

NATIONAL QUALITY FORUM

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MEDICAID AND CHIP SCORECARD COMMITTEE
IN-PERSON MEETING

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FRIDAY, JANUARY 11, 2019

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The Committee met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 9:30 a.m., Richard Antonelli and Harold Pincus, Co-Chairs, presiding.

PRESENT:

RICHARD ANTONELLI, MD, Boston Children's
Hospital, Chair

HAROLD PINCUS, MD, Columbia University, Chair

ORGANIZATIONAL MEMBERS (Voting)

RHONDA ANDERSON, RN, American Nurses Association

JULIE BERSHADSKY, PhD, Human Services Research
Institute

SHAYNA DAHAN, BSN, RN, MSN, National Association
of Pediatric Nurse Practitioners

JOY HAMMEL, PhD, American Occupational Therapy
Association

ENRIQUE MARTINEZ-VIDAL, MPP, Association for
Community Affiliated Plans

ELIZABETH MATNEY, National Association of
Medicaid Directors

MARK RIZZUTTI, Ohio Department of Medicaid

JOSH ROMNEY, MD, Intermountain Healthcare

CLARKE ROSS, DPA, American Association on Health
and Disability

ORGANIZATIONAL MEMBERS (Voting) (cont.)

CAROL SAKALA, PhD, MSPH, National Partnership
for Women and Families

SALLY TURBYVILLE, DRPH, MS, MA, Children's
Hospital Association

STEPHANIE A. WHYTE, MD, MBA, Aetna Medicaid

INDIVIDUAL SUBJECT MATTER EXPERTS (Voting)

KAMALA ALLEN, MHS, Center for Health Care
Strategies

LINDSAY COGAN, PhD, New York State Department of
Health

CAMILLE DOBSON, MPA, National Association of
States United for Aging and Disabilities

DAVID EINZIG, MD, Children's Minnesota

KIM ELLIOTT, PhD, CPHQ, Health Services Advisory
Group

AMY HOUTROW, MD, PhD, MPH, University of
Pittsburgh, Children's Hospital of Pittsburgh

DAVID KELLEY, MD, MPA, Pennsylvania Department
of Human Services

SREYRAM KUY, MD, MHS, FACS, Department of
Veterans Affairs

STEPHEN LAWLESS, BS, MD, MBA, FAAP, FCCM, FSMB,
Nemours Children's Health System

JILL MORROW-GORTON, MD, MBA, Office of Clinical
Affairs, MassHealth

ELISABETH OKRANT, MPH, MSP, PhD, Beacon Health
Options

LISA PATTON, PhD, IBM Watson Health

KENNETH SCHELLHASE, MD, MPH, Children's
Community Health Plan

JEFF SCHIFF, MD, MBA, Minnesota Department of
Human Services

MARISSA SCHLAIFER, RPh, MS, OptumRx

JUDY ZERZAN, MD, Washington State Health Care

Authority

FEDERAL LIAISONS (Non-Voting)

LAURA JACOBUS-KANTOR, PhD, Substance Abuse and
Mental Health Services Administration

SUE KENDIG, JD, WHNP-BC, Health Resources and
Services Administration

KAREN LLANOS, Center for Medicaid and CHIP
Services, CMS

KAMILA MISTRY, PhD, MPH, Agency for Healthcare
Research and Quality *

MARSHA SMITH, MD, MPH, FAAP, Centers for
Medicare and Medicaid Services

NQF STAFF:

SHACONNA GORHAM

JORDAN HIRSCH

MIRANDA KUWAHARA

DEBJANI MUKHERJEE

ELISA MUNTHALI, Senior Vice President, Quality
Measurement

ALSO PRESENT:

SEPHEEN BYRON, National Committee for Quality
Alliance

SUE KENDIG, Center for Patient Safety *

VIRGINIA RANEY, Centers for Medicare and
Medicaid Services

ROBERT SAUNDERS, National Committee for Quality
Alliance *

KYLE STOCK, Community Catalyst

JANICE TUFTE, Patient Advocate

* present by teleconference

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1 P-R-O-C-E-E-D-I-N-G-S

2 9:31 a.m.

3 MS. MUKHERJEE: Hi, everybody.

4 Welcome back today to our day two of the Medicaid
5 and CHIP MAC Scorecard Committee in-person
6 meeting.

7 My name is Debjani, and I'm going to
8 turn it over to our Chairs for some welcoming
9 words and then get started.

10 CHAIR PINCUS: So we had an extremely
11 busy day yesterday, making our way through all of
12 the removals and all but one of the additions.
13 We also had the opportunity to practice on
14 -- more than practice, actually -- implement the
15 new voting, which seemed to work out quite well.
16 And hopefully, we had enough discussion so that
17 CMS is well-informed about our thoughts about
18 each of the measures.

19 So this morning, just to give an
20 overview, we have one more measure to discuss
21 with regard to addition, the all-cause
22 readmission, and then, we are actually going to

1 be voting on each of the motions from yesterday
2 afternoon's discussion and whatever discussion
3 comes out of that all-cause readmission
4 discussion.

5 After that, we are going to be going
6 with the little dots to prioritize. We still
7 work with the little dots. We have little
8 stickies. And so we'll give them out to
9 everybody and we'll go through that process.

10 And then, after that, we're going to
11 have a very broad discussion about, No. 1, what
12 do we see as sort of, basically, how to maximize
13 the utility of the Scorecard, to think about how
14 states can get involved, the impact on providers
15 and plans, and things like that, to help advise
16 CMS on this.

17 And then, to talk about what do we
18 foresee for the future in terms of how it can
19 evolve over time. So we'll have an opportunity
20 to have that discussion. And then, we're done.

21 I don't know if you want to say
22 something about the lunch.

1 CHAIR ANTONELLI: And I just also want
2 to welcome everybody back to the second day of
3 this.

4 And I want to make one observation.
5 Marissa, in particular, sort of started this with
6 her comment yesterday. CMS reinforced that. And
7 I really want to make sure we're all starting
8 from the same place.

9 I think for those of us that have been
10 in this room for other reasons multiple times,
11 the modus operandi often is you come in, you
12 evaluate measures, you promote measures, and if
13 you were successful, that's a great thing because
14 they got promoted to move forward. And if it
15 didn't, that's somehow there wasn't a measure of
16 success.

