Making Sense of Behavioral Health Measurement

Key Takeaways

- Behavioral health service providers are adopting data collection practices and quality measurement strategies.
- Commonly used measures span multiple quality domains and draw on a range of data sources.
- Recent literature and guidance signal a clear evolution toward outcome-oriented, system-level, and improvement-focused approaches.
- Behavioral health measurement is moving toward aligned, systemwide accountability tied to Medicaid, state reform, and population outcomes.
- Service providers that build measurement readiness in phased, realistic ways—paired with appropriate investment and technical support—will be essential to delivering outcomes that matter.

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Introduction

Like much of the American healthcare delivery system, providers of services for Mental Health and Substance Use Disorder services (collectively referred to as Behavioral Health, or BH) are increasingly expected to quantify the impacts of their efforts. These efforts to track quality of care help behavioral health service providers achieve the Triple Aim: optimized experience of care, improved outcomes, and controlled costs.

Behavioral health service providers have begun adopting data collection practices and quality measurement strategies that impose significantly more emphasis on tracking and oversight. These efforts are intended to identify successes, opportunities, and gaps to drive quality improvement in every aspect of service delivery.

What Is Quality Measurement and Why Do Quality Measures Matter?

In healthcare, quality measurement looks at whether people get the *right* care, *the right way*, *at the right time, and whether the care helps them achieve outcomes that matter*. Quality measures check whether health care is doing what it's supposed to do. Think of quality measures like a report card for health care. Just as schools track attendance, graduation rates, or test scores, health care uses quality measures to track things like:

- How often people receive recommended care.
- How safe care is.
- Whether people are respected and included in decisions about their care.

Quality measurement matters because health care is complex, and without measurement, problems can stay hidden. Quality measures have multiple uses by different kinds of health care stakeholders like health care providers, health plans, payers, consumers, and others:

- **Quality improvement.** Health plans and health care providers use quality measures to find out whether they are doing a good job and identify how they can improve.
- **Incentives and payment.** Payers – including states, the federal government, and employers – use quality measures to encourage improvement, often by giving incentives or other payment arrangement for higher quality care.
- **Consumer choice.** Data on quality can help people select a health plan or provider.

Quality measurement looks at structure, process, and outcomes:

- S**tructural measures** deal with standards and criteria for participation in a system or care continuum.
- **Process measures** look at what was done, such as whether an evidence-based intervention was used.

- **Outcome measures** look at the impact or outcome of care, such as assessing symptoms or level of functioning after an intervention
    - **Care Experience measures** are a type of outcome measure that looks at factors like satisfaction with services, a likelihood of recommending a service, provider, or facility to others for their own care.

Healthcare stakeholders from different sectors use one, some, or all these ways to measure and evaluate their services and impact on the individual being cared for and the program or system in which they operate (as shown in *Table 1: Common Process and Outcome Measures by System*). Process and outcome measures are the most common ways stakeholders measure, with some entities integrating experience into their outcome measurement. For example, quality can be measured for a state population or program, for a managed care plan or for an individual clinic, facility or clinician. Patient experience, as a subset of outcomes, can be measured by a managed care plan or a facility providing some aspect of care.

Table 1: Common Process and Outcome Measures by System

	Measure Category	State	Managed Care	Facility
OUTCOMES	BH Symptom functioning improvement (i.e., measurement-based care)	✓	✓	✓
	Patient goal attainment		✓	✓
	Patient experience		✓	✓
	Social outcomes (e.g., kindergarten readiness, crime rate, employment)	✓		
	BH integration – outcomes and effectiveness	✓	✓	
	Cost	✓	✓	
PROCESS	Social service coordination (e.g., linkages)		✓	✓
	Care coordination/referral success		✓	✓
	Evidence-based treatment (e.g., fidelity to intervention model)	✓		✓
	Patient goal setting	✓	✓	✓
	BH integration processes (e.g., data sharing, warm handoffs)		✓	✓

The Quality Measures Landscape in Behavioral Health

Who defines quality in behavioral health?

Several different stakeholders are involved in defining quality and selecting quality measures.

- **Government.** The Centers for Medicare and Medicaid Services (CMS) set national priorities for health care quality and select measures for programs. The Substance Abuse and Mental Health Services Administration (SAMHSA) is focused on improving care for people with behavioral health problems and uses quality measures for its programs. States set priorities for quality, often building on federal criteria.
- **Professional societies.** Both the American Psychiatric Association (APA) and the American Psychological Association (APA) publish care guidelines that may inform quality measures.
- **Measure stewards.** Organizations like the National Committee for Quality Assurance (NCQA), both APAs, and others develop and maintain quality measures.
- **Other stakeholders.** People with lived experience, advocacy groups, plans, health systems and other providers, employers, and researchers are often involved in the development and selection of quality measures.

Quality measures are developed using a structured process that aims to ensure that measures address meaningful and important topics, are scientifically acceptable, feasible, and useful for improving quality.

What are commonly used behavioral health quality measures?

Commonly used measures span multiple quality domains, such as access to care, quality and effectiveness of services, outcomes, and experience of care. They draw on a range of data sources, including claims and encounter data, clinical records, and self-reported experience measures. Together,

BH Quality Measures in Action

Follow-up After Hospitalization for Mental Illness

Quality measures can focus attention on ways that service providers can ensure that people get access to services they need. For example, *Follow-up After Hospitalization for Mental Illness* looks at whether people who were hospitalized for mental health problems have an outpatient visit within a week of leaving the hospital and is important for preventing poor outcomes. Recently discharged individuals can face health risks like substance use or suicidal ideation or self-harm, challenges in obtaining or adhering to recommended medications or therapy, or financial or practical challenges, such as stable housing.[1]

In 2024, 40% of Medicaid beneficiaries had a follow up visit with an outpatient provider within 7 days. Tracking this measure helped service providers improve their ability to coordinate care and manage risks for this population.

