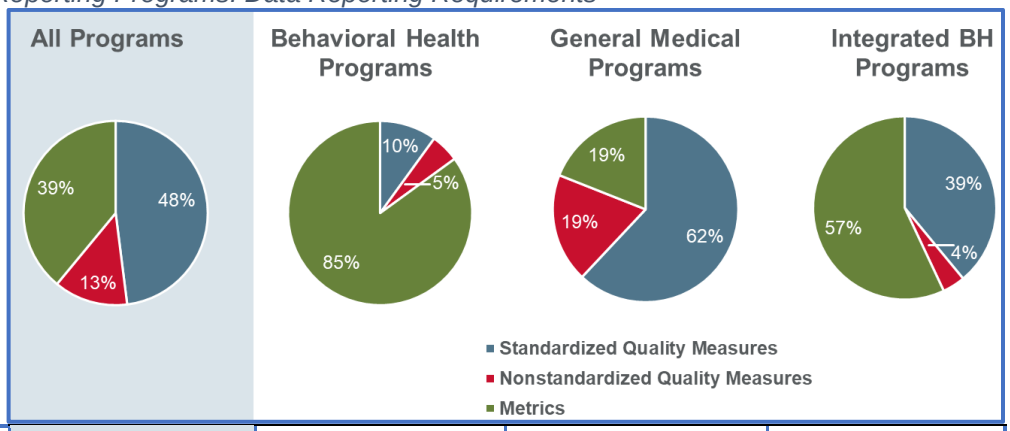
Metrics: Data used to monitor progress toward program implementation or goals; for example, utilization of service counts or counts of patients who have engaged in a particular service. Unlike measures, metrics may not allow apples-to-apples comparison across entities due to lack of standardization and specification.

Key insights about the state of quality measurement across Federal Reporting Programs are detailed below.

Key Insight 1: Federal programs, especially those focused on BH care, rely heavily on metrics and nonstandardized quality measures.

Of the 1,410 measures and metrics used across the 39 Federal Reporting Programs included in this study, 48% were standardized quality measures, 13% were nonstandardized quality measures, and 39% were metrics *(Figure 1).* Notably, BH and BHI programs included a higher proportion of metrics (85% and 57%, respectively) than general medical programs (19%), and a lower proportion of standardized quality measures (10% and 39%, respectively) than general medical programs (62%) *(Figure 1).*

Figure 1: Federal Reporting Programs: Data Reporting Requirements



	All Programs	Behavioral Health Programs	General Medical Programs	Integrated BH Programs
Number of Programs	39	6	27	6
Median Number of Measures & Metrics per Program	24	37	17	23
Range of Number of Measures & Metrics per Program	1-217	16-127	1-217	5-55

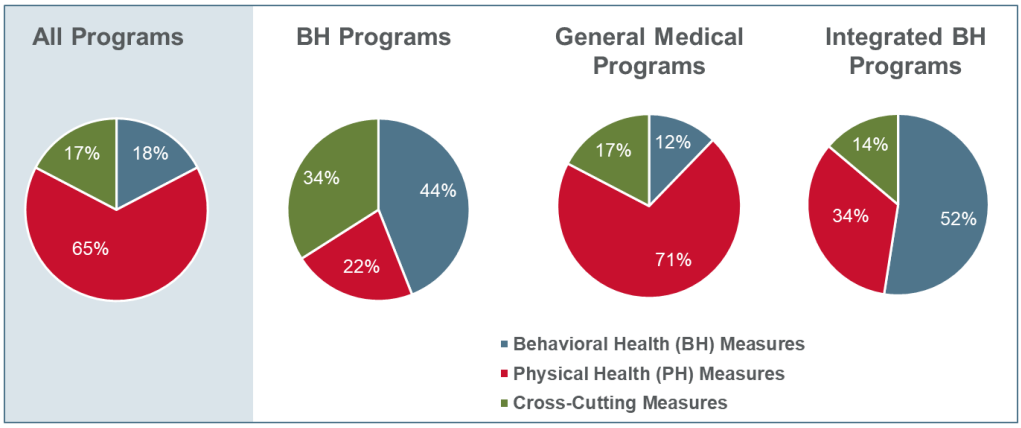
Differences were also identified in the number of measures and metrics required for reporting among program types. Overall, BH programs were found to be more burdensome, with a higher median number of required measures and metrics than general medical programs and BHI programs *(Figure 1).* Common metrics in BH and BHI programs measure cost, program enrollment, network adequacy, diagnoses, service utilization, and patient and caregiver experience.

These findings suggest that existing standardized quality measures may not meet the needs of BH and BHI programs and their stakeholders, and reliance on metrics or nonstandardized quality measures limits their usefulness in benchmarking programs and/or value-based payment models.

Key Insight 2: Standardized quality measures used in Federal Reporting Programs include a mix of BH and PH quality measures.

Following our review, we found that standardized measures selected for use in programs mirrored program goals (programs focused on BH included a higher proportion of BH measures) *(Figure 2).* Programs generally employed a mixture of BH, PH, and cross-cutting measures, suggesting that they may be working to foster whole-person care through reporting. Cross-cutting measures identified in programs captured data on patient experience, social service access, patient safety, cost, and care coordination. The highest proportion of cross-cutting measures (34% of standardized quality measures) was found in BH programs, compared to general medical programs (17%) and BHI programs (14%).

Figure 2: Standardized Quality Measures, by Measure Type

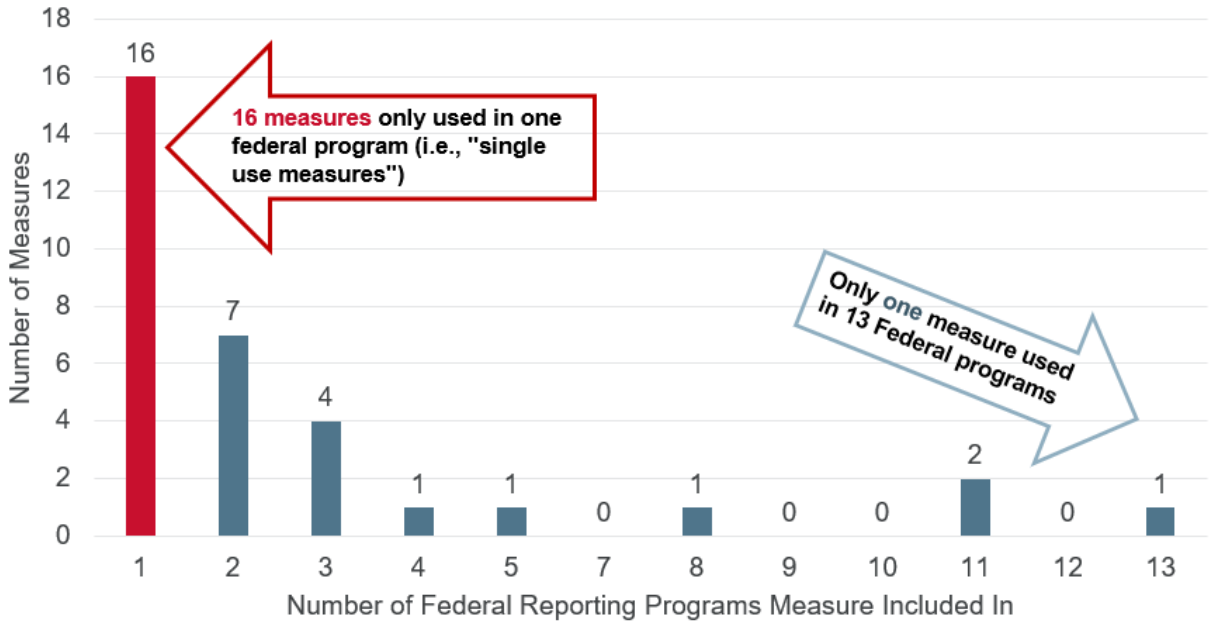


Key Insight 3: Standardized BH quality measures used in Federal Reporting Programs focus on narrowly specified conditions or processes and are misaligned and used variably across programs.

We identified 35 unique standardized BH quality measures across federal programs. Of these, 31 (86%) were process measures, 1 was an intermediate outcome measure and 3 were outcome measures. We did not identify any BH structural measures. Most measures were narrowly specified and related to evidence-based treatment processes for specific BH conditions (e.g., depression, schizophrenia). Most relied on administrative claims data. A few used patient-reported data for screening, symptom monitoring, or functional status monitoring. These findings are consistent with other published findings related to gaps in quality measurement for BH, including those identified by Pincus et al.[17] and Patel et al.[21]

Figure 3 shows how frequently the 35 unique standardized BH quality measures are used across the 39 identified federal programs. Of the 35 BH measures, 16 were used only once. Single-use measures varied with regard to the population of focus (e.g., depression, dementia, SUD) and intent (e.g., symptom assessment, screening, monitoring smoking abstinence).

Figure 3: Use of the 35 Unique Standardized BH Quality Measures Across Federal Programs



Notably, four standardized BH quality measures were most frequently used in federal programs *(Table 1).* All assess narrow care processes and rely on administrative claims data and focus on screening for depression and tobacco use, SUD treatment access, and follow-up after acute hospitalizations for mental illness. Together, these efforts suggest federal priorities to incentivize broader aspects of BH care (e.g., patient-reported outcomes) or the use of more granular clinical data from electronic systems to improve BH care delivery, and quality may be hampered by limitations of existing standardized measures and reporting capabilities. Consequently, insights about care for a wider range of BH conditions, treatments, and outcomes are limited.