17 That's not really the calculus for
18 what we're about today. With all deepest respect
19 -- and, Karen, it was so helpful for you
20 yesterday to acknowledge a lot of the questions
21 we have about what next, what next, what next --
22 CMS needs to figure that out. And so therefore,

1 we're dealing with a fairly uncertain ecosystem.
2 Because of that, none of us should be feeling
3 that, if we were promoting a measure and it,
4 quote, didn't make it into the Pillar 1
5 Scorecard, that someone we didn't value that
6 domain or the measure itself. So be mindful of
7 that.

8 Success, I would actually argue,
9 especially in an environment where there are as
10 many questions as there are solid answers about
11 what next, success may actually be holding back a
12 little bit before we put something into a
13 situation where we don't know what the
14 implications of that are. So that should be our
15 collective perspective on what defines success.

16 And because this is an ongoing
17 process, this is not a one-and-done, CMS has to
18 figure out the implications. The capital A,
19 small a, accountability conversation yesterday
20 was powerfully compelling for my thinking.

21 So we will continue to have some fun
22 today, do really, really good work. The staff,

1 as usual, you guys are amazing.

2 So I'm going to hand it over to
3 Miranda.

4 MS. KUWAHARA: Thanks, Rich.

5 As Shaconna mentioned yesterday, after
6 we adjourn today's meeting, we'll be walking
7 about two blocks over to P.J. Clarke's for lunch.
8 And I just wanted to get a quick head count for
9 folks who would like to join us for that lunch.
10 So if you're interested, please raise your hand.

11 All right. Thank you very much.
12 We're excited to dine with everyone this
13 afternoon.

14 MEMBER ANDERSON: I really appreciate
15 what both of you have said as our leaders. And
16 I'd just like to also underscore something that
17 Marissa said yesterday that is part of that
18 frame. And that is that the core sets exist, and
19 this is the next step in terms of the Scorecard.
20 But I think, as I went back last night and
21 reflected about a couple of the things that we
22 didn't add, it's not that they're not there.

1 MS. GORHAM: Okay. We'll jump back
2 into our measure review with our last measure,
3 1768.

4 Before I start that, I just want to
5 remind you to open your Discussion Guide.

6 All right. So 1768, Plan All-Cause
7 Readmissions. The description of this measure:
8 for patients 18 years of age and older, the
9 number of acute inpatient stays based on the
10 measurement year that was followed by an
11 unplanned acute readmission for any diagnosis
12 within 30 days and the predicted probability of
13 an acute readmission. The measure type is a
14 process, and the data source is instrument-based
15 data.

16 Twenty-five states reported this
17 measure in 2017. It aligns with the QRS program,
18 as well as Health Home Core Set.

19 A little history of this measure:
20 during the 2014 review, MAP conditionally
21 supported the continual use of NQF 1768. At the
22 time the Committee was considering this measure,

1 as well as 1789, which is another all-cause
2 hospital readmission measure. So during the
3 review in 2014, MAP urged CMS to consider the
4 potential uses of the measure, feasibility of
5 data collection, and issues of alignment with
6 other programs. MAP remained concerned at the time
7 about the lack of risk adjustment methodology
8 available for the Medicaid adult population, and
9 public comments shared that view as well. So
10 that's just some history on the measure.

11 And then, the lead discussants for
12 this measure are Jill and Kim.

13 MEMBER MORROW-GORTON: So I looked at
14 this measure as filling a gap in the Scorecard,
15 giving us a measure of more acute inpatient care
16 as opposed to preventive outpatient office-based
17 care.

18 I also looked at this measure as it's
19 not just a measure of quality of what happens in
20 the hospital, but it's a measure of transitions
21 between hospital and home or hospital and nursing
22 facility, or whatever, or hospital and rehab, or

1 whatever those transitions are. And I think that
2 those handoffs are where there are significant
3 risks for patients, and especially patients that
4 are Medicaid patients because many of them have
5 low health literacy rates.

6 I think that this can potentially
7 promote assuring readiness for discharge and
8 assuring that everything is in place for follow-
9 up after discharge, and is somewhat more a
10 measure of care coordination and the
11 effectiveness of that, or as much a measure of
12 that as it is of the quality of the hospital
13 care.

14 MEMBER ELLIOTT: I had several of the
15 things that Jill talked about, but a few other
16 things.

17 First, this is a very complicated
18 measure from a specification standpoint. So it
19 is a little bit more challenging. It does fit
20 into the making care affordable domain. I also
21 know that this is not one of the favorite
22 measures of a lot of the facilities and hospital

1 systems because it does sometimes impact their
2 pay.

3 But it is a very actionable measure,
4 which is why I think it's a really good choice
5 for the Scorecard. And the rate really tells us
6 not only about the care and services in the
7 hospital system, but a lot of what happens before
8 and after.

9 It does align with a lot of Medicaid
10 requirements that we really want to focus on,
11 such as assessing care needs prior to being
12 admitted, making sure that we have everything in
13 place to prevent admissions and readmissions,
14 transitions of care, the discharge planning
15 process.

16 It really does, in my mind, align a
17 lot with best practices, such as medication
18 reconciliation when people are discharged
19 from the facilities, follow-up visits within 7
20 and 30 days. There's also the things that you
21 would put in place in order to ensure that people
22 don't get readmitted.

1 There are significant opportunities
2 for care coordination, which is really why we do
3 Medicaid managed care, to make sure that we're
4 looking at the person from a whole-person
5 perspective, including all the physical and
6 behavioral health that may result in a person
7 being readmitted.

8 Also looking at all of the long-term
9 services and supports to make sure those are in
10 place upon discharge, to make sure we don't have
11 readmissions. It's an opportunity to look at all
12 of the social determinants of health to prevent
13 those readmissions, and the management of the
14 chronic health conditions.

15 It's an opportunity to also involve
16 community, which is also a big focus on the
17 Medicaid side. So looking at all of the
18 community health workers, assistance from them
19 and others, family, caregivers, and scheduling
20 follow-up appointments, ensuring prescriptions
21 are refilled to prevent readmissions, and
22 transportation for follow-up visits.