[1] New Mexico Behavioral Health Providers Association. (2025). Metrics That Matter: Year 3 final report. Health Management Associates.

these measures provide a more complete picture of behavioral health system performance than any single metric alone.

State Medicaid and Children's Health Insurance Program (CHIP) programs are required to report annually on a core set of behavioral health measures designated by CMS[2]. Often, states require Medicaid managed care plans and others to report these measures and may give incentives based on their performance on these measures, for example, network adequacy, which examines the availability of behavioral health providers for a population, typically on a time and distance basis (e.g., provider must be within 30 minutes or 30 miles distance from any beneficiary). SAMHSA has identified a set of measures for Certified Community Behavioral Health Clinics (CCBHCs)[3]. NCQA and other accrediting organizations also require reporting of measures.

Some measures are used in several of these programs. *Table 2: Examples of Quality Domains and Measures*, below, illustrate measures that are in these programs by domain (i.e., what part of quality is being assessed) and measure topics (i.e., how that aspect of quality is measured); please note that sometimes measures in different programs are similar in focus but have different specifications.

Table 2: Examples of Quality Domains and Measures: Process Measures

Type	Domain	Measure Topic	BH Core Set	CCBHC	NCQA
PROCESS	Effectiveness of Care	Use of Pharmacotherapy for Opioid Use Disorder	✓		✓
	Effectiveness of Care	Screening for Depression and Follow-Up Plan	✓	✓	✓
	Care Coordination	Follow-Up After Hospitalization for Mental Illness	✓	✓	✓
	Timeliness	Time to Services		✓	
OUTCOME	Clinical Outcomes	Depression Remission		✓	✓
	Intermediate Outcomes	Controlling High Blood Pressure		✓	✓
	Person-Centeredness	Patient Experience of Care		✓	
STRUCTURE	Access	Network Adequacy[4]	✓		Pending

[2] Centers for Medicare & Medicaid Services. (2027). Core set of behavioral health measures for Medicaid and CHIP (PDF). https://www.medicaid.gov/medicaid/quality-of-care/downloads/2027-bh-core-set.pdf

[3] Substance Abuse and Mental Health Services Administration. (2024). Certified Community Behavioral Health Clinics quality measures: Technical specifications and resource manual (PDF). https://www.samhsa.gov/sites/default/files/ccbhc-quality-measures-technical-specifications-manual.pdf

[4] Note. "Network adequacy" in behavioral health refers to whether a health plan's provider network is sufficient (in size and geographic distribution) to ensure timely access to services.

What Does It Mean to Be "Measurement-Ready" in Behavioral Health?

Being measurement-ready, or, "measurement readiness," means direct service providers can reliably produce, interpret, and use performance metrics to understand access, quality, outcomes, and equity—without disrupting care delivery. It's less about sophisticated analytics and more about foundational clarity, consistency, and capacity.

Measurement readiness looks different across provider types, such as at a community-based organization (CBO) versus larger health care providers or systems—particularly in the behavioral health space. For example, many CBOs play a critical role in engagement, trust building, prevention, outreach, and ongoing support, yet they may not have the same infrastructure, staffing models, or technical resources as an organization that provides clinical treatment and/or recovery-focused services. For some service providers, readiness must begin with understanding why measurement matters, how it connects to high-quality behavioral health care, and what it means to be part of a broader care ecosystem. Without this shared understanding, performance measurement can feel abstract, burdensome, or misaligned with an organization's mission.

When measurement readiness is approached in this way, measurement becomes a tool for learning, improvement, and system participation—rather than a compliance exercise. This approach allows service providers to grow into their role within care ecosystems at a pace that reflects their starting point, while still moving toward shared accountability for outcomes and quality over time.

With these considerations in mind, measurement readiness may include the following characteristics and traits:

1. **Clarity of purpose and use:** Measurement-ready providers have a shared understanding of why performance measurement is being implemented and how metrics will be used to support service delivery, program improvement, accountability, and learning. Providers can distinguish between measures used for reporting or compliance and those intended to inform operational decision-making and quality improvement.
2. **Clear service and population definitions.** Providers maintain consistent definitions of services, levels of care, and target populations. This ensures that metrics are interpretable and comparable over time and across programs, and that staff apply service categories and eligibility criteria consistently in documentation and reporting.
3. **Standardized and reliable data capture.** Key data elements needed to support priority behavioral health metrics are defined, structured, and captured consistently at the point of care. This typically includes

What Measurement Readiness *Is Not*

- ✘ Perfect data
- ✘ Advanced dashboards
- ✘ Full interoperability
- ✘ Outcomes only measurement
- ✘ Punitive accountability

referral, intake, service delivery, and discharge information, as well as basic demographic and screening data. Data collection processes are designed to align with existing workflows to minimize burden on frontline staff

4. **Basic data quality and ownership practices.** Measurement-ready providers establish clear roles and responsibilities for data entry, review, and oversight. Routine checks for completeness, accuracy, and internal consistency are conducted, even if informally, to ensure that reported metrics are credible and usable.

5. **Ability to produce core performance metrics.** Providers can generate a small, defined set of core metrics—such as access, engagement, continuity of care, and early outcome or screening measures—on a regular basis. While automation and dashboards may be limited, providers can reliably produce and interpret these metrics over time.

6. **Staff understanding and engagement**. Measurement-ready organizations ensure that leadership and frontline staff understand what is being measured, how results are interpreted, and how data will be used. Metrics are framed as tools for learning and improvement rather than individual performance management, supporting staff buy-in and data integrity.