Table 1: Most Frequently Used BH Quality Measures Across Federal Reporting Programs

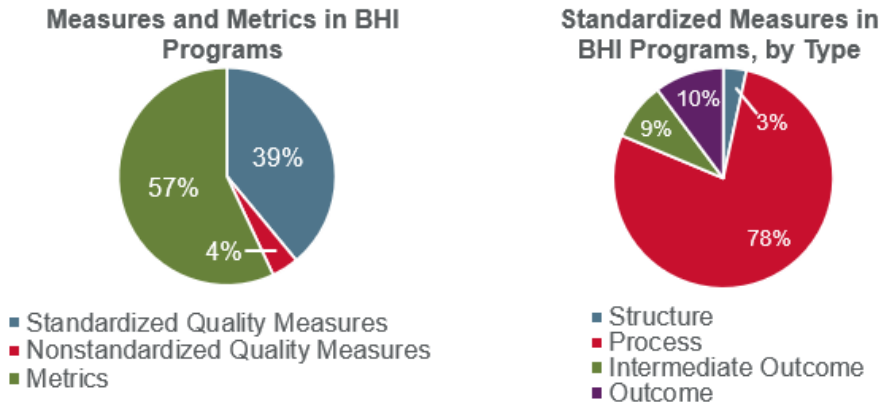
	Number of Federal Programs Measure Used In	NQF Number	Developer	Measure Type (Donabedian)	Data Source
Follow-up After Hospitalization for Mental Illness	13	0576	NCQA	Process	Claims
Screening for Depression and Follow-Up Plan	11	0418	CMS	Process	Claims, Registry
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	11	0004	NCQA	Process	Claims
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	8	0028	NCQA	Process	Claims

Overall, the narrow focus of existing standardized BH quality measures, high frequency of single-use measures, and variability of measure use across programs suggest significant opportunity to better align efforts to both reduce waste and improve coordination in the quality measurement landscape.

Key Insight 4: BH integration is inconsistently measured across BHI Federal Reporting Programs, and efforts lack measures of critical aspects of whole-person care.

The increasing focus on integrating BH and PH care as a way to address challenges in BH care access and quality has led to calls for implementation of national quality measures related to BHI.[17] We thus examined, in detail, the six federal programs aimed specifically at BHI *(Appendix A)*. Among these programs, we saw higher reliance on metrics—rather than on standardized quality measures—to assess quality and hold reporting entities accountable (57% and 39% of data collected in BHI programs, respectively) *(Figure 4)*. This finding may suggest a paucity of relevant or feasible standardized quality measures from which to select for use in programs and a lack of alignment across the health care system for how to best evaluate BHI.

Figure 4: Reporting Requirements in BH Integration Programs



A review of the standardized quality measures used in federal BHI programs (summarized in *Appendix A*) resulted in insights. First, measures used in these programs predominantly focused on narrow processes and relied on administrative claims data. Second, across all BHI programs, no quality measures assessed access to social services, integrated care practices, organizational structure, or cost of care—all criteria of higher levels of integrated care, as defined by the SAMHSA Center for Integrated Health Solutions.[22] Third, quality measures related to care coordination (e.g., *Closing the Referral Loop: Receipt of Specialist Report*), a critical component of BHI, were infrequently seen. These notable gaps in standardized and structured quality measures in BHI programs limit the ability to assess the effectiveness of the programs' efforts and ascertain if they are driving and incentivizing whole-person care.

Section 3: Key Stakeholder Interviews with States Participating in Federal Initiatives

To enrich environmental scan insights on the role of quality measurement in driving BH care, we conducted a series of key stakeholder interviews that focused on state Medicaid systems. Medicaid is the largest single payer of BH services and state Medicaid programs represent an area of both innovation and financial model diversity. Ultimately, five exemplary diverse states were selected for inclusion.

The five states—California, Washington, Colorado, Louisiana, and Pennsylvania—were selected to optimize 1.) geographic variation, 2.) diversity in financial models for BH care delivery, and 3.) innovation in BH, according to an index of their participation in BH or BHI Federal Reporting Programs. *Table 2* highlights the characteristics of each state's BH care delivery model. *Appendix B* contains information on each state's Medicaid delivery model, how each state incentivizes and assesses the quality of BH care, and current innovation regarding BH care delivery and management.

Table 2: Description of State BH Medicaid Models

	California	Washington	Colorado	Pennsylvania	Louisiana
State Medicaid Information					
Medicaid Enrollment (2020)	11,289,937	1,779,628	1,141,130	2,980,867	1,515,189
CHIP Enrollment (2020)	1,297,062	70,271	73,984	177,944	135,051
Proportion Medicaid Budget for BH	3.4%	15%	9%	15.1%	9%
Medicaid BH Coverage and Management					
BH Financing Model: Carve-In/Out	Traditional specialty carve-out for SMI/SED and SUD	Carve-in	BH carve-out	BH carve-out	Carve-in
Differentiation by BH Severity	Y	N	N	N	N (except Coordinated System of Care for children)
BH Payment Model	VBP: Mild/Mod FFS: SMI, SUD	VBP	VBP for BH (vs. FFS for PH)	VBP and FFS	VBP
Entity Responsible for BH Care Management & Coordination	County MH plans (specialty) and managed care plans (non specialty)	MCOs (integrated) or "BH Services Only" contracts through MCOs	Regional Accountable Entities	BH MCOs, through contracts with counties (or state office of MH and Substance Abuse Services, if county opts out)	Managed Care Entities

BH= Behavioral Health; **MH**= Mental Health; **PH**= Physical Health; **SMI**= Serious Mental Illness; **SED**= Severe Emotional Disturbance; **VBP**= Value Based Payment; **FFS**= Fee for Service

In each of the five selected states, we interviewed at least one entity operating at the following levels of accountability: 1.) state BH and/or Medicaid agency, 2.) managed care organization (MCO) or managed BH care organization (MBHCO), and 3.) facility (practice/clinic). For states where county or regional entities play a significant role in BH service management and delivery, interviews also included an entity at that level.

We conducted 21 interviews *(Table 3)*. Interviews focused on how entities finance and deliver BH care, current BH quality strategies and tools, how quality improvement efforts align with quality measurement efforts, and how quality efforts have been impacted by COVID-19. Information about the methods used in this analysis, as well as interview questions and domains, can be found in *Appendix C*.

Table 3: Characteristics of Entities Involved in Key Stakeholder Interviews

Level of Delivery System	Entity	Number of Interviews Conducted
State	State Medicaid Office or Agency	5
	County or Regional Medicaid Office (Not Managed Care)	2
Managed Care	Managed Care Organization	4
	Managed Behavioral Health Care Organization	2
Facility	Health Care Practice or Clinic (Facility)	6

Key insights emerged from the interviews, highlighted below in detail.

Key Insight 1: BH care is supported through a complex assortment of funding streams, often to augment coverage with ancillary services.

Organizations operating at all levels of the health system rely on multiple funding streams to manage and deliver BH care, with the greatest complexity observed at the facility level. At the state level, funding streams include taxes, state provisions, and federal dollars. Facilities and MCOs reported the need to frequently augment state Medicaid benefits with auxiliary services that are either not reimbursable or not fully covered by grants, federal demonstration program dollars, or participation in various programs. These include wraparound care (e.g., in-home services, flexible funding for food or housing services), case management, and services rendered by particular BH providers or trained specialists (e.g., marriage and family therapists, peer support specialists). Facilities and MCOs stressed the need for more flexible funding to drive whole-person care, citing earmarked funds as antithetical to patient-centered care efforts.

Supplementing Medicaid Funding

*"…**We have 32 funding streams.** And every single one comes with a unique set of requirements."*

—Facility

Many facilities and MCOs, even those operating in states that carve in BH services, expend significant resources on identifying and procuring supplemental funding to address critical needs of their BH populations, especially for those with complex needs. This finding suggests that existing BH benefits are inadequate to support critical services that address social determinants of BH.

Key Insight 2: Current BH quality reporting efforts are burdensome and limit resources for improving and measuring aspects of care quality most meaningful at different levels of the system.

Entities operating at all levels of the delivery system, but especially MCOs and facilities, are burdened by existing quality oversight requirements. Our work identified three primary sources of burden:

1. The sheer volume of reporting requirements associated with funding oversight. Entities that rely on multiple funding streams and participate in multiple accountability programs can be held responsible for reporting thousands of quality measures and metrics each year.
2. Variation across oversight and accountability reporting requirements, including documentation requirements, reporting systems, formats, and frequency of submissions.
3. Lack of meaningful measures and reliance on homegrown metrics in reporting requirements.