1 So to me, it's much broader than just
2 looking at the readmission, but all of the things
3 that are going to really prevent it. It's really
4 an indicator of how successful the Medicaid
5 programs and the health plans are with preventing
6 those readmissions from occurring.

7 CHAIR ANTONELLI: So we'll open it up
8 for discussion. Harold, Amy. And remember if
9 you're way out in the bleachers, turn the card so
10 I can see the name, please. Harold, Amy, Jeff.

11 CHAIR PINCUS: So I think this is an
12 additional measure that's definitely worthy of
13 consideration. But I just want to make sure that
14 we also have some discussion about some of the
15 recent health services research that's come out
16 about the potential that this measure may be
17 incentivizing some practices that actually have
18 -- there's some evidence, and one could argue
19 about the strength of the evidence, about
20 increasing mortality because people are actually
21 avoiding readmissions when they're needed. So
22 it's just worth having some discussion about

1 that.

2 MEMBER HOUTROW: Yes, as someone on
3 the receiving end of transfers from acute care
4 hospitals to rehabilitation, I can say that our
5 department, you know, one of the reasons that we
6 are able to encourage primary services to hold
7 onto their patients in the hospital to maintain
8 medical stability prior to transfer is measures
9 like this, because bounce-backs negatively impact
10 the service that's discharging the individual to
11 rehab.

12 And we have over the years had a major
13 problem with high-acuity patients needing a
14 higher level of care than can be provided in the
15 inpatient rehab setting. This has been very
16 helpful in terms of making sure that the
17 referring services assure that the patient is
18 actually medically stable to transfer.

19 To Harold's point, I think thinking
20 about how these types of measures incentivize
21 behaviors kind of across the spectrum is really
22 important when we consider adding it. And so the

1 concern that people are just not being allowed to
2 be readmitted, and that might actually be
3 increasing morbidity and mortality, is also
4 incredibly concerning.

5 CHAIR ANTONELLI: Jeff?

6 MEMBER SCHIFF: I have a question that
7 I'm not sure David or Judy would know. But we
8 did, the Medicaid Medical Directors did a review
9 of readmissions, and many or most of these were
10 for mental health conditions. And I just wanted
11 to learn more about that from somebody who had
12 more expertise, if they knew.

13 And then, just one other quick comment
14 is, in the Scorecard, I wonder if this would fail
15 because of some of the comments that were made by
16 the lead discussants under promote effective
17 communication and coordination of care versus the
18 chronic care domain. I think that this seems to
19 be appropriately in that category.

20 CHAIR ANTONELLI: Ken, and then,
21 Steve. And then, Sue Kendig, you're third in
22 line.

1 MS. KENDIG: Okay. Thank you.

2 MEMBER SCHELLHASE: So to answer
3 Jeff's question, at least in little ol'
4 Wisconsin, in our corner, the mental health
5 diagnoses are clearly the largest cause of
6 readmissions. So that's certainly true for us.

7 I have a couple of things. One is a
8 question. And that is, for this measure, I was
9 just looking at the specifications. I can't
10 tell. Does the index admission have to be a
11 truly inpatient status admission or can it be an
12 observation admission? Is that something we
13 know?

14 MEMBER MORROW-GORTON: I believe it
15 has to be an actual inpatient admission, not a --

16 MEMBER SCHELLHASE: Not obs?

17 MEMBER MORROW-GORTON: -- you're going
18 to stay in the ED forever and try and figure out
19 what do you call that.

20 MEMBER SCHELLHASE: Well, an
21 observation, actually, is people sitting in the
22 hospital on a regular floor.

1 MEMBER MORROW-GORTON: Right.

2 MEMBER SCHELLHASE: And just, you
3 know, it's the whole idea of lower-acuity care.

4 MEMBER MORROW-GORTON: But that's an
5 outpatient --

6 MEMBER SCHELLHASE: It is. So you're
7 following that dichotomy. I just wanted to make
8 sure that that was clear.

9 CHAIR ANTONELLI: We'll get the
10 specific case. So the measure developer, we're
11 not going to ask you for comment, but if you
12 would like to just specifically answer that
13 question?

14 MEMBER SCHELLHASE: From a clinician's
15 perspective, that doesn't usually look very
16 different.

17 CHAIR ANTONELLI: Right.

18 MEMBER SCHELLHASE: Right? I mean,
19 that's really an insurance industry distinction.
20 And so that's why I'm asking. From a clinician's
21 perspective, they look awfully similar.

22 CHAIR ANTONELLI: Okay.

1 MEMBER SCHELLHASE: The last thing is
2 getting to the risk adjustment concerns that I'm
3 well aware of. And this is probably a dumb
4 question. The Scorecard is really intended to
5 stay at the state level. So we're looking at a
6 score that an entire state's Medicaid program
7 gets. Is that really how this will get pushed
8 out?

9 MS. LLANOS: So the measures submitted
10 by states are at a state level, and that's what
11 we would use for the Scorecards, yes.

12 MEMBER SCHELLHASE: Okay. So I think
13 certainly, again in our little corner of the
14 world, there are real differences in risk. Our
15 State pays us differently because we have a
16 higher-risk population using their own risk
17 adjustment methodology. So it's a real thing.

18 But if you equalize that on a state
19 level, certainly the health plans probably won't
20 be in a kerfuffle about that. The states might
21 feel like they look bad if we think that
22 Wisconsin has got a lot of sicker people than

1 Illinois, whatever. But I think that that
2 addresses some of that risk adjustment issue if
3 this remains at a state-level score.

4 So thank you.

5 CHAIR ANTONELLI: Stephen?

6 MEMBER LAWLESS: Yes, actually, ditto
7 on both. So I'm not going to repeat both the
8 comments he made here.

9 The one comment I have here is, is the
10 readmission, multiple readmissions within 30 days
11 counted as a one or is multiple counted as the
12 number of readmissions?

13 MEMBER MORROW-GORTON: I believe it's
14 counted as one. I mean, we can ask the
15 developers. But it's an index stay and it is one
16 admission, even though there might be multiple
17 admissions within that 30-day period. It's just
18 one.