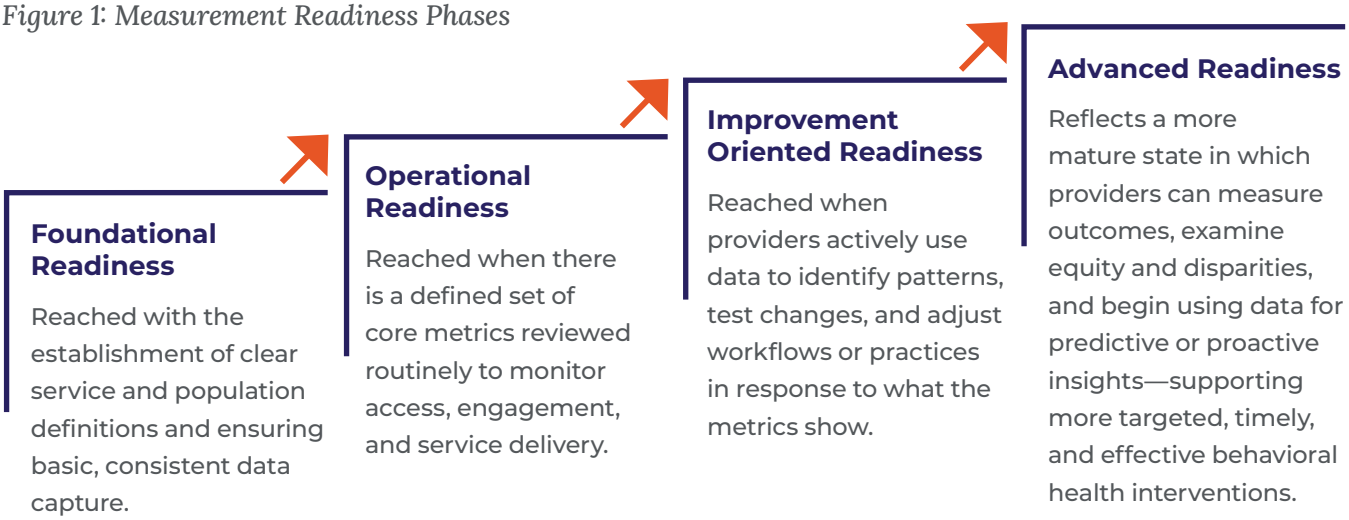
7. **Alignment with workflows and operations.** Measurement processes are integrated into existing clinical and administrative workflows, rather than operating as parallel or duplicative reporting requirements. Providers understand how data move from service delivery to documentation, reporting, and review.

8. **Capacity to use data for action.** Finally, measurement ready providers can use performance data to identify patterns, monitor change over time, and inform operational or programmatic adjustments. Even at an early stage, providers can link metrics to questions, hypotheses, and improvement actions.

Readiness does not all happen at once; and it can be developed over time, in phases. *Figure 1: Measurement Readiness Phases* illustrates the stair-step nature of measurement readiness as it progresses from foundational to advanced readiness.

Foundational readiness focuses on establishing clear service and population definitions and ensuring basic, consistent data capture. ***Operational readiness*** builds on this foundation by producing a defined set of core metrics and reviewing them routinely to monitor access, engagement, and service delivery. ***Improvement-oriented readiness*** is reached when providers actively use data to identify patterns, test changes, and adjust workflows or practices in response to what the metrics show. ***Advanced readiness*** reflects a more mature state in which providers show capability to measure outcomes, examine equity and disparities, and begin using data for predictive or proactive insights—supporting more targeted, timely, and effective behavioral health interventions.

Figure 1: Measurement Readiness Phases



Case Study in Measurement Readiness

New Mexico Behavioral Health Providers Association Metrics that Matter (MTM)

The New Mexico Behavioral Health Providers Association (NMBHPA) led a Metrics that Matter pilot project that gathered medical groups, State agencies, and health plans to track quality measures across sectors and foster innovation to improve patient outcomes, reduce health care cost and maximize value[5]. One of the primary goals was to encourage behavioral health providers to participate in innovative payment arrangements. A longer-term goal was identifying successful behavioral health services models that could be replicated by other behavioral health providers across the state. Critical to its success and its sustainability was having a strong set of relevant quality measures that were meaningful to behavioral health providers. Guiding principles for the MTM measure attributes were identified across the following principles:

- **Person and Family Centered:** Services targeted to the needs and priorities of patients and families; encourages patient and family participation in improvement efforts and incorporates feedback.
- **High Value:** Impacts financial sustainability, promotes whole-health, and/or uses data to drive clinical decision-making processes.
- **Organizational Impact:** Organizations can directly influence measure performance.
- **Accessible:** Measure is currently tracked or easily available to organizations.
- **Coordinated:** Measure requires exchanges between organization and hospitals, emergency care, specialty care, community-based supports, and primary care teams.
- **Innovation:** Measure related to a new approach, process, intervention, or strategy.

[5] New Mexico Behavioral Health Providers Association. (2025). Metrics That Matter: Year 3 final report. Health Management Associates.

Ten behavioral health providers joined the pilot starting in 2024. To participate, a provider had to demonstrate several measurement readiness factors, among other criteria. First and foremost, providers had to agree to:

- Share data for purposes of evaluation, including performance monitoring and benchmark establishment.
- Adopt the technical specifications of the metrics.
- Collect and report a set of six mandatory metrics and an additional four self-selected metrics.
- Collect and share data within the prescribed measurement timeframe.
- Help to coordinate data sharing agreements to facilitate secure and compliant health information exchange and data transfer.
- Implement and monitor data integrity to identify any issues that could trigger volatility in metric performance.

The three-year project, begun in 2022 and concluded in 2025 resulted in broad programmatic impact across provider types that in turn enhanced service delivery, improved organizational efficiency, prepared providers for participation in advanced payment arrangements, and helped stakeholders better understand the landscape for ongoing measurement culture change. For example, the initiative saw more widespread use of data for clinical decision-making and adoption and standardization of validated screening tools used for patient care and provider evaluation; in addition, provider organizations enhanced care coordination and tracking via health information exchange. In turn, such programmatic changes influenced organizational efficiencies and positioning for participation in alternative payment arrangements. Participating organizations surmised that using electronic health records and health information exchanges offers the state better data for clear insights, as opposed to claims data only.