Burden: Number of Quality Measures Associated with Funding Oversight

"Every year, for every product line, when you combine it all together, ***we submit 2,700 measures****."*
—Managed Care Organization

Burden: Documentation and Reporting Processes for Funding Oversight

"Right now, we estimate that ***our staff spend 40% of their time documenting.*** *That is 40% of their time they could be spending with consumers, and instead they're doing paperwork."*
—Managed Care Organization

Burden: Reliance on Homegrown Metrics

*"We always struggled with having really good measures around behavioral health, mental health, substance use. At the national level, at the time, back in 2014****, there were not really good national measures. … So, we didn't wait around for NQF or national folks to figure it out."***
—State Agency

The high volume of misaligned quality oversight requirements limits the capacity for measuring what entities believe to be the most important aspects of BH quality. Interviewed MCOs and facilities unanimously reported having limited remaining resources to innovate or measure additional aspects of care that may be more valuable for the population outside established quality reporting requirements. Multiple facilities mentioned that they were contractually required to report on measures used in state or MCO-level accountability programs, especially the Medicaid Core Set, which they did not feel were relevant to their level of the delivery system. Lack of standardization and misalignment of measures across and within care delivery systems result in performance data that cannot be used for benchmarking and challenges BH provider capacity to participate in value-based payment models.

Limited Remaining Resources to Measure What Matters

"… There's so much effort put into the reporting requirements that it's ***hard to step back and have the energy and resources to then go, "What do we care about?"***
—Facility

Key Insight 3: Entities at different levels of the delivery system have unique—and unmet—quality measurement needs**.**

Interviewed entities describe existing BH measures as rudimentary, limited primarily to measures of penetration, utilization, and narrow processes of BH care, and insufficient for improving care for their BH populations. Entities operating at different levels of the delivery system shared distinct opinions about aspects of quality that matter most to them *(Table 4)*.

Key quality concepts universally regarded as important across the system include improvement in BH symptoms and functioning, equity in BH outcomes, and patient goal-setting processes. What's interesting is that while the concept of equity was prioritized by entities for both process and outcome measurement, there was no common or clear vision for what this should look like. In fact, many entities described structural components of care when discussing ways they might measure care equity, including assessing cultural competency of staff, culturally sensitive care workflows, and provider diversity. With regard to equity outcome measures, entities discussed a need to measure disparities in outcomes for individuals with BH conditions by stratifying measures by sex, race, ethnicity, and geographic location.

Discussing Equity: Stratifying Existing Measures

"That includes starting to ***stratify the measures by race and ethnicity*** *to really start to dive deeper into making sure that we're really measuring what matters at the end of the day, and it may show us things that we didn't see at first."*
—State Agency

States expressed interest in BH quality measures related to cost of care, outcomes of BHI (depending on model—MH with SUD or BH with PH), and social outcomes (e.g., incarceration, employment). While states did not articulate a clear vision about what constitutes an important outcome of BHI, they did express that they want a more objective way to measure and assess the effectiveness of such care models.

MCOs also expressed interest in measuring cost of care and BHI outcomes and were interested in patient-centered care related to patient goal attainment and experience, as well as care processes such as linking patients to relevant social services, care referrals, BHI processes, and patient goal setting.

Facilities expressed interest in many of the same measures of outcomes (with the exception of cost and BHI outcomes). Facilities were adamant that measures of cost, social outcomes, and BHI outcomes were inappropriate as accountability measures for their level of the delivery system because they do not see themselves as having the right levers or resources to impact outcomes in these areas. However, facilities did express interest in measures that assess BHI care processes (e.g., data sharing, warm handoff for BH evaluation), linking patients to relevant social services, care referrals, and patient goal setting. Facilities also expressed interest in assessing use of and fidelity to evidence-based care for BH.

Table 4: Meaningful Aspects of BH Care Quality by Delivery System Level

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

Despite reported challenges with BH quality measures, a few facilities highlighted their success in managing populations with BH needs through innovative quality measurement efforts. For example, one multi-site facility, in collaboration with other facilities in its area and with financial support of a privately funded demonstration program, developed a common set of 12 core measures it felt were meaningful. The set included both patient- and staff-reported measures of care equity, integration, and patient well-being.

Discussing Equity: New Concepts

"It's a four-point scale, from 'agree' to 'disagree'… ***'I believe my care team feels comfortable around people who look like me and/or sound like me.'*** *And the next one is, 'At times I feel I am treated differently here based on my race, ethnicity, and or gender identity.'"*

—Facility

Another facility, which operates as a Federally Qualified Health Center (FQHC), self-funded development of a set of internal measures of whole-person care that assessed BHI processes, including warm handoffs between different provider types and treatment continuity across PH, BH, and dental care. The facility also developed a standardized way to collect patient demographic data alongside quality data, to drive equity through transparency and measure stratification.

Across levels of the delivery system, entities noted that existing BH quality measures are insufficient for driving high-quality BH care. Currently, expanding and improving quality measurement is limited to individual entities or small groups of entities within systems.

Relevant Quality Measures

*"It's really about putting the harm reduction model in action—**first help patients identify what is important to them, help them address what is important to them, and then tackle the next thing**. A1c might be further down on the list, but it will eventually appear on the list for most people. There is no stronger determinant [of care quality] from my perspective on whether or not someone is able to sustain care they're seeking and their recovery... and **if there's nobody else [measuring], then I guess we're going to have to do it.**"*

—Facility

Key Insight 4: BHI is viewed as key to addressing access and stigma, but entities lack clarity about who is accountable for driving integration and how to measure its quality.

Across all levels of the delivery system, entities embraced the concept of BHI to improve access to BH care and to address stigma, but they were less certain about who should be responsible for supporting BHI implementation and what quality measures should be used to assess the impact of BHI on quality and outcomes for individuals with BH conditions.

BHI efforts are heavily influenced by the financial, operational, and clinical realities in a system, such as restrictions on same-day billing for BH and PH (financial), 42 CFR Part 2 data protections (operational), and provider BH and BHI training (clinical). Entities across the delivery system expressed differing opinions about their ability to impact and drive integration efforts and the degree to which they should be held accountable. For example, some MCOs noted that practice-level "culture shifts" and care delivery processes must first take place and providers must be willing to work collaboratively before payment or reimbursement policies can be an effective tool. Some facilities felt that true integration could only be achieved when there is a streamlined or singular funding mechanism that prioritizes and incentivizes full-person care.

Customizing Approaches to Integrated Care

"***I think trying to have one kind of version of what integrated care looks like is kind of a fool's errand.*** *…Everybody does it differently, everybody has different capabilities, everybody has different goals, everybody has different realities in which they operate in their communities."*

—State Agency

Measuring the Quality of BHI Efforts

*"I could go on for hours about how behavioral health integration measurably improves clinician quality of life, clinician productivity, the ability of practices to take on a higher number of complex attributed patients. ...**But then we just see a bunch of screening rates and other things that aren't all that important or compelling in terms of what's the business case for behavioral health integration.** We just think it's a logical thing to do."*

—Managed Care Organization

Entities recognize standardized quality measures for measuring BHI processes and resulting care quality outcomes as critical for accountability, value-based purchasing efforts, and establishing a business case for BHI efforts. Although there is no clear vision about what BHI quality measures would include, entities noted that a group or bundle of quality measures and metrics would be more effective than any single measure.

Key Insight 5: Large-scale solutions and incentives are regarded as necessary to improve BH data.

Standardized data collection and exchange is critical for care coordination and patient-centered, whole-person care, yet there are significant infrastructure challenges in the BH care delivery system. At the highest level, fragmented financial models for BH care delivery create challenges to data exchange across the delivery system. Additional challenges include lack of BH data standards, inconsistent data protections and confidentiality requirements, and limited and nonintegrated BH information technology.

BH Data Exchange

"*… There is not one standard. Every standard is customized… so* ***each and every interface has to be tested and built, and there's a lot of work and money and effort.*** *In the end, you get a few more data hits*."
—Managed Care Organization

Why Is BH Data Different from PH Data?

*"****Outside of primary care or [an] ACO program, there really wasn't a meaningful use type push for behavioral health.*** *There aren't measures that really look at behavioral health and there's just no measure focus.* ***The market is not organized.*** *You basically have a handful of large traditional county or mental health center systems, hospitals, SUD providers, and then this wild west of independent, small mom and pop [,] mostly independent therapists. …* ***so, when we get to like, "Oh, well, we're going to do a value-based payment model or a vendor-based network for behavioral [care]," all of those underlying resources are not there or have not evolved in the same way."***
—Managed Care Organization

To account for the lack of standardized data exchange, organizations managing and treating individuals with BH conditions rely on piecemeal and laborious exchange of individual data elements, primarily to meet quality oversight requirements, rather than assessing full-person care for care delivery improvement. For example, one MCO highlighted how it negotiates a yearly license with its managed BH organization that allows sharing of specific data elements needed to report quality measures. While this labor-intensive yearly process does allow limited exchange of some data, it does not allow either organization to see the full picture of a member's care for the purpose of improving health outcomes, nor is it a scalable solution.

Current BH data exchange is limited and stymied by long-standing financial and regulatory barriers that represent a legacy of stigma and systemic bias toward individuals with BH conditions. Many entities noted that the most impactful way to realize widescale progress toward purposeful exchange of BH data is through federal incentives, such as those used in general health care (e.g., the former Meaningful Use program).

Key Insight 6: BH quality measures challenged efforts to monitor quality during the COVID-19 pandemic.

Multiple entities noted they could not effectively monitor care quality during the pandemic with existing quality measures. Because existing measures primarily focus on care utilization, when care patterns were disrupted during the COVID-19 pandemic, they were not useful. Entities discussed how more relevant BH measures—focused on patient goal setting and attainment, connecting patients to relevant services, and outcomes—would have better equipped them to understand the pandemic's real impact on BH care quality.