19 MEMBER LAWLESS: I think that counts,
20 if you do it that way, to the person who is the
21 frequent flyer, the bouncing and bouncing around
22 gets missed.

1 MEMBER ROMNEY: So it says in the
2 measure description the numerator is the count of
3 30-day readmissions. So that would imply each
4 admission is counted.

5 MEMBER LAWLESS: But if you go to
6 description, it's one or more.

7 CHAIR ANTONELLI: Yes, NCQA is here.
8 So let's pause for a second. Why don't you jump
9 in, please?

10 MS. BYRON: Thanks. This is Sepheen
11 from NCQA.

12 So each admission can be an index
13 stay. This is looking at observed over expected.
14 So I have colleagues on the phone who can speak
15 more deeply about the technical specifications.

16 Robert Saunders should be on. So if
17 you want to unmute? Robert, do you want to go
18 into more detail?

19 MR. SAUNDERS: Hi. Yes. So there may
20 be some element of confusion about the history of
21 the measure. Once upon a time, we would only
22 count, we would count the readmission within 30

1 days of its own index of that. And so that
2 limited the pool.

3 But the way the measure is set up now,
4 every readmission can itself be an index of that.
5 And so if you were readmitted within 15 days,
6 that new admission becomes a new opportunity to
7 prevent another 30-day readmission.

8 MEMBER COGAN: I think the question is
9 what is the count of the numerator? So the way I
10 interpret this is it's the count of index stays
11 that resulted in a readmission. I think that's
12 the part that we're stuck on, is, what is the
13 numerator actually counting?

14 MR. SAUNDERS: Right. So it is
15 saying, how many of the index stays had a
16 readmission that occurred within 30 days?

17 MEMBER COGAN: And if there were
18 multiple admissions, it would be at least one?

19 MR. SAUNDERS: So if you had a
20 readmission 15 days later and a readmission 20
21 days later, it is you're just counting one. One,
22 this index readmission had a readmission. It,

1 therefore, failed the quality measure. We don't
2 pile on that you had two or three or four
3 readmissions for the same index of that.

4 CHAIR PINCUS: But I think what you're
5 saying is that there would be two index events.
6 So there actually would be two readmissions?

7 MR. SAUNDERS: Right. So for any
8 index stay, there can only be one readmission
9 within 30 days. And you start a new calendar
10 for -- so if you're admitted on January 1st and
11 get readmitted on January 15th, that closes out
12 the books on that first index stay. So now,
13 we're looking at the January 15th stay. Did that
14 have a readmission within 30 days? And that one
15 might not have a readmission for 30 days.

16 So this person would contribute two
17 index events. They would have one readmission
18 that is within 30 days. And that would be their
19 count, and that would contribute to the total
20 number of index stays and the total number of
21 index stays that had a readmission within 30
22 days.

1 CHAIR ANTONELLI: Stephen, were you
2 done?

3 MEMBER LAWLESS: That's good, I mean
4 the clarity. So thank you for that.

5 Where it hurts, then, is if you are
6 trying to do a benchmarking and seeing how many
7 patients who have more than one disease have been
8 multiply admitted. So it captures the data on an
9 aggregate level, but just limits the benchmarking
10 capability on looking at individual patients, I
11 think. Maybe I'm missing it, but I think it
12 does. So it hurts with the drilldown after that.

13 CHAIR ANTONELLI: Sue, on the phone.

14 MS. KENDIG: Hi. First of all, it's
15 really hard not to be there. I miss being with
16 you all. It's hard to participate over the
17 phone.

18 But I want to kind of bring us back to
19 something that was said when this was introduced.
20 And that was the importance of integration with
21 community supports for this. I think that's why
22 I think this is such an important measure because

1 it's not just about what's happening in the
2 hospital and the clinical care, which seems to be
3 what we tend to focus on, but really provides the
4 opportunity to look at those root causes of why
5 there are disruptions and discontinuities in care
6 once a patient is discharged into the community.

7 So I think it really incentivizes
8 providers to better integrate with community
9 resources and also provides us with the
10 opportunity to look at why these readmissions are
11 occurring and why people may not be accessing the
12 care they need during those 30 days. So for
13 example, are there transportation failures, even
14 though services may be provided by the payers,
15 and so forth?

16 So I like the idea that this actually
17 helps to incentivize us in getting where I think
18 we want to go, which is aligning both the
19 community and clinical resources to improve
20 outcomes.

21 Thanks.

22 CHAIR ANTONELLI: Sally, David, Jill,

1 Josh.

2 MEMBER TURBYVILLE: Good morning.

3 This is just a comment because in
4 child health measurement -- and I just want to
5 make sure it's kind of accounted for -- we're
6 often put in a position where measures that work
7 and are really important in adult health systems
8 probably apply to child health systems. And
9 there is a very similar measure not on the core
10 set yet, I believe, that has a lot of value, and
11 that's looking also at readmissions for
12 pediatrics, all cause. I just want to note that
13 we do not see the same high rates -- usually,
14 average 5 to 6 percent readmissions -- with that
15 standardized measure. There are some
16 subpopulations where we might see higher, like 10
17 percent.

18 So just as a note, whatever happens to
19 this measure, that a re-deliberation on any kind
20 of similar measure being applied to children
21 would be really critical in order to mesh out
22 whether or not it's worth the juice to squeeze

1 with other quality issues being present in
2 pediatrics.

3 CHAIR ANTONELLI: David?

4 MEMBER KELLEY: So I would support
5 adding this measure. We've looked at this
6 extensively. Our Medical Directors Network
7 published an article on multiple states. There
8 were a significant number of mental health
9 admissions, but they were not the majority.

10 In our State what we do, we've
11 actually been reporting this and it's been part
12 of our MCO pay-for-performance for, I'm going to
13 say, many years, probably five or six or maybe
14 even seven years. We have not established a
15 benchmark because NCQA did not have a benchmark
16 established. So we incent our plans on
17 incremental improvement year over year.

18 We also use this measure specifically
19 at both physical and behavioral health
20 readmissions for individuals with serious mental
21 illness. We have our EQRO create a specific
22 measure to hold both our physical and behavioral

1 health plans accountable. And that model, the
2 majority of admissions clearly on the physical
3 health side.