Other lessons learned include better understanding of the limited interoperability of some electronic health records, which require manual data entry and extraction, as well as the wide variation of provider readiness and capacity for quality improvement. For more information, see the Appendix for a robust program overview.

Persistent Challenges in Quality Measurement

Measurement readiness prepares organizations to identify and overcome or address persistent challenges in quality measurement and performance improvement.

Administrative Burden, Duplication, and Fragmentation

Administrative burden – often because of measurement duplication, and fragmentation - are not abstract challenges to organizations; they directly shape how service providers experience accountability, funding, partnership, and visibility within behavioral health and human services systems.

Providers face duplicative and fragmented reporting requirements across funders, agencies, and initiatives, often with inconsistent definitions and timelines. Research literature links these challenges to administrative burden, staff burnout, and low data usefulness.[6] This is similarly challenging across provider types, but especially so for providers that often operate with lean administrative capacity. Common pitfalls include reporting requirements that may exceed available infrastructure or staffing, or the perception, and sometimes reality, that time spent reporting may reduce time spent delivering services or improving practice.

Lack of Shared Definitions and Measurement Standards Across Systems

There is limited alignment across systems on how key concepts are defined and measured (e.g., engagement, retention, stability), and a lack of interoperability between data standards across electronic health records and other information management systems.[7] This prevents aggregation, comparison, and shared learning across organizations.[8] Service providers may be asked to report similar information in multiple, incompatible ways. Additionally, data cannot always easily be rolled up to show system-level impact. As a result, some providers, like smaller, less resourced providers are often excluded from shared dashboards or analyses due to "non-standard" data.

Weak Connection to Outcomes That Matter to People and Communities

Many existing measures fail to reflect patient centered and community defined outcomes, such as quality of life, functioning, cultural relevance, and equity. Recent literature emphasizes that this disconnect undermines trust in measurement systems and limits their usefulness. Providers often work most directly on outcomes people care about (stability, dignity, safety, belonging). When these outcomes are not measured, providers' work appears peripheral rather than essential. Equity impacts and culturally responsive practices are harder to demonstrate without appropriate measures.

Limited Measurement Readiness Support for Behavioral Health and Human Services Providers

Most measurement systems are designed around clinical infrastructure (EHRs, diagnostic coding, standardized assessments). CBOs are often expected to comply without commensurate investment in capacity building or technical assistance, Behavioral health measurement still leans heavily on process and claims based measures (e.g., screenings completed, visits attended, follow up within X days) requiring EHRs and use of claims processing systems. While useful for monitoring access, these measures provide limited insight into whether services improve people's lives.[9] **Because many CBOs do not generate claims data, their contributions are often invisible in claim driven systems. Process measures fail to capture core CBO functions such as stabilization, engagement, trust building, and prevention, leading CBOs to be labeled "not data ready" rather than supported to become measurement ready. Expectations that are not scaled to roles or resources further reinforce power imbalances between clinical systems and community partners.**

[6] Substance Abuse and Mental Health Services Administration. (2024). Certified Community Behavioral Health Clinics quality measures: Technical specifications and resource manual (PDF). https://www.samhsa.gov/sites/default/files/ccbhc-quality-measures-technical-specifications-manual.pdf

[7] Kilbourne, A. M., Beck, K., Spaeth-Rublee, B., Ramanuj, P., O'Brien, R. W., Tomoyasu, N., & Pincus, H. A. (2018). Measuring and improving the quality of mental health care: A global perspective. World Psychiatry, 17(1), 30–38. https://doi.org/10.1002/wps.20482

[8] Substance Abuse and Mental Health Services Administration. (2024). Certified Community Behavioral Health Clinics quality measures: Technical specifications and resource manual (PDF). https://www.samhsa.gov/sites/default/files/ccbhc-quality-measures-technical-specifications-manual.pdf

[9] National Institute of Mental Health. (2025). Developing tools for measuring mental health outcomes. https://www.nimh.nih.gov/news/science-updates/developing-tools-for-measuring-mental-health-outcomes

These ongoing challenges in behavioral health performance measurement are particularly important for CBOs providing services and supports because they determine:

- Whether accountability feels punitive or collaborative
- Whether data are a burden or a tool for improvement
- Whether CBOs are treated as vendors—or as essential system partners

Until these challenges are addressed, measurement systems will continue to fall short of capturing how behavioral health outcomes are achieved.

Where is the Field Headed?

From Process to Outcomes

Performance measurement is shifting from "Did services occur?" to "Did people improve, function better, and experience meaningful changes in their lives?"

Recent literature and guidance at the federal, state, and local levels signal a clear evolution in behavioral health performance measurement toward outcome-oriented, system-level, and improvement-focused approaches. This is a substantial change from previous, process heavy measurement frameworks—such as visit counts, follow up rates, and screening completion—that were sometimes used as proxies for efficacy. While these measures remain important for access and accountability, recent literature emphasizes the need to center clinical and functional outcomes that matter to individuals and communities.

Three themes consistently emerge based on research, state efforts, and federal policy, as reflected in recent CMS initiatives and presentations at the CMS 2026 Quality Conference:

- Moving to fewer high value measures that focus on improving health, empowering individuals to take more active roles in their health and helping people to live their best lives.
- Aligning measures and incentives across the health care system.
- Investing in digital, interoperable infrastructure that will support real-time quality measurement and improvement.

Outcomes Oriented Measurement Research

In 2025, the National Institute of Mental Health (NIMH) funded six projects to "develop, test, and validate outcome-focused measures of mental health." Topics included:

- Quality measures to advance suicide prevention
- Patient-centered outcomes of Goal-Directed Care for people with serious mental illness
- Quality of Life measurement
- Pediatric anxiety outcome measures
- Addressing bias and disparities in Depression and anxiety measures
- Outcomes measures of mental health care quality

Building on changes in quality initiatives across federal and state programs, the behavioral health field is increasingly recognizing the limitations of process heavy measurement frameworks.