Monitoring BH Quality During COVID-19

"*I would say a lot of attention has gone into understanding how COVID is potentially impacting other performance measures like ED utilization…* ***There's a lot of concern because those measures are tied to a reimbursement rate or an incentive pool.*** *And, so, I think a lot of the focus has been on that* ***rather than turning forward and saying, 'How do we ensure that the services that are going on now are meeting quality standards?'"***
—Managed Care Organization

Section 4: Recommendations and Next Steps

The COVID-19 pandemic and consequent social and economic hardships have amplified the need for high-quality BH care, especially among underserved groups. As a result, under the Biden Administration, the Department of Health & Human Services (HHS) identified BH as a priority area and put in motion a series of historic investments in BH systems, services, and innovation. Examples of these investments include $3 billion in American Rescue Plan funding for Substance Abuse and Mental Health Services Administration (SAMHSA) block grants to address the BH crisis[24] and increased Federal Medical Assistance Percentage for certain Home and Community-Based Services to expand BH capacity.[23] HHS also established a new Behavioral Health Coordinating Council to "facilitate collaborative, innovative, transparent, equitable, and action-oriented approaches to addressing the HHS' behavioral health agenda." [24] Now, more than ever, we need robust quality measures and tools to assess how this significant investment in BH services impacts care quality and outcomes.

Need for a system framework

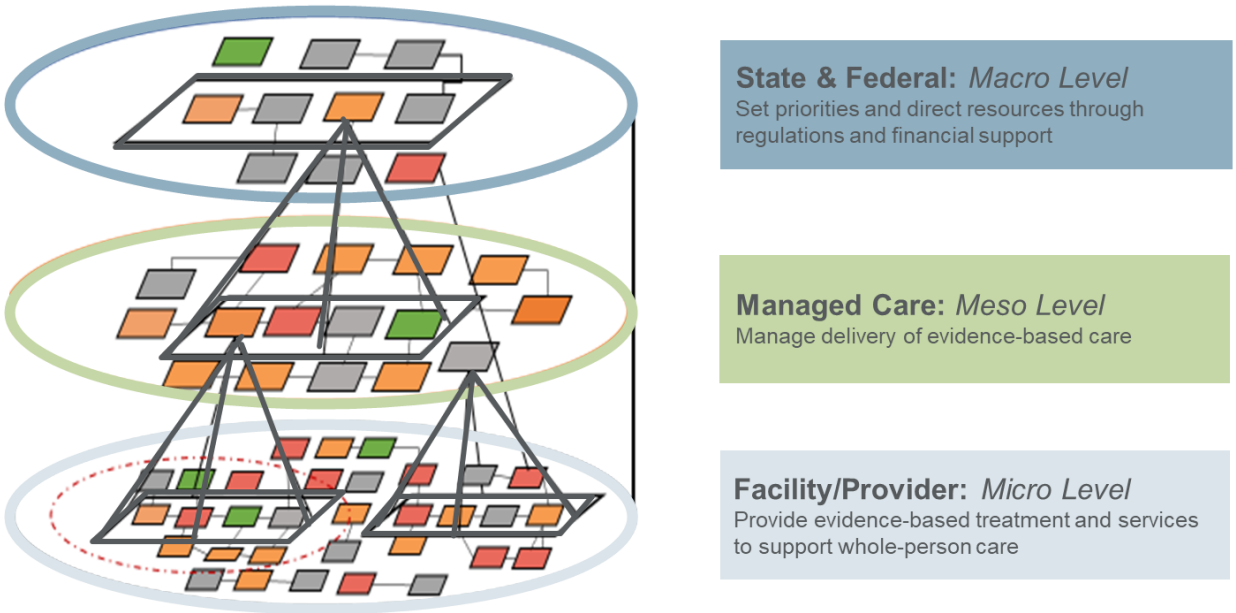
To drive improvements in BH quality and promote joint accountability across entities responsible for serving individuals with BH needs, we propose developing a **BH Quality Framework** that includes three components: 1.) use of a population health management structure to guide efforts, 2.) purposeful, coordinated alignment of measures and metrics across the delivery system to drive common goals, and 3.) investment in infrastructure supports to ensure accountability and drive improvement.

What is a BH Quality Framework?

The fragmented nature of BH care delivery in the United States calls for a coordinated approach to manage and deliver care to populations with BH needs. The guiding principles of this approach should be grounded in care equity and include a focus on underserved populations that have been historically marginalized due to stigma, misperceptions about BH, and inadequate access to treatment.

We apply the Applegate Alignment Model to highlight an approach for collaboration, cooperation, and coordination across a fragmented delivery system. This model calls for prioritizing the use of meaningful bundles of quality measures targeted to each level of the delivery system and coordinated to achieve population level goals.[25] The model *(Figure 5),* or **BH Quality Framework,** calls for both top-down and bottom-up strategies to engage stakeholders in identifying priority populations, an end-user defined set of quality measures, and transparent public reporting of quality data.

Figure 5: BH Quality Framework: Aligning Measures Across the Delivery System

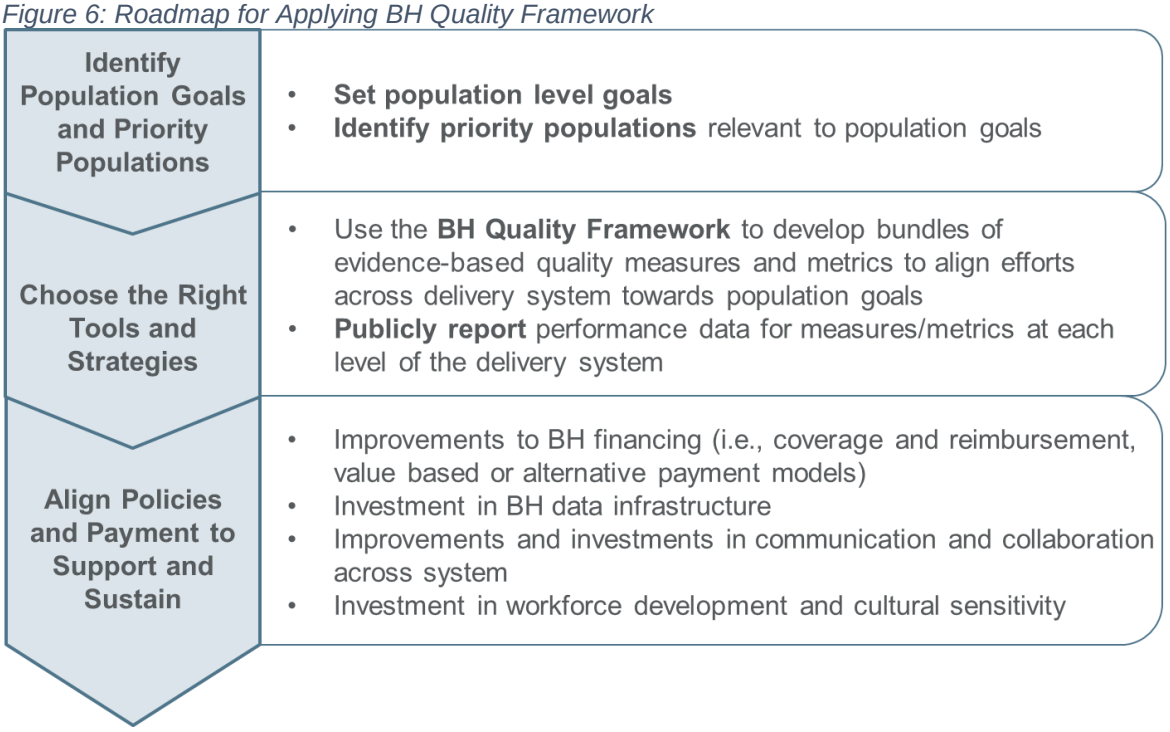


Stakeholders at each level of the system (macro or state/federal; meso or MCO; micro or facility) will identify the most salient, meaningful, and relevant performance measures and metrics. In this model, the goal is not to replicate measures across system levels; rather, measure bundles are transparently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

Proposed Roadmap to Joint Accountability: Applying the BH Quality Framework

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

Figure 6: Roadmap for Applying BH Quality Framework



Step 1: Identify Priority Goals and Relevant Populations

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

Step 2: Choose the Right Tools and Strategies

Following identification of population goals and relevant populations, stakeholders should convene to establish bundles of meaningful quality measures and metrics for use at each level of the delivery system. Convening a diverse and representative group of stakeholders from across the delivery system is critical because targeting the drivers of BH inequities requires understanding the needs, resources, and change levers unique to each entity.