4 So this is a metric that at the state
5 level we're fine with reporting it. And even
6 though it's not perfect, it's a good indicator
7 for care coordination, especially between
8 physical health and behavioral health, to make
9 sure that they're working together.

10 And from my standpoint, our managed
11 care plans do pay attention to this measure. We
12 also have an upside-only positive incentive for
13 hospitals for both preventable and readmissions.
14 So we're only rewarding the hospitals in our
15 model. Our MCOs do not have a penalty as well.
16 This is all upside-only.

17 MEMBER ZERZAN: Although part of that
18 study that I think Jeff was getting at, if you
19 drill down into the physical things -- I think
20 Pennsylvania did this and Colorado did, too, at
21 the time -- a lot of the GI readmissions are
22 related to alcohol abuse. A lot of the

1 cardiovascular readmissions were related to IV
2 drug use. So even though the behavioral health
3 alone wasn't it, if you drilled into a lot of the
4 physical health, they had that behavioral health
5 overlay.

6 CHAIR ANTONELLI: Jill?

7 MEMBER MORROW-GORTON: So I just want
8 to speak real quickly to the Health Affairs
9 article that Harold was talking about that I
10 actually happened to read like two days before I
11 came. And I thought, oh, no, because I was
12 supposed to be, you know, really positive for
13 this measure, and I really am.

14 (Laughter.)

15 But when I thought more about that
16 article, the population is a very different
17 population. This was the over-65 population. It
18 was a Medicare population.

19 They looked at three conditions, and
20 the results were really mixed. One of the
21 conditions, the mortality was higher. The other
22 two, it was not.

1 So I think the sort of answer to that
2 is still not clear. It's clearly a risk. I
3 think if you look at it from an upside payment,
4 rather than looking at downside, you may avoid
5 that perverse incentive.

6 And I think from a statewide vantage
7 point, we've started benchmarking this measure,
8 at least to get a sense of where everybody is.
9 So I think it's doable, even without a defined
10 benchmark. You know, you can use some of the
11 benchmarking frameworks and principles.

12 CHAIR PINCUS: Yes, I wasn't
13 necessarily endorsing the study, but I wanted to
14 make sure we had a discussion about it.

15 CHAIR ANTONELLI: Josh?

16 MEMBER ROMNEY: I just think, as we
17 transition to a world of value-based care and
18 population health management, transition of care
19 is maybe the top one, two, or three things we
20 need to do better at, and to have that on the
21 Scorecard is important, as there's always
22 measures, other measures you can do. But this is

1 something that people are familiar with; they've
2 been working on. And it's something that does
3 drive coordination between hospitals, post-acute
4 settings, and clinics. And everyone needs to do
5 a better job of coordinating.

6 CHAIR ANTONELLI: Josh, I want to ask
7 you a follow-up question. What I heard you say
8 was that it's an important concept, but I didn't
9 necessarily hear you say and this is the measure.
10 So could you say a little bit more concept and
11 specific to this measure versus --

12 MEMBER ROMNEY: To me, the concept is
13 transition of care.

14 CHAIR ANTONELLI: Correct.

15 MEMBER ROMNEY: Transitions of care
16 need to be improved. And you can look at people
17 looking at this as, oh, I need to not readmit
18 people. But what we really send the message with
19 using this measure is improve your transitions of
20 care. And this is the best measure that I know
21 of to facilitate that vital behavior.

22 CHAIR ANTONELLI: Okay. So you are

1 talking about the concept and specifically 1768?
2 Okay. Thank you.

3 Harold?

4 CHAIR PINCUS: Just one point about
5 the discussion raised earlier about behavioral
6 health admissions. Yes, behavioral health
7 readmissions represent a significant proportion,
8 but, interestingly, a not insignificant
9 proportion of those readmissions are not for
10 behavioral health reasons, but are for general
11 medical reasons.

12 CHAIR ANTONELLI: And Jordan, no hands
13 online?

14 MR. HIRSCH: No hands.

15 CHAIR ANTONELLI: Okay. Is there a
16 motion?

17 MEMBER ANDERSON: I move that we add
18 1768, All-Cause Readmissions, to the Scorecard.

19 CHAIR ANTONELLI: Second?

20 MEMBER KELLEY: I'll second.

21 CHAIR ANTONELLI: Okay. So what's
22 going to happen now is we'll open for public

1 comments. And then, we have the measures from
2 yesterday and the one from this morning. We'll
3 actually go through that voting process.

4 So let's open for public comment,
5 please.

6 MS. KUWAHARA: Sure. So everyone's
7 lines are open.

8 And just to recap the measures that we
9 put forth to vote on, there's Adherence to Anti-
10 Psychotic Medications for Individuals with
11 Schizophrenia; NQF No. 0105, Antidepressant
12 Medication Management; NQF No. 0038, Childhood
13 Immunization Status; 1448, Developmental
14 Screening in the First Three Years of Life, and
15 1768, Plan All-Cause Readmissions.

16 If any member of the public would like
17 to offer a comment, your lines are open.

18 And are there any members in the room
19 with us today that would like to offer a comment?

20 CHAIR ANTONELLI: All set? Shall we
21 vote?

22 MS. KUWAHARA: All right. We'll

1 proceed to voting.

2 CHAIR ANTONELLI: So it's the same
3 link as yesterday.

4 MR. HIRSCH: So we are now voting on
5 Adherence to Anti-Psychotic Medications for
6 Individuals with Schizophrenia. And your options
7 are, 1, to support recommendation for addition to
8 the Scorecard, or, 2, do not support
9 recommendation for addition to the Scorecard.

10 CHAIR PINCUS: Does everybody have it
11 up on their computer? Okay.

12 CHAIR ANTONELLI: Miranda, it came
13 from you? Or did it come from MAC?

14 MS. KUWAHARA: It came from the MAC
15 Scorecard yesterday morning. And if it's helpful
16 for folks in the room, I can forward that again,
17 so it's at the top of your inboxes.

18 CHAIR ANTONELLI: Yes. Could you,
19 please?

20 MS. KUWAHARA: Okay. I'll do that
21 now.

22 CHAIR ANTONELLI: I've gotten a

1 thousand emails since yesterday.