The National Institute of Mental Health (NIMH) highlights that, unlike physical health, behavioral health has lagged in the development of validated outcome focused quality measures, particularly those capturing symptom improvement, functioning, and recovery over time. In response, NIMH-funded initiatives are now explicitly focused on developing and validating outcome measures suitable for use in real world systems and submission to CMS and national measure stewards, signaling a structural shift toward outcome accountability in mental health care.[10]

Similarly, the growing emphasis on measurement-based care (MBC) reflects this outcome orientation. MBC relies on the routine collection of standardized symptoms and functioning measures to track patient progress and guide treatment decisions. Evidence synthesized in systematic reviews demonstrates that MBC improves symptom outcomes, enhances patient engagement, and reduces the likelihood of deterioration—particularly when measures are used longitudinally rather than episodically.[11, 12] Importantly, this literature underscores that outcomes must be clinically meaningful and interpretable at the point of care, not merely aggregated for reporting.

At the policy level, states are also expanding beyond traditional process metrics. As an example, California's Behavioral Health Transformation (BHT) framework explicitly links performance measurement to population-level outcomes such as quality of life, social connection, housing stability, justice involvement, and suicide prevention—representing a notable move toward broader definitions of behavioral health success.[13] New Mexico's Metrics that Matter (as noted above) establishes a behavioral health quality model that integrates both clinical and claims data and supports state and federal program and policy objectives and advances data-driven approaches to enhance clinical practice.

At the federal level, CMS leaders are emphasizing the need to reduce the number of quality measures and to focus on wellness and patient empowerment. Last year, CMS sought input on ways to measure well-being including nutrition and physical activity across all quality reporting programs. New demonstration models are testing innovative ways to encourage people to take an active role in their health. For example, the ACCESS (Advancing Chronic Care with Effective, Scalable Solutions) Model will use an outcomes-aligned payment approach to expand access to technology-supported care options to help with chronic conditions like depression.

The move from measuring processes (e.g., referrals made, screenings completed, services delivered) to measuring outcomes (e.g., symptom improvement, stability, functioning, quality of life) has significant implications for community-based and behavioral health providers—even when those organizations are not delivering clinical services. This shift matters for providers across the service spectrum – whether in a clinical or non-clinical setting because it:

[10] National Institute of Mental Health. (2025). Developing tools for measuring mental health outcomes. https://www.nimh.nih.gov/news/science-updates/developing-tools-for-measuring-mental-health-outcomes

[11] BMJ Mental Health. (2025). Quantifying care, qualifying experiences: Measurement-based care in psychiatry. https://mentalhealth.bmj.com/content/28/1/e301663

[12] American Psychological Association. (2023). Measurement-based care is giving psychologists a better picture of treatment progress. https://www.apa.org/monitor/2023/06/measurement-based-care-patients-treatment

[13] California Department of Health Care Services. (2025). Behavioral health transformation performance measures (Workbook). https://policy-manual.mes.dhcs.ca.gov/__attachments/347832365/County%20Population-Level%20Behavioral%20Health%20Measure%20Workbook%20Version%202.xlsx?inst-v=4633b731-268d-4012-9614-0e9c5a0199ca

- Makes your work visible and valued in behavioral health systems
- Aligns funding and accountability with what actually improves people's lives
- Elevates all types of providers as essential co-contributors to behavioral health outcomes
- Encourages partnership, prevention, and population level impact

From Siloed Programs to System-Level Accountability

Behavioral health measurement is moving from grant or program specific silos toward aligned, systemwide accountability tied to Medicaid, state reform, and population outcomes.

A second major shift is the move away from fragmented, program-specific reporting toward integrated, system-level accountability frameworks. Behavioral health measurement is increasingly embedded within Medicaid, cross-agency performance strategies, and statewide transformation efforts. This is aligned with CMS' overall emphasis on aligning programs to focus on a Universal Foundation of high priority quality measures.[14] The Universal Foundation includes behavioral health as a key domain, with screening for depression and follow-up plan now included in 15 active quality programs.

At the federal level, CMS's 2025 Behavioral Health Core Set for Medicaid and CHIP establishes a common national measurement floor, integrating behavioral health measures into broader healthcare quality accountability. The Core Set expands expectations around depression screening and follow-up, substance use disorder treatment engagement, pharmacotherapy for opioid use disorder, and serious mental illness care—signaling that behavioral health outcomes are no longer peripheral to Medicaid performance oversight.[15]

Certified Community Behavioral Health Clinics (CCBHCs) represent perhaps the most concrete example of system-level measurement integration. SAMHSA's Quality Measures for Behavioral Health Clinics Technical Specifications Manual aligns clinic-level measures with Medicaid Core Sets, social drivers of health screening, and outcome monitoring, while requiring standardized reporting across states and clinics.[16] This alignment reduces fragmentation and enables comparisons across programs, payers, and geographies.

The move from siloed, program-by-program measurement to system-level accountability represents a fundamental change in how behavioral health and human services systems define success—and who is considered responsible for achieving it. For CBOs and non-clinical behavioral health providers, this shift has meaningful implications for visibility, funding, partnership, and influence. At its core, system-level accountability reframes outcomes as shared responsibilities, not the product of any single program or sector.

[14] Centers for Medicare & Medicaid Services. (2025). The Universal Foundation: Streamlining High Priority Quality Measures for a Healthy America. https://www.cms.gov/medicare/quality/cms-national-quality-strategy/universal-foundation

[15] Centers for Medicare & Medicaid Services. (2025). 2025 core set of behavioral health measures for Medicaid and CHIP (PDF). https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-bh-core-set.pdf

[16] Substance Abuse and Mental Health Services Administration. (2024). Certified Community Behavioral Health Clinics quality measures: Technical specifications and resource manual (PDF). https://www.samhsa.gov/sites/default/files/ccbhc-quality-measures-technical-specifications-manual.pdf

From Compliance to Improvement

Measurement is evolving from "reporting for compliance" toward "data for learning, improvement, and population health action."