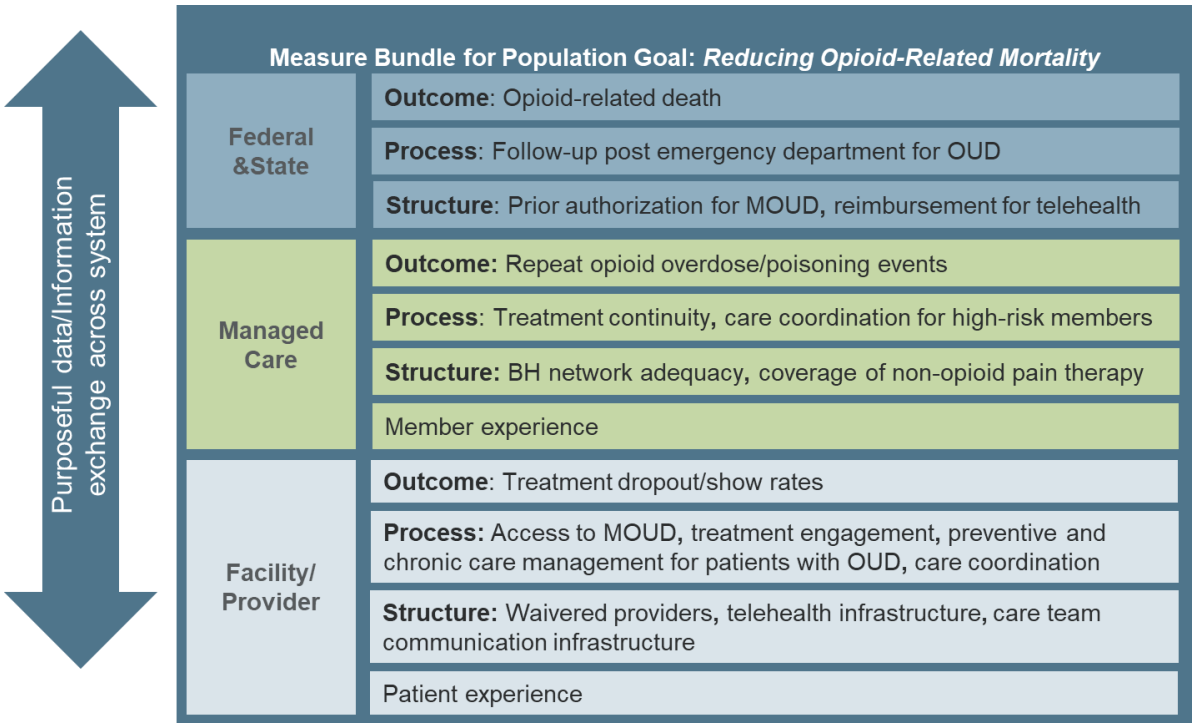
Selecting measures for use. Measures identified for use at each level of the system must be meaningful to the entities that will report them, must be based on high-quality evidence, and must have a relationship to measures used by adjacent entities at the same level (horizontal alignment) and entities at different levels (vertical alignment). Alignment across and between levels of the delivery system will facilitate a coordinated approach to impacting population goals and outcomes.

Development of measure bundles should consider traditionally marginalized groups that experience disparities in care—such as children with special needs, racial and ethnic minorities, and individuals with complex BH and health conditions—and should begin with evaluating existing quality measures and agreed-on standards used in active programs. Such efforts are likely to reveal gaps in existing measures (such as those discussed in *Sections 1 and 2* of this report) or highlight where current measures require adaptation, expansion, or replacement. Transparency and standardization are critical to ensure that measure bundling is coordinated, meaningful, and does not result in proliferation of new or single-use measures for similar care constructs.

Ensuring transparency in measurement. Use of the BH Quality Framework should be accompanied by incentivization of data sharing and transparency across the delivery system. Because measures at each level must have a relationship to measures at adjacent levels and might be based on data that is not available at adjacent levels (e.g., facility-level measures based on clinical data, MCO measures based on administrative claims data), transparency is critical for anticipating challenges and adapting BH care management and delivery to support whole-person care and population outcomes. To ensure transparency and data accessibility, web-based dashboards that display current performance for all measures and metrics across the system should be considered.

Example. *Figure 7* illustrates how measures and metrics can be aligned to address the population-level goal of reducing opioid-related mortality.

Figure 7: Aligning Quality Measures Across the Delivery System to Address Population-Level Goals



State stakeholders might prioritize a bundle of quality measures that includes their primary outcome of interest (opioid related mortality) as well as other process and structure measures that support the same outcome, including follow-up care after acute opioid-related events, prior authorizations and coverage of medications to treat OUD (MOUD), and maintenance of state Prescription Drug Monitoring Programs.

MCO stakeholders: To support progress toward reducing opioid-related deaths, states might develop contracts with MCOs to incentivize a focus on the goal. Because they have visibility into claims for ER services for opioid-related overdoses, MCOs might concentrate their efforts on reducing repeat overdose events (which are predictive of future opioid-related mortality).[28] MCOs might also establish process and structure measures to encourage evidence-based interventions and processes that promote treatment continuity and reduce overdose events and mortality (e.g., adequate coverage of MOUD, BH network adequacy, coverage of non-opioid pain management, care coordination or case management services for high-risk individuals who were recently released from incarceration or who had a previous overdose event).

Facility/provider stakeholders: MCOs can then contract with facilities and providers that prioritize outcomes. In this case, because treatment adherence is associated with reduced risk of overdose, facilities and providers might track patient engagement or dropout rates.

The measures in facility-level bundles may differ by the facility/provider type and their role in managing opioid misuse or abuse. In this example, process measures might be related to ensuring that at-risk individuals receive adequate pain management for chronic conditions and have access to and continuity of MOUD. Structural measures might assess availability of buprenorphine-waivered providers, facility telehealth infrastructure, and care coordination supports for managing individuals with complex conditions.

Step 3: Align Policies and Payment to Sustain

Driving a BH Quality Framework to achieve population-level goals requires that effective regulations, policies, and payment structures are in place to incentivize engagement and joint accountability

among payers, delivery systems, public health and social service organizations, community-based organizations—and patients. While stakeholders at all levels should convene to identify opportunities for system advancement, stakeholders at different levels will have different roles, given their position in the system and their leverage opportunities. Below we highlight four key areas that should be prioritized to support implementation of a BH Quality Framework *(Figure 8)*.

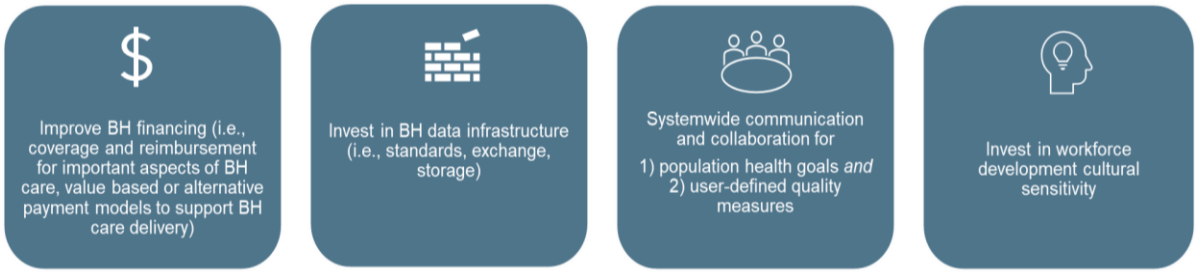
BH financing. Effective implementation of a joint accountability framework requires continued progress in payment reform that incentivizes value over volume and focuses on shared goals, community engagement, leadership alignment, and data exchange.[29] Systems must work to reconcile and reform existing regulations that challenge BHI, increase flexible funding resources, and improve coverage of and reimbursement for important aspects of whole-person care, including reimbursement for wraparound care and case management. Efforts to address the BH workforce shortage are also critical. To incentivize development of a more robust BH workforce, reimbursement for BH support services provided by auxiliary providers (e.g., peer specialists, case managers) must be a priority.

Data infrastructure. Significant investment and incentives are needed to improve the standardization, storage, and purposeful exchange of BH data across entities that provide direct services and manage care for individuals with BH conditions. Although recent efforts in use of digital platforms, health information exchanges, and tele-behavioral health platforms are being leveraged to improve data infrastructure, entities interviewed for this study expressed that federal initiatives like the 2009 Meaningful Use program could help drive large-scale improvements to BH data infrastructure.

Systemwide communication and collaboration. Effective use of the BH Quality Framework to spur system transformation is contingent on stakeholder buy-in, collaboration, and communication. Entities in the delivery system should be incentivized to set population goals and define bundles of quality measures and metrics that will collectively drive common outcomes. A starting point for this type of collaboration is multi-stakeholder quality measurement advisory groups assembled by state agencies or MCOs.

Workforce and cultural sensitivity development. Creating a systemwide culture of joint accountability requires investment in a multi-level workforce to promote a focus on common goals and whole-person care. Investment in development and training the health care workforce to provide high-quality, culturally competent BH care will equip entities at all levels to engage in meaningful progress toward equitable care.

Figure 8: Infrastructure to Support BH Quality Framework



Conclusion

NCQA recommends testing the proposed BH Quality Framework to promote joint accountability for whole-person BH care. To assess the framework's viability, we encourage pilot work using the roadmap outlined above.

Federal and state entities are positioned to drive improvements and impact population health goals for individuals with BH conditions by setting priorities and directing resources through regulations and financial support—but stakeholders, organizations, and individuals at all levels of the delivery system play a critical role. The BH Quality Framework calls for convening a diverse group of stakeholders that

includes state policymakers, payers, providers, and consumers to prioritize population goals for BH, develop relevant measure bundles, and address known inequities in care that stymie progress.

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

Looking Ahead: Potential Opportunities to Pilot the BH Quality Framework in California

As we explain in in *Appendix B*, Medi-Cal (California's Medicaid Program) is administered through the state Department of Health Care Services (DHCS) and includes three delivery options for public MH treatment: managed care plans, fee-for-service plans, and county MH plans. By January 1, 2022, DHCS intends to transition all existing managed care authorities into one consolidated 1915(b) California managed care waiver—*CalAIM: California Advancing and Innovating Medi-Cal*—that will prioritize integration of the Medi-Cal delivery systems, alignment of funding sources, and attention on SDOH. A key aspect of the *Medi-Cal (CalAIM)* proposal relates to reforming BH payment and administrative oversight requirements for counties and shifting from a cost-based reimbursement structure to a value-based reimbursement structure that incentivizes outcomes and BHI.