2 I think we're waiting for one. Oh,
3 there we go.

4 MR. HIRSCH: All right. For Adherence
5 to Anti-Psychotic Medications for Individuals
6 with Schizophrenia, 23 Committee members have
7 voted in support; 7 Committee members have voted
8 to not support. This amounts to 77-percent
9 Committee members voting to recommend addition of
10 Adherence to Anti-Psychotic Medications for
11 Individuals with Schizophrenia to the Scorecard.

12 Committee members will now vote on NQF
13 No. 0105, Antidepressant Medication Management.

14 For NQF 0105, Antidepressant
15 Medication Management, 12 Committee members have
16 voted in support and 19 Committee members have
17 voted to not support this measure, which amounts
18 to 39 percent in support and 61 percent of
19 Committee members have voted to do not support.
20 Therefore, Committee members have voted not to
21 recommend the addition of NQF 0105,
22 Antidepressant Medication Management, to the

1 Scorecard.

2 Committee members will now vote on NQF
3 No. 0038, Childhood Immunization Status, with
4 option 1, to support recommendation to the
5 Scorecard and, option 2, do not support
6 recommendation to the Scorecard.

7 Committee members have voted for 29 in
8 support of NQF 0038, Childhood Immunization
9 Status, while 2 Committee members have voted do
10 not support. Ninety-four percent of Committee
11 members have voted in support of recommending NQF
12 0038, Childhood Immunization Status, to the
13 Scorecard.

14 Committee members will now vote on NQF
15 No. 1448, Developmental Screening in the First
16 Three Years of Life.

17 For NQF No. 1448, Developmental
18 Screening in the First Three Years of Life, 28
19 Committee members have voted in support; 3
20 Committee members have voted do not support.
21 Ninety percent of the Committee has voted in
22 support of recommending NQF No. 1448,

1 Developmental Screening in the First Three Years
2 of Life, to the Scorecard.

3 And now, Committee members will vote
4 on NQF No. 1768, Plan All-Cause Readmissions.

5 For NQF No. 1768, Plan All-Cause
6 Readmissions, 27 of the Committee members have
7 voted in support; 3 Committee members have voted
8 do not support. Ninety percent of the Committee
9 has voted to recommend NQF 1768, Plan All-Cause
10 Readmissions, to the Scorecard.

11 MS. KUWAHARA: So to summarize the
12 votes today, the Committee recommended the
13 addition of the four measures to the MAC
14 scorecard, adherence to antipsychotic medications
15 for individuals with schizophrenia, NQF Number
16 0038, childhood immunization status, NQF Number
17 1448, developmental screening in the first three
18 years of life, and NQF Number 1768, plan all
19 cause readmissions.

20 And for those of you in the room
21 monitoring the voting screen, you'll notice that
22 the denominator was 31 today. We've confirmed

1 with Julie Bershadsky, who is a member, she is
2 casting her votes remotely. She was unable to
3 join us yesterday, so.

4 CHAIR PINCUS: So I would add to that
5 summary that not only have we made these,
6 conducted these voting processes, but we've also
7 had ample and active discussion across all of
8 these that will hopefully inform some of the
9 decision making at CMS.

10 CHAIR ANTONELLI: Rhonda.

11 MEMBER ANDERSON: During the
12 discussion, the all cause readmissions was
13 discussed as potentially care coordination. And
14 when we look at it, it is not in that area of, or
15 that domain right now.

16 Is it a recommendation that goes into
17 the minutes or what happens in terms of where it
18 might be moved?

19 Because it really, to me, and I think
20 I heard kind of consensus from everyone, that it
21 is care coordination or more of the care
22 coordination principles.

1 CHAIR PINCUS: Let me ask Karen, just,
2 you know, how important is it in terms of the
3 categories that you have and how do you use the
4 categories?

5 MS. LLANOS: So we use the categories
6 to see how if there are, how we are aligning to
7 our agency's meaningful measure of stream work,
8 which is what comprises those categories.

9 So as I noted yesterday, they are
10 subjective. There is a lot of overlap, as you
11 can imagine. Several measures could fit into
12 multiple domains.

13 So I think if there is a suggestion
14 that you want to make we can certainly take that
15 into consideration. And then I'll also say we
16 also used it to see where some key gap areas are.

17 MS. GORHAM: And I just want to add
18 that, when you all sent your measure
19 recommendations in, the domains that we placed
20 recommendations in were NQF Staff. So that was
21 where we placed the domains. But we also noted,
22 as Karen just said, that they could fall into

1 multiple domains.

2 CHAIR ANTONELLI: Lindsay and then
3 Rich.

4 MEMBER COGAN: So, Karen, and this
5 goes back to, again, either accountability or
6 maybe further development of the scorecard, so
7 you may not be able to answer this, but is there
8 any plans to take these measures, roll up domains
9 and then roll up across to give almost a
10 composite, like in a quality rating system, but a
11 quality rating system for a state Medicaid
12 agency?

13 MS. LLANOS: So we haven't made those
14 types of decisions. I think in terms of things
15 that have been discussed, the display and how, if
16 the measure would be rolled up or not, all of
17 those things have come up in terms of feedback
18 that we've actually gotten from a lot of our
19 stakeholders.

20 So it's a common question. But we
21 haven't made any decisions in terms of something
22 like that.

1 MEMBER COGAN: Okay. That's where I
2 think the issue of domain gets to be important,
3 because we currently have a lot of measures in
4 the one domain. And if we were to kind of roll
5 those up, they would significantly have less
6 weight, unless you were inherently weighting
7 them. So just some further notes to think about.

8 CHAIR ANTONELLI: Yes. And so I'm
9 actually going to step out of my co-chair roll
10 and like to make a comment.

11 I am a member of the NQF Patient and
12 Experience and Function Committee, which is about
13 to get renamed, I think I can say that, Patient
14 Experience and Function and Care Coordination
15 Committee.

16 One of the issues that I have had,
17 working with individual states and delivery
18 systems when they are looking for measures, will
19 often go to places like the readmission measure,
20 which, on its face, is about utilization. And
21 that there is a conflation that, well yeah, we
22 can fix that by doing care coordination, whatever

1 that is.