The third shift is a reframing of performance measurement from a compliance exercise to a tool for continuous quality improvement (CQI) and learning. Infrastructure to support interoperable digital quality measures is necessary for this orientation. There are significant federal efforts underway to support interoperability and the use of digital technology to empower individuals and care teams. By January 2027, Medicaid programs and plans are required to be able to exchange prior authorization data electronically using standard terminology; CMS is looking to use this same infrastructure to support quality reporting. In addition, the CMS Health Tech Ecosystem is a public-private collaboration to expand people's access to their own health care data and their ability to share their data with providers.

SAMHSA guidance for CCBHCs explicitly positions quality measurement as a mechanism for ongoing improvement rather than static reporting. Measurement is intended to inform clinical practice, organizational management, and system level decision making through regular feedback loops and data-driven adjustment.[17] This aligns closely with the principles of MBC, where data are actively used to guide care in real time rather than retrospectively assessed for accountability alone.

Recent reviews caution, however, that this shift requires careful implementation. Clinicians and patients express concern when measures are perceived as disconnected from care decisions, overly burdensome, or primarily used for oversight rather than improvement. Successful implementation depends on integrating measures into clinical workflows, providing clear guidance on interpretation, and ensuring transparency about how data are used.[18]

At the population level, states and federal agencies are increasingly using performance measurement to identify emerging risk, disparities, and system gaps—supporting a public health-oriented approach to behavioral health. Federal performance strategies and state transformation efforts emphasize using timely data to guide prevention, crisis response, and resource allocation rather than solely to document past performance.[19]

The shift from compliance to improvement matters for providers throughout the health and human services system, because it reframes data collection from a funder requirement to a practical tool for learning and better results. Improvement-oriented measurement emphasizes feedback loops, workflow fit, and shared problem-solving—making it more likely that community-based services are recognized as essential contributors to outcomes and that performance signals are used to fix system barriers rather than penalize providers serving high-need populations.

[17] ibid
[18] BMJ Mental Health. (2025). Quantifying care, qualifying experiences: Measurement-based care in psychiatry. https://mentalhealth.bmj.com/content/28/1/e301663
[19] U.S. Department of Health and Human Services. (2024–2025). Agency priority goal: Behavioral health (FY 2024–2025). Performance.gov. https://www.performance.gov/APG/hhs-behavioral-health

The shift from siloed programs to system-level accountability matters for service providers throughout the continuum because:

- Measurement is shifting from reporting to learning.
- Accountability is becoming collective, not punitive.
- Non-clinical providers like CBOs are essential contributors to improvement—without becoming clinical.

Compliance, measurement readiness, and risk management

The behavioral health sector is adopting a measurement-driven culture that is shifting away from data collection for simple compliance at the same time that regulators at the State and Federal level have introduced increased scrutiny to detect and prevent Fraud, Waste, and Abuse (FWA), in Medicaid and other publicly funded programs that provide health care coverage and services. In this context, measurement readiness requires close attention to data hygiene and data quality to support risk management and prevention of FWA.

Data Hygiene and Data Quality

Data hygiene—the process to ensure data are consistently accurate and complete—is a fundamental component of measurement readiness. Data hygiene governs how you consistently document service delivery and impact, support standardization and interoperability, build efficiency, mitigate potential for error, and eliminate duplication of effort and waste of resources.

Data hygiene features:

- Automation of some tasks, like using templates and formulas to complete forms.
- Standardization of data by using consistent coding, keywords, and data entry methods across areas in an organization.
- Ease of Use rules that simplify data entry and summarization, and eliminate error potential.

Data quality standards include:

- Accuracy, to ensure the data set is true.
- Completeness, to ensure all the information needed for comprehensive and informed decision making is present.
- Consistency, to ensure data and processes are reliable and can be trusted.
- Timeliness, to ensure that the data are up to date and the most recent available.

Providers that consistently and sustainably demonstrate and document their eligibility to provide services, clients' eligibility to receive services, and the effectiveness of their work are practitioners of good data-hygiene.

Example – FWA/Risk Management in a Multiple Funding Stream Environment

ABC Services is a mental health provider organization that delivers Medicaid reimbursed mental health counseling to children with mental health needs and their families. They also provide social services navigation through a contract with the Local Social Service District and operate a food pantry through their State Department of Agriculture. Both the Education and Agriculture Department contracts require ABC Services to conduct a social needs screening for any service recipient.

ABC Services realizes that a new requirement and a newly available funding stream from the State Medicaid agency ties social needs screening of Medicaid members to potential reimbursement. However, accessing those reimbursements requires extra attention to how ABC Services conducts their screening for various program participants, documents their outcomes, and makes sure that they are not duplicating any services for people participating in multiple programs.

Before ABC Services integrates this new type of screening for Medicaid members and submitting claims for reimbursement they first must:

- Establish eligibility criteria to determine what program a person is eligible for and which screening they need.
- Create policy and procedure that clearly identifies the "Payer of Last Resort," e.g., Medicaid only pays claims for covered items and services if there are no other liable parties for the same items and services.
- Train staff on what data to collect and how to safeguard recipients' data according to health information privacy laws like Health Insurance Portability and Accountability Act (HIPAA) and Health Information Technology for Economic and Clinical Heath (HITECH).
- Develop and practice workflows to ensure these steps are followed in a timely way that reduces burden for the provider and limits potential for errors, as well as optimizes the experience for clients.

The table below maps ABC Services' preparatory steps to how it supports data hygiene and data quality.

Step	Data Hygiene feature	Data Quality feature
Establish and document eligibility criteria	Standardization; Ease of Use	Consistency; Completeness
Create policy and procedure about payer of last resort	Automation; Standardization	Accuracy; Consistency
Train staff in data collection standards	Automation; standardization; Ease of use	Accuracy, Completeness; Consistency
Develop and practice work-flows	Automation; East of use	Consistency; Timeliness

Conclusion

Enabling people with behavioral health conditions to thrive requires a reliance on data driven strategies for delivering the highest quality of care possible, in the most resource conscious way. Quality measurement is a practical tool for closing gaps by helping service providers understand where they need to focus to improve access, effectiveness, experience of care, and cost.