Opportunities to pilot framework
Using the BH Quality Framework as a guide, stakeholders in California could work collaboratively to identify a high-need priority goal and relevant populations for impact. Following this, stakeholders can reach consensus around an aligned and coordinated set of bundled quality measures and metrics across entities within the system. The pilot of the BH Quality Framework could be statewide, in more near-term efforts, and/or be part of the full integration plans that will be tested under *CalAIM* starting as early as 2027.

Build upon existing scaffolding
Of note, there are already multiple active stakeholder groups in California, including the California County BH Directors Association, the California MH Services Authority, the California Department of Health Care Services BH Task Force, and multiple MCO and facility-led quality measurement groups. These groups suggest that multi-level collaboration is a natural extension of current state efforts.

Appendix

Appendix A: Environmental Scan Supplemental information

Figure A1: Federal Reporting Program Identification and Selection for Study Inclusion (as of October 2020)

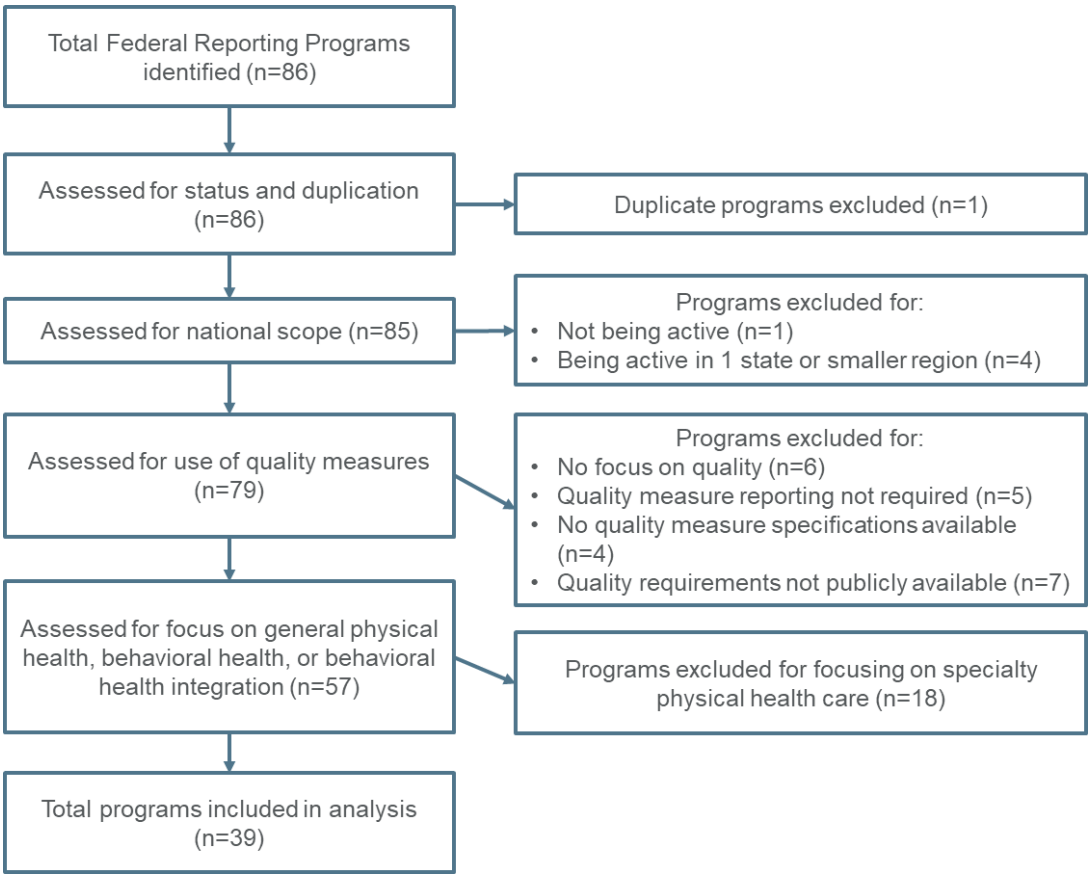


Table A2: Federal Reporting Programs Included in Environmental Scan (N=39)

Program	Sponsoring Agency	Demonstration (Y/N)	Reporting Entity	Program Type		
				Gen. Med.	BH	BHI
1. Substance Abuse Prevention and Treatment Block Grant (SABG)	SAMHSA		States		X	
2. Community Mental Health Services Block Grant (MHBG)	SAMHSA		States		X	
3. Section 1115 SMI/SED Demonstration	CMS	Y	States		X	
4. Section 1115 SUD Demonstration	CMS	Y	States		X	
5. Medicaid 1115 Community Engagement	CMS	Y	States		X	
6. Inpatient Psychiatric Facility Quality Reporting Program (IPFQR)	CMS		Inpatient		X	
7. Integrated Care for Kids (InCK) Model	CMS (CMMI)	Y	Multilevel			X
8. Certified Community Behavioral Health Clinics	SAMHSA, CMS, ASPE	Y	Multilevel			X

Program	Sponsoring Agency	Demonstration (Y/N)	Reporting Entity	Program Type		
				Gen. Med.	BH	BHI
9. Promoting Integration of Primary and Behavioral Health Care Cooperative Agreements [PIPBHC]	SAMHSA, CMS		States			X
10. Health Centers Program	HRSA		Practices			X
11. Comprehensive Primary Care Plus (CPC+) Model	CMS (CMMI)	Y	Practices			X
12. Maternal Opioid Misuse (MOM) Model	CMS (CMMI)	Y	States			X
13. Community Health Access and Rural Transformation Model: Community Transformation Track	CMS	Y	Multilevel	X		
14. Financial Alignment Initiative for Medicare-Medicaid Enrollees: Capitated model	CMS (CMMI)	Y	States	X		
15. Financial Alignment Initiative for Medicare-Medicaid Enrollees: Managed Fee-for-service model	CMS (CMMI)	Y	States	X		
16. CMS Adult Core Set	CMS		States	X		
17. CMS Child Core Set	CMS		States	X		
18. Medicare Advantage (including Star Rating measures)	CMS		MA Organizations	X		
19. Next Generation ACO Model	CMS (CMMI)	Y	ACOs	X		
20. Direct Contracting Model Options	CMS (CMMI)	Y	ACOs	X		
21. Medicare Shared Savings Program	CMS		ACOs	X		
22. Medicare-Medicaid Plans (MMP)	CMS		Health plans	X		
23. Marketplace Quality Rating System	CMS		Health plans	X		
24. Inpatient Rehabilitation Facilities (IRF) Quality Reporting Program	CMS		Inpatient	X		
25. Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program	CMS		Inpatient	X		
26. Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents: Phase Two	CMS (CMMI)	Y	Inpatient	X		
27. Hospital Outpatient Quality Reporting	CMS		Hospitals	X		
28. Hospital Inpatient Quality Reporting (IQR) Program	CMS		Hospitals	X		
29. Long-Term Care Hospital (LTCH) Quality Reporting Program	CMS		Hospitals	X		
30. Hospital Readmissions Reduction Program	CMS		Hospitals	X		
31. Hospital Value-Based Purchasing (VBP) Program	CMS		Hospitals	X		
32. Bundled Payments for Care Improvement (BPCI) Advanced Model	CMS (CMMI)	Y	Hospitals	X		
33. Skilled Nursing Facility (SNF) Quality Reporting Program	CMS		Inpatient	X		
34. Rural Community Hospital Demonstration	CMS (CMMI)	Y	Hospitals	X		
35. Programs of All Inclusive Care for the Elderly (PACE)	CMS		Community-based programs	X		
36. Independence at Home Demonstration	CMS (CMMI)	Y	Practices	X		
37. Primary Care First Model	CMS (CMMI)	Y	Practices	X		
38. Merit-Based Incentive Payment System (MIPS) Program	CMS		Practices, providers	X		
39. Medicaid Health Homes Program	CMS		States	X		

Table A3: Quality Measures in Federal Reporting Programs Focused on Behavioral Health Integration