2 And I want to caution us. There's no
3 question that there are opportunities for
4 improving care coordination across settings and
5 sectors and disciplines, including patient
6 self-management, et cetera, et cetera.

7 But I want to make sure, I for one
8 don't feel comfortable just saying, yes, just
9 drop it in a domain. Because I think that the
10 opportunity to bring measures that are meaningful
11 for care coordination and integration is also,
12 for me, it's as important as selecting which
13 measure that we use.

14 So, Rhonda, wherever you went, thank
15 you for raising, raising that issue. But I think
16 we need to have a conversation with appropriate
17 minutes collected about what does that mean.

18 But on its face, I can tell you most
19 entities that I have dealt with, especially on
20 the payer side, think readmission is a
21 utilization measure and that the care
22 coordination will get, just, stuff will get

1 figured out. And that's not how systems are
2 organically designed.

3 So I would appreciate it if that could
4 get recorded in the minutes and NQF doing its
5 internal reorganization with the PEF Committee, I
6 think is really, really important. I think
7 you're on that Committee with me aren't you,
8 Carol? Aren't you on PEF? You're not.

9 That's the Page and Experience and
10 Function Committee. And then care coordination
11 is going to get folded into that. Jeff.

12 MEMBER SCHIFF: So, Rich, I'm a little
13 confused by your comment. Are you advocating for
14 this being in the care coordination domain or
15 not?

16 CHAIR ANTONELLI: So what I'm
17 advocating for, so now I'll sort of flip back to
18 my Chair role, is I'd like to have a discussion
19 with it. I didn't feel comfortable that somebody
20 would make a suggestion, and that kind of makes
21 sense.

22 And Lindsay sort of set the stage for

1 me to make that discussion. If you're looking at
2 how many measures are in each bucket, and with
3 the appropriate way things would be.

4 MEMBER SCHIFF: Right.

5 CHAIR ANTONELLI: So I'm making the
6 observation as the Co-Chair, there hasn't been
7 enough discussion, in my view --

8 MEMBER SCHIFF: Okay.

9 CHAIR ANTONELLI: -- to justify that,
10 okay, yes, care coordination, this is a care
11 coordination domain measure. We haven't
12 discussed that.

13 So I would like, at some point, to
14 bring that up for discussion, either in this
15 group or, Karen, if allocating measures to each
16 of those domains is something that CMS would
17 prefer to do. So I'm calling it as an open
18 question right now.

19 I'm willing to make a recommendation,
20 but I'd like to hear other people's thoughts --

21 MEMBER SCHIFF: Right.

22 CHAIR ANTONELLI: -- if this Committee

1 is inclined to debate it.

2 MEMBER SCHIFF: I think that was my
3 comment originally, was that I think it would
4 serve the people we represent better to have it
5 in the care coordination domain. It's not, like,
6 all these measures, none of them are perfect, but
7 putting it in that domain would have systems that
8 just look at where they land and hence who is
9 assigned the task of dealing with that as less of
10 a utilization measure and merit of a system care
11 coordination measure.

12 CHAIR ANTONELLI: That kind of
13 language embedded in the recommendation is
14 exactly what I want to capture. Lisa.

15 MEMBER PATTON: Yes, that's where I
16 was going to go was that we have to be very clear
17 in the accompanying language, that that's really
18 sort of the impetus for this group in putting
19 this forward.

20 Because I think that in many instances
21 beyond a lot of the people in this room, people
22 are going to look at that measure and look at it

1 strictly as a utilization measure. And they're
2 going to be interested in hitting that mark and
3 that's it.

4 And so I think to drive it and to have
5 an expanded look at it, moving it to the care
6 coordination domain and talking about it very
7 clearly in that manner will help.

8 I'm the co-chair for the recently
9 launched NQF Social Determinants of Health Data
10 Integration Work Group. And so we're looking
11 very carefully at the disparate data sources that
12 would bring in a lot of those SDOH factors and
13 those kinds of community collaborations.

14 And this is essentially a different
15 tool and a different approach that would be
16 supportive of that big picture thinking around
17 these issues.

18 CHAIR ANTONELLI: Okay. So David,
19 Carol, and Kamala. And Jill.

20 MEMBER KELLEY: So I would think of
21 the readmission measure really being associated
22 with care coordination. And in our programs, we

1 are incenting plans and -- or incenting in our
2 patient-centered medical home, coordination of
3 care to reduce readmissions.

4 So our patient-centered medical homes
5 are focused on getting individuals with, enable
6 to our care sensitive conditions, missions
7 related to those, not all admissions, but to get
8 them back in their, back to their primary home,
9 medical home, within X number of days.

10 So we really look at this as a metric
11 that tells us whether or not we're seeing better
12 care coordination. It is a utilization measure
13 and we hit our plans up on that. But we expect
14 our plans, as well as our patient-centered
15 medical homes, to really coordinate care looking
16 at both preventable admissions but also
17 readmissions.

18 So in my mind, it is a proxy for,
19 hopefully better care coordination. I would also
20 say that when you look at initiation and
21 engagement, that measure, if that is done
22 correctly, that is all about care coordination.

1 Because these are new individuals with
2 a new diagnosis in what is actually happening to
3 them. So are they initiating into treatment but
4 are they staying engaged in treatment.

5 That is a coordination of care
6 measure. And we handle that as such. It is in
7 our combined integrated care program incentive
8 for our MCOs.

9 And we just rolled out an incentive
10 program to EDs in Pennsylvania.

11 CHAIR ANTONELLI: Yes.

12 MEMBER KELLEY: So it is, we really
13 view this as a care coordination measure.

14 CHAIR ANTONELLI: Yes.

15 MEMBER KELLEY: It's access and
16 availability of services, but it's also a care
17 coordination measure.

18 CHAIR ANTONELLI: Yes.

19 MEMBER KELLEY: Thirdly I would
20 probably argue that for Medicaid, the dental
21 measure, it's an access to care measure. But if
22 you really want to hold your plans accountable,

1 it's also a coordination of care measure.

2 It's getting that child, getting care
3 management there so that child actually gets to
4 that visit. Because in many instances, we have
5 access to care and we have availability, but just
6 not getting there.