Being "measurement-ready" depends less on advanced analytics and more on clear purpose, consistent service and population definitions, reliable and workflow-aligned data capture, basic data governance, and the ability to generate and act on a small set of core metrics.

The behavioral health sector will continue to move toward fewer, higher-value measures, stronger alignment across payers and programs, and interoperable digital infrastructure that supports continuous learning and shared accountability. Service providers that build measurement readiness in phased, realistic ways—paired with appropriate investment and technical support—will be essential to ensure that measurement strengthens care, elevates community partners, and ultimately delivers outcomes that matter.

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Appendix

1. HMA Crosswalk of Behavioral Health Quality Measures in National Programs
2. CMS 2026 Core Set of Behavioral Health Measures information sheet
3. For Further Information

	Measure Name	Steward	Medicaid BH Child Core Set	Medicaid BH Adult Core Set	CCBHC
PROCESS	Adherence to Antipsychotic Medications for Individuals w/Schizophrenia	NCQA		✓	✓
	Antidepressant Medication Management	NCQA		✓	✓
	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment	Mathematica			✓
	Diabetes Screening for People with Schizophrenia or Bipolar Disor-der	NCQA		✓	
	Follow-Up After ED Visit for Mental Illness	NCQA	✓	✓	✓
	Follow-Up After ED Visit for Substance Use	NCQA	✓	✓	✓
	Follow-Up After Hospitalization for Mental Illness	NCQA	✓	✓	✓
	Follow-Up Care for Children Prescribed ADHD Medication	NCQA	✓		✓
	Glycemic Status Assessment for Patients with Diabetes	CMS			✓
	Initiation and Engagement of Substance Use Disorder Treatment	NCQA		✓	✓
	Major Depressive Disorder: Suicide Risk Assessment	Mathematica			✓
	Metabolic Monitoring for Children and Adolescents on Antipsychotics	NCQA	✓		✓
	Postpartum Depression Screening and Follow-Up	NCQA	✓	✓	
	Prenatal Depression Screening and Follow-Up	NCQA	✓	✓	
	Screening for Depression and Follow-Up Plan	CMS	✓	✓	✓
	Screening for Social Drivers of Health	CMS			✓
	Time to Services	SAMHSA			✓
	Tobacco Use: Screening and Cessation Intervention	NCQA			✓
	Unhealthy Alcohol Use: Screening and Brief Counseling	NCQA			✓
	Use of First-Line Psychosocial Care for Children on Antipsychotics	NCQA	✓		✓
	Use of Pharmacotherapy for Opioid Use Disorder	SAMHSA / CMS		✓	✓
	Weight Assessment & Counseling for Children/ Adolescents	NCQA	✓		✓
OUTCOMES	Controlling High Blood Pressure	NCQA		✓	✓
	Depression Remission at Six Months	MN Commission on Measurement			✓
	Diabetes Care for People with Serious Mental Illness – Poor Glycemic Control	NCQA		✓	
	Hemoglobin A1c Control for Patients with Diabetes	NCQA			✓
	Patient Experience of Care Survey	SAMHSA			✓
	Plan All-Cause Readmissions	NCQA		✓	✓
	Youth/Family Experience of Care Survey	SAMHSA			✓

Program Overview
Updated November 2025

NMBHPA Metrics that Matter

Introduction

In 2022, the New Mexico Behavioral Health Providers Association (NMBHPA) leaders identified a set of process and outcome, uniform behavioral health (BH) metrics to inform quality improvement. This measurement framework lays the foundation for behavioral health providers to be meaningfully incentivized for demonstrating quality and value.

Currently, 16 participating behavioral health organizations submit monthly data to the state's HIE to populate a metrics dashboard featuring risk stratification and predictive analytics. Participating organizations meet regularly for technical assistance, office hours, and leadership sessions to monitor performance, share best practices, and drive improvements.

About Participating Organizations

- Project includes community-based organizations in urban, rural, and frontier communities.
- 6 of the 7 NM CCBHC organizations are part of the Metrics that Matter project.
- 7 of the 16 organizations are 42 CFR Part 2 organizations--only a minimal number of states' HIE are collecting these data.

See page 2 for more information on project benefits and goals.

How Does "Metrics That Matter" Differ from Traditional Approaches?

In the standard model, data flows mainly for billing and administrative reporting. In *Metrics That Matter*, the same type of data is structured and submitted in a way that allows actionable insights—dashboards that use predictive analytics for future risk, track outcomes, and support statewide focus on improvements in care delivery. This structure and model of care turns routine documentation into a tool for clinical decision-making and policy planning.

Standard Approach	Metrics that Matter
Rely on physical health-derived metrics and standardized measures such as HEDIS. These are often claims-based, physical health focused and not tailored to behavioral health realities.	Uses provider-driven, clinically relevant measures that providers believe can have a meaningful impact. These are mostly derived from real-time EMR data and support clinical decision-making.
Data is collected primarily for billing and administrative reporting.	Data is structured for actionable insights via quality measures dashboards and predictive analytics.
Focused on compliance and reporting.	Supports structured activities like technical assistance, collaborative learning, and practice transformation to drive continuous improvement.
Often, it lacks interoperability and long-term planning.	Invests in interoperability with SYNCRONYS HIE, prepares providers for federal EHR requirements, and lays groundwork for value-based care models.
Over **1.3 million New Mexicans** live in designated Mental Health Professional Shortage Areas,[i] with only **19% of mental health needs being met**.[ii] In 2023, New Mexico had the 5th highest suicide rate in the U.S., at 22.8 per 100,000—60% above the national average.[iii]	MTM program uses both measurement-informed and measurement-based care to screen for and monitor depression and suicide outcomes across the system. By implementing evidence-based practices and using real-time data from EHRs, the project helps identify care gaps, streamline workflows, and guide targeted interventions. Collaborative peer learning and shared strategies support more efficient service delivery, especially in resource-limited settings—ultimately improving outcomes and building a foundation for long-term practice transformation.