	Certified Community Behavioral Health Clinics	Comprehensive Primary Care Plus Model	Health Centers Program	Integrated Care for Kids Model	Maternal Opioid Misuse Model	Promoting Integration of Primary and BH Care Cooperative Agreements	Total
Measures and Metrics							
NQF or CMIT endorsed	22 (69%)	17 (100%)	11 (20%)	8 (62%)	1 (20%)	0 (0%)	59 (39%)
Not NQF or CMIT endorsed	2 (6%)	0 (0%)	3 (6%)	1 (8%)	0 (0%)	0 (0%)	6 (4%)
Metric	8 (25%)	0 (0%)	41 (75%)	4 (31%)	4 (80%)	28 (100%)	85 (57%)
Type of NQF-Endorsed and CMIT Measure							
Donabedian Measure Type							
Structure	0 (0%)	1 (5%)	0 (0%)	1 (13%)	0 (0%)	n/a	2 (3%)
Process	19 (86%)	12 (71%)	9 (82%)	6 (75%)	0 (0%)	n/a	46 (78%)
Intermediate Outcome	1 (5%)	2 (12%)	1 (9%)	1 (13%)	0 (0%)	n/a	5 (8%)
Outcome	2 (9%)	2 (12%)	1 (9%)	0 (0%)	1 (100%)	n/a	6 (10%)
Data Source*							
Admin/Claims	18 (82%)	12 (71%)	7 (64%)	7 (88%)	0 (0%)	n/a	44 (75%)
EHR	6 (27%)	9 (53%)	10 (91%)	5 (63%)	0 (0%)	n/a	30 (51%)
Survey	1 (5%)	2 (12%)	0 (0%)	1 (13%)	1 (100%)	n/a	5 (8%)
Paper medical records	4 (18%)	7 (41%)	10 (91%)	3 (38%)	0 (0%)	n/a	24 (41%)
Other	6 (27%)	1 (6%)	5 (45%)	1 (13%)	0 (0%)	n/a	13 (22%)
Measure Domains							
General Medical Domains (Subtotal)	**3 (14%)**	**7 (41%)**	**8 (73%)**	**2 (25%)**	**0 (0%)**	n/a	**20 (34%)**
General medical screening or diagnostic assessment and prevention	1 (5%)	6 (35%)	8 (73%)	2 (25%)	0 (0%)	n/a	17 (29%)
Access to general medical care	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	n/a	0 (0%)
General medical outcomes	2 (9%)	1 (6%)	0 (0%)	0 (0%)	0 (0%)	n/a	3 (5%)

	Certified Community Behavioral Health Clinics	Comprehensive Primary Care Plus Model	Health Centers Program	Integrated Care for Kids Model	Maternal Opioid Misuse Model	Promoting Integration of Primary and BH Care Cooperative Agreements	Total
BH Domains (subtotal)	**19 (86%)**	**4 (24%)**	**3 (27%)**	**4 (50%)**	**1 (100%)**	n/a	**31 (53%)**
BH screening or assessment and follow-up	7 (32%)	2 (12%)	2 (18%)	2 (25%)	0 (0%)	n/a	13 (22%)
BH evidence-based treatment	11 (50%)	1 (6%)	0 (0%)	2 (25%)	0 (0%)	n/a	14 (24%)
BH patient-centered care	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	n/a	0 (0%)
Access to behavioral healthcare	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	n/a	0 (0%)
BH outcomes	1 (5%)	1 (6%)	1 (9%)	0 (0%)	1 (100%)	n/a	4 (7%)
Cross-Cutting Measures (Subtotal)	**0 (0%)**	**6 (35%)**	**0 (0%)**	**2 (25%)**	**0 (0%)**	n/a	**8 (14%)**
Family/patient perception of care	0 (0%)	1 (6%)	0 (0%)	0 (0%)	0 (0%)	n/a	1 (2%)
Continuity and coordination of care	0 (0%)	1 (6%)	0 (0%)	1 (13%)	0 (0%)	n/a	2 (3%)
Social service access	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	n/a	0 (0%)
Patient safety	0 (0%)	2 (12%)	0 (0%)	0 (0%)	0 (0%)	n/a	2 (3%)
Cost, efficiency, and utilization	0 (0%)	2 (12%)	0 (0%)	1 (13%)	0 (0%)	n/a	3 (5%)
Total Measures	**22**	**17**	**11**	**8**	**1**	**n/a**	**59**

Measures may allow use of more than one type of data and thus may be counted in more than one category.

CPC+ = Comprehensive Primary Care Plus InCK = Integrated Care for Kids MOM = Maternal Opioid Misuse
PIPBHC = Promoting Integration of Primary and BH Care Cooperative

Appendix B: State Profiles

California

Administration & Financing

California's Medicaid Program, *Medi-Cal*, is administered through the state Department of Health Care Services (DHCS) and includes three delivery options for public mental health (MH) treatment: managed care plans (MCP), fee-for-service (FFS) plans, and county mental health plans (MHP).[30] For California residents with mild to moderate MH conditions, DHCS contracts with MCPs to deliver both MH and physical health (PH) services on a capitated basis.[31]

For Medicaid beneficiaries and residents severe mental illness (SMI) and without insurance, DHCS contracts with county MHPs through an FFS model financed through a 1915(b) waiver to provide MH services.[31,32,33] For state residents with a substance use disorder (SUD) who are in Medicaid or are uninsured, services are available through the county under two models. The first model comprises FFS *Drug Medi-Cal* plans that cover a limited set of services through state contracts. The second model (previously known as the *Drug Medi-Cal Organized Delivery System*) is a managed care model financed through a Section 1115(a) waiver.[34]

California's estimated $5.6 billion Medicaid budget for MH services in state fiscal year (FY) 2020–2021 is funded through federal funds (59%), state funds (11%), and local funds from the 1991 and 2011 realignments, the Mental Health Services Act (MHSA), and other local funds (roughly 30%). The federal and state funds portion of MH services in Medi-Cal represent approximately 3% of total Medicaid funding in the 2020–2021 Budget Act. (Local funds for MH are not appropriated as part of the state Medi-Cal budget.)[35]

Innovation

DHCS developed a framework to build on the achievements of *Medi-Cal* 2020 (2015–2020 1115 Medicaid Waiver) that will address delivery system fragmentation and other priorities. By January 1, 2022, DHCS intends to transition all existing managed care authorities into one consolidated 1915(b) California managed care waiver, *CalAIM: California Advancing and Innovating Medi-Cal,* that will prioritize integration of the Medi-Cal delivery systems, alignment of funding sources, and increased attention for social determinants of health. [36] Under *CalAIM*, California will also pursue efforts to eliminate duplicate processes for quality improvement and performance measurement.

Behavioral Health Accountability

With regard to accountability for mild and moderate MH care, DHCS requires MCPs to report annually on Managed Care Accountability Sets (MCAS) that include measures for MH and SUD treatment selected primarily from the Medicaid Adult and Child Core Sets.[37] Additionally, in FY 2019–2020, DHCS implemented a value-based reimbursement model for risk-based accountability of MCPs, including the Value-Based Payment Program and the Behavioral Health Integration Incentive Program, to incentivize improvement of PH and MH outcomes.[38] Participants in these programs will be evaluated using quality measures, many of which are included in the Medicaid Core Sets and HEDIS.

With regard to accountability for severe MH managed through counties, DHCS, local and state authorities, and the legislatively mandated Mental Health Services Oversight and Accountability Commission (MHSOAC) provide funding and financial oversight. MHPs must report annually on MHSA programs and expenditures and must submit three-year plans on how they will use funds to address community-based needs.[39] Tracked outcomes of interest for MHSOAC include school failure, incarceration, suicide, homelessness, unemployment, out-of-home placement, and prolonged suffering.

Washington

Administration & Financing

The Washington state Health Care Authority (HCA) provides funding and oversight for BH services for Washington's Medicaid and CHIP programs, known collectively as *Apple Health*.[40] Most *Apple Health* enrollees access BH treatment through managed care organizations (MCO) that offer fully integrated PH and BH care. Individuals who are not eligible for managed care (e.g., dual-eligible Medicare/Medicaid beneficiaries) can access BH benefits through Behavioral Health Services Only (BHSO) operated by MCOs under a Section1915(b) waiver.[41] Regardless of insurance status or income level, individuals experiencing an MH crisis can access a Behavioral Health—Administrative Services Organization (BH-ASO) (partially funded through federal block grants). BH-ASOs may also provide noncrisis MH services to low-income individuals not eligible for *Apple Health* but who meet other program criteria.[42]

15% of Apple Health's $21 billion biennial Medicaid budget goes toward BH. In the FY 2019–2021 budget, the state general fund accounted for over one-third of the public mental health budget and federal sources made up nearly two-thirds.[43]

Innovation

In 2014, the Washington State Legislature mandated a two-step transition to integrated care, beginning with integration of MH and SUD treatment services and proceeding to full integration of managed care for PH and MH services by January 2020.[44] Over 84% of full-benefit Medicaid beneficiaries are now enrolled in one of five MCOs that contract with the state to serve each county.[45, 46]

As part of the *Healthier Washington* initiative, the state developed the Medicaid Transformation Project (MTP) through a Section 1115 demonstration waiver approved by CMS in January 2017. At the core of the MTP are nine regional Accountable Communities of Health (ACH), self-governing organizations of regional coalitions focused on improving health and transforming care delivery in their communities. ACHs play an integral role in advancing MTP initiatives, including long-term services and supports, supportive housing and supported employment, and institutions for mental diseases waivers for SUD and MH.