Program Benefits & Alignment

Organizational and Provider:
Established a foundational framework for behavioral health providers to measure, monitor, and improve quality through data-informed practice improvements. Designed to be flexible and inclusive to support non-traditional service models and foster a culture of continuous quality improvement across diverse providers and patient settings.

Patient:
Improves patient experiences, strengthens communication between provider and patient, and increases access to care. Supports improved clinical outcomes through more consistent use of screening tools, assessments, evidence-based practices, and follow-up protocols.

System/State:
Established a standardized, provider-driven framework for behavioral health measurement and reporting. Provides statewide data infrastructure to support outcome tracking, risk stratification, and predictive analytics. These capabilities empower providers to develop targeted interventions, inform system-level planning, and help reduce disparities in behavioral health outcomes across New Mexico communities.

Programmatic Goals

1. **Advance practice transformation** by supporting organizations in using data to improve performance on selected BH quality measures
2. **Strengthen care delivery** by promoting health equity, enhancing outcomes, and improving patient experience through targeted quality improvement strategies.
3. **Promote the use of evidence-based and community-informed practices** to address population needs and regional variation in behavioral health care.
4. **Strengthen data infrastructure and reporting capacity** by building sustainable systems for collecting, analyzing, and reporting quality data, enabling providers to track progress, identify gaps in patient care, and inform decision-making.
5. **Promote statewide alignment and shared learning** by fostering collaboration among providers, sharing best practices, and alignment on statewide priorities.

Program Impact, Lessons Learned, and Insights

Program Impact

- Elevated use of data for clinical decision-making.
- Adoption of validated screening tools (e.g., PHQ-9) for patient care and provider evaluation.
- Enhanced care coordination and outcome tracking via health information exchange.
- Operational efficiencies: streamlined documentation and standardized intake.
- Positioned organizations for value-based contracting and risk-sharing.
- Participating organizations believe EHR data offers clearer insights for state-level decisions than claims data.

Lessons Learned

- Multiple organizations must manually extract and submit data due to limited EHR interoperability which is time consuming and resource intensive.
- Provider organizations vary significantly in their readiness and capacity for quality improvement.

Organizational and Provider Insights

- “Metrics That Matter has served as a critical steppingstone in our journey to becoming a CCBHC.”
- “The project shifted the organization from compliance-based reporting to actively tracking quality measures that drive clinical process improvements.”[Participating FQHC].

Other Program Information

Funded by (Years 1-3): New Mexico Health Care Authority (HCA) Behavioral Health Services Division (BHSD)
Led by: New Mexico Behavioral Health Provider Association
Supported by: Health Management Associates, SYNCRONYS, HBI Solutions, New Mexico Behavioral Health Services Division
Other state and national alignments:

- Supported CCBHC implementation for newly certified providers.
- Aligns with SB3 Behavioral Health Reform and Investment Act.
- Positions NM as a national leader in BH measurement and outcome improvements.

The Program Quality Measures

Type	#	Measure	Children/ Adults	Adolescents/ Adults	Adults Only
MANDATORY *Orgs report all*	1	Measurement Based Care: PHQ-9 Screening (APA)		X	
	2	Social Needs Assessment (Org-specific)	X		
	3	Patient Experience of Care (SAMHSA)	X		
	4	Regular Engagement of Care (Org-specific)	X		
	5	Time from Initial Contact to First Billable Service (SAMHSA)	X		
	6	All-Cause Readmissions (NCQA)			X
ACCESS *Orgs report all*	1	Follow-up After Emergency Department Visit for Mental Illness (FUM)	X		
	2	Follow-up After Emergency Department Visit for Substance Use (FUA)	X		
	3	Follow-up After Hospitalization for Mental Illness (FUH)	X		
PROCESS *Orgs choose two*	1	Measurement Based Care: GAD-7 (Org-specific)		X	
	2	Improving Language Access (Org-specific)	X		
	3	Measure of Financial Burden to Patient (Org-specific)	X		
	4	Functional Assessment Score Change: Vineland Behavior Scale (ICHOM)	X		
	5	Net Promoter Score (Brain & Co)	X		
OUTCOME *Orgs choose two*	1	Depression Remission (MNCM)		X	
	2	Successful Discharges (Org-specific)	X		
	3	Emergency Department Utilization (Org-specific)	X		
	4	Deaths by Suicide (SAMHSA)	X		

[i] As of March 31, 2025.

[ii] Health Resources and Services Administration (HRSA). Designated HPSA Quarterly Summary: As of March 31, 2025. Bureau of Health Workforce. Available at: https://data.hrsa.gov.

[iii] Centers for Disease Control and Prevention. Suicide Rates by State. March 26, 2025. Available at: https://www.cdc.gov/suicide/facts/rates-by-state.html.

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https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures

This webpage includes reporting guidance, the core set final rule, and links to updates of measures and requirements.

Menschner, C. (2024). What We Measure Matters: Centering Lived Experience in Developing Behavioral Health Quality Measures. Center for Health Care Strategies.

https://www.chcs.org/resource/what-we-measure-matters-centering-lived-experience-indeveloping-behavioral-health-quality-measures

This report offers a deep dive into the process for developing behavioral health measures centered on lived experience, and focusing measurement on what matters most to those seeking care.

Substance Abuse and Mental Health Services Administration (2025). Quality Measures Guidance and Webinar Series.

https://www.samhsa.gov/communities/certified-community-behavioral-health-clinics/guidance-and-webinars

This webpage includes technical specifications, data reporting templates, guidance, and links to updates of quality measures applicable to behavioral health clinics, including the Certified Community Behavioral Health Clinics (CCBHC).

Making Sense of Behavioral Health Measurement

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