Behavioral Health Accountability

In 2014, the Washington Legislature established the Statewide Common Measure Set, which includes both PH and BH measures and is used to for both state population health monitoring and for value-based contracting. By the end of 2021, HCA seeks to drive 90% of state-financed health care into value-based arrangements. ACH's, providers, and partnering organizations are also eligible for incentive payments by achieving value-based plan milestones.[47] HCA drives quality improvement through transparent goal setting and performance measure rate display through both *Results Washington* and *Results HCA*. The Washington Health Alliance, a private nonprofit organization, publishes a yearly statewide "Community Checkup" report that includes quality measure performance scores for clinics, medical groups, hospitals, health plans, counties, and each of the nine ACHs operating in the state. The measures included in the Community Checkup report change in response to changing priorities, but currently include measures to monitor progress of BH integration and access to MH and SUD treatment services.[48, 49]

Colorado

Administration & Financing

The Colorado Department of Health Care Policy & Financing (HCPF) oversees the state's Medicaid program, *Health First Colorado*. Medicaid services in Colorado are coordinated by seven Regional Accountability Entities (RAE) that finance care delivery through a hybrid approach, with BH services under a capitated model and PH services under an FFS model.[50,51] BH care for Colorado residents who are uninsured or underinsured is managed by the Office of Behavioral Health in the Colorado Department of Human Services.[52]

9% of the $10.7 billion state Medicaid budget was allocated to BH programs in FY 2019–2020.[53] Of note, a 2019 State Behavioral Health Task Force proposed that Colorado work to consolidate the over 60 unique funding streams that finance state BH services, to reduce inefficiencies and fragmentation.[54]

Innovation

In 2011, HCPF launched the Accountable Care Collaborative (ACC) to improve members' health and reduce costs. Operating under a Section 1915(b) waiver, the ACC program is a hybrid model that combines elements of the Accountable Care Organization and Primary Care Case Management Entity models.[55] Phase one of ACC focused on connecting *Health First Colorado* members to primary care providers, improving health outcomes and controlling costs. Phase two advances Health First Colorado's care delivery and payment model. Objectives include integration of PH and BH, transitioning to value-based care, enhancing care coordination and patient engagement, and promoting greater accountability and transparency.[56]

Behavioral Health Accountability

HCPF uses key performance indicators (KPI) to assess the overall performance of the ACC and reward RAEs for improved health outcomes and cost efficiencies. RAEs have the opportunity to earn back HCPF-withheld administrative PMPM payments by meeting performance thresholds on KPIs, which include both PH and BH measures.[57] Additionally, the BH Incentive Program allows RAEs to earn up to 5% above their annual capitation payment by meeting participation performance requirements and targets across five MH and SUD measures.[58] HCPF is developing a public reporting dashboard to publish data on KPIs, including clinical and utilization measures, for greater transparency and accountability.[59]

Pennsylvania

Administration & Financing

97% of state Medicaid beneficiaries are enrolled in the fully capitated managed care program, *HealthChoices*. Oversight for *Physical HealthChoices* and CHIP falls to the Office of Medical Assistance Programs (OMAP); oversight of the *Behavioral HealthChoices* program and six state mental hospitals and one restoration center fall to the Office of Mental Health and Substance Abuse Services (OMHSAS). *Behavioral HealthChoices* is a carve-out model managed at the county level through capitated agreements between behavioral health managed care organizations (BH-MCO) and local county entities. Pennsylvania counties have the "right of first opportunity" to enter into direct agreements with BH-MCOs for provision of BH benefits and, to date, 43 counties have opted into these direct contracts. For the 24 counties that waived this option, OMHSAS contracts directly with a BH-MCO to administer the *Behavioral HealthChoices* program.[60]

In 2018, the Department of Human Services (DHS) implemented its managed long-term services and supports (MLTSS) program, *Community HealthChoices (CHC),* for low-income older adults and adults with physical disabilities. CHC, which is administered by the Office of Long-Term Living, provides PH and LTSS services for individuals over age 21 who are either dually enrolled in or eligible for Medicaid and Medicare, or are eligible for both Medicaid and nursing facility care. SUD care for Pennsylvania residents who are uninsured or underinsured is managed by the Department of Drug and Alcohol Programs, which also manages licensing and certification of drug and Alcohol Treatment Facilities and administers funding for community-based SUD services to the state's 47 Single County Authorities.[61]

15% of the state's $32.2 billion dollar Medicaid budget in FY 2020–2021 went toward provision and management of BH services.[62]

Innovation

In 2016, OMHSAS and OMAP launched the Integrated Care Program (ICP) pay for performance (P4P) program for state PH managed care organizations (PH-MCOs) and BH-MCOs to integrate physical and BH care management activities for members diagnosed with serious and persistent mental illness (SPMI) or SUD.[63] MCOs that demonstrate collaboration are eligible to receive financial incentives based on

performance on five quality measures. DHS is exploring options to increase the number of measures and expand beyond the SPMI and SUD populations.

In 2018, Pennsylvania received a five-year grant from SAMHSA for the PIPBHC (Promoting the Integration of Primary and Behavioral Health Care) program to develop a comprehensive approach to improve the overall wellness of special populations, such as adults with SUD, children with serious emotional disturbance, and adults with co-occurring mental illness and physical health conditions.[64] In 2020, the governor announced his administration's plan for Whole-Person Health Reform, which includes three initiatives to expand and prioritize integrated care and value-based purchasing reforms.[65]

Behavioral Health Accountability

The Pennsylvania Department of Health Services requires yearly reporting of quality measures, which include HEDIS measures; measures in the Medicaid Adult, Child, and BH Core Sets; and state-developed "Pennsylvania Performance Measures." The department conducts Quarterly Quality Review Meetings to review MCO performance against stated goals, monitor performance, and establish new targets. In 2021 OMHSAS intends to launch a P4P program that will provide incentive payments to county-based primary contractors based on HEDIS measure performance and improvement goals.

Louisiana

Administration & Financing

84% of Medicaid beneficiaries in Louisiana are enrolled in the state Medicaid managed care program, *Healthy Louisiana*, which provides full coverage for both PH and specialized behavioral health (SBH) through managed Care Entities (MCEs).[66] The Office of Behavioral Health (OBH), within the Louisiana Department of Health (LDH), provides oversight for *Healthy Louisiana* BH services, coordinates BH care for uninsured populations, and operates two state psychiatric facilities.[67] For children and youth with complex BH challenges who are at risk for out-of-home placement, the Coordinated System of Care, a prepaid inpatient health plan that operates under a 1915(c) HCBS waiver, provides intensive home and community-based supportive services.[68]

The OBH FY 2020 budget was approximately $13 billion. Federal sources contributed to nearly three-quarters of the budget, while the state's general fund and other state funds accounted for 15% and 11% of the *Healthy Louisiana* budget, respectively.[69] 9% of Louisiana's total Medicaid budget goes toward BH services.

Innovation

In 2008, the Louisiana legislature mandated local administration of the state's BH system as part of a statewide integrated human services delivery system.[70] Ten independent health care authorities, *Human Service Districts* (or *Local Government Entities*), provide services including screening and assessment, emergency crisis care, and clinical casework services for both insured and uninsured residents with MH conditions, SUDs, and developmental disabilities.[71] In 2018, Louisiana received a five-year PIPBHC grant from SAMHSA to promote the integration of primary and BH services among four Federally Qualified Health Centers (FQHC) in the state.

Behavioral Health Accountability

Louisiana requires all MCEs to report annually on a set of quality performance measures, including measures from the Medicaid Adult and Child Core Sets, HEDIS, Agency for Healthcare Research and Quality Prevention Quality Indicators, CAHPS® (Consumer Assessment of Healthcare Providers and Systems), and state-specified measures. LDH withholds 1% of MCEs' monthly capitated payments for the measurement year, which can be earned back by meeting or improving on performance measurement targets established by LDH. LDH also requires MCEs to submit Performance Improvement Projects, including one LDH-approved BH project, each contract year.[72]

Appendix C: Stakeholder Interview Methods

Interview guides and survey questions were developed to solicit data from organizations in each of the following domains: 1.) organizational structure and financing of BH care; 2.) accountability through BH quality measurement; 3.) BH quality improvement priorities; 4.) alignment of BH quality measurement across accountability levels; and 5.) impact of COVID-19 on BH care delivery and quality measurement.

Following transcription, interview data was coded using the qualitative Framework Method[73] to systematically analyze data and identify key themes and issues. Two research team members reviewed transcripts and developed a codebook, which was updated and revisited throughout coding to account for emergent themes. Following establishment of interrater reliability (0.82), the research team coded all interviews, using weekly check-in meetings to discuss ongoing coding memos, uncertainties or questions in code application, and any need for revisions to the codebook. Following coding, the research team further refined codes into broader themes and into a final thematic framework used to identify key insights. The team organized the framework by delivery system level to help identify patterns across like entities or within systems.

To enhance validity of results, preliminary study findings were presented to NCQA external stakeholder groups. Study participants were also invited to provide input on our summaries of their state profiles.

Table C1 contains the five domains and related questions used to guide stakeholder interviews.

Table C1: Interview Domains and Topics Covered Through Key Stakeholder Interviews

Domain	Interview Guide Questions
Organizational Structure and Financing	• How are BH services delivered and financed? • How are different entities incentivized to deliver high quality BH services through their unique payment model? • How are entities incentivizing or being incented to integrate BH care?
Accountability Through Quality Measurement	• How is the quality of BH services assessed? • How is the quality of integrated BH care assessed? • How does BH data for quality measurement flow between accountable entities in different care delivery models?
Quality Improvement Priorities	• How are quality measurement and quality improvement strategies aligned in different entities?
Alignment Across Accountability Levels	• What are the challenges, and successes around aligning BH quality measures for reporting within and across levels of the delivery system? • How are entities aligning measurement across levels of the delivery system?
Impact of COVID-19 on MH/SUD Care Quality and Measurement	• How is the quality of BH care monitored during public health emergencies such as COVID-19? • How are entities using telehealth to provide BH care during COVID-19 and how are they monitoring the quality of care delivered?

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