7 CHAIR ANTONELLI: Yes.

8 MEMBER KELLEY: So, again, some of
9 these measures could be bumped up into the
10 coordination a little bit more.

11 CHAIR ANTONELLI: Yes. And if I could
12 just make the observation. So you just gave an
13 elegant rendering of all the reasons why an all
14 cause readmission measure would be an indicator
15 of appropriate care coordination, but it wasn't
16 that, there was a period of magical thinking and
17 that somehow this would happen.

18 I mean, you talked about access, you
19 talked about the PCMH, you talked about the
20 hand-offs, you talked about engagement, et
21 cetera. So that's the kind of stuff that I want
22 to capture back into this report. So thank you,

1 David.

2 Carol, Kamala and then Jill and then
3 Shayna.

4 MEMBER SAKALA: So I'm going to also
5 support this measure, plan all cause
6 readmissions, as a care coordination measure.
7 And I'd like to do it from the point of you, of a
8 system that's moving toward alternative payment
9 models.

10 I would include different types of
11 healthcare homes, episode, population. What we
12 want is everybody to be working together toward
13 the same goals.

14 So from the point of view of where our
15 system is heading, I think this is a good move as
16 well.

17 MEMBER ALLEN: And my comment is
18 really, as we think about the end user of the
19 scorecard, that putting it in the care
20 coordination domain makes it clear the intent of
21 the measure.

22 Because I think, just as the

1 conversation was going on about the measure, not
2 being a clinician, it was important for me to
3 hear that that's how it was really being used on
4 the ground. So I think without having that
5 reflection, people would miss that.

6 CHAIR ANTONELLI: Jill, Shayna.

7 MEMBER MORROW-GORTON: I have some
8 concern about that in the sense that people tend
9 to associate care coordination with people with
10 complex medical needs and disabilities. And not
11 the person who needs help getting from A to B,
12 who could use some assistance.

13 And I would worry that if we put it in
14 that group without sort of using the broader
15 meaning or broader definition of the word, that
16 it would get interpreted in the more narrow way
17 and we would lose the other pieces around it.

18 So I think it really is a utilization
19 measure. I think it really belongs where the
20 acute care hospital stuff is because I think it's
21 got to get to the attention of those individuals
22 and not to the attention of the disability

1 community, which is much smaller and already is
2 all over care coordination.

3 It also is, I wouldn't want it to try
4 to take the place of a real care coordination
5 measure because I don't, you know, I think its
6 way up in the stream. Yes, it can give you some
7 sense of how well people are doing around the
8 discharge planning and looking at transportation
9 and those sorts of things.

10 But that would be my concern is that
11 then people would say, well, we got a care
12 coordination measure, it's perfectly good, we
13 don't need to think beyond it. And, we don't
14 have to think about that because it's care
15 coordination, they're going to do it.

16 CHAIR ANTONELLI: Shayna.

17 MEMBER DAHAN: So I like this measure
18 because it looks, it does seem pretty much care
19 coordination to me, but I do think that these
20 types of measures should get a little bit more
21 specific because hospitals are now saying follow
22 up with your PCP in two to three days.

1 So sometimes that does cause some
2 unnecessary utilization, would be to come back to
3 me to make an appointment with a pulmonologist
4 that then I put you on a list for three months
5 for that appointment. Where what I think really
6 should happen within the hospital system is, they
7 make the appointment with the specialist.

8 Because, if you've been inpatient,
9 most of that stuff is not going to be probably
10 best treated sometimes at the primary care so I
11 think that, as far as when you look at
12 readmissions, what would actually be the most
13 useful data would be to see if after an inpatient
14 stay that person was given an appointment with
15 the appropriate specialist or follow-up in
16 management and treatment for the reason that they
17 were admitted.

18 CHAIR ANTONELLI: Thank you. Kamala,
19 are you left over?

20 Good. So, Stephen, last word to you.

21 MEMBER LAWLESS: I'm actually
22 fascinated in a lot of ways but also intrigued

1 that it's a process measure. So I think if it
2 links with process it really is more about the
3 process care coordination or part of the process
4 of care coordination system versus an outcome
5 measure. Which would be in results.

6 I think it was, I think it supports
7 that it's a process measure, it's about care
8 coordination. Rather than outcome, which would
9 be something different.

10 CHAIR ANTONELLI: Yes. Okay, thank
11 you. So what I'm hearing is, there's general
12 consensus for this to be in the domain around
13 coordination of care.

14 But if the report, the recommendation
15 could have underlying it, and in fact, Dave
16 Kelley's rendering I think is exquisite. And
17 it's not just blue sky it's what they're doing,
18 that's almost the play book that we could
19 shamelessly steal and promote.

20 So I'm really comfortable with moving
21 that forward. And I don't have the need to have
22 a motion made. So I think we're going to close

1 this out now.

2 And then, Shaconna, over to you.

3 MS. GORHAM: So I'll actually turn it
4 over the Miranda. She'll read all of our final
5 decisions and recommendations that will be put
6 forth to CMS, and then we will go into ranking of
7 the measure additions.

8 And we have, on the wall behind you,
9 the actual measures listed. And Jordan will pass
10 out stickies. So we have four measures that you
11 all voted on to recommend to CMS, so he will give
12 you three stickies.

13 You can put all of your dots on the
14 same measure. And when we say ranking, just as a
15 reminder, we mean that you can put all three
16 bullets on 1768, for example, and that could
17 potentially be your signal to CMS to say this is
18 the most important measure to add to the
19 scorecard.

20 But we will see where the dots fall
21 out and we will rank and we'll give you the
22 listing after the ranking.

1 MS. KUWAHARA: Thanks, Shaconna. So
2 ordinarily we would hold this exercise for both
3 removals and additions, but because we only
4 recommended removal of one measure, which was use
5 of multiple concurrent antipsychotics, Pages 1
6 through 17, we're only holding this exercise for
7 measure of additions.

8 And to recap again, there were four
9 measures recommended for addition to the MAC
10 scorecard. The first is 0038, childhood
11 immunization status, NQF Number 1448,
12 developmental screening in the first three years
13 of life, 1768, plan all cause readmission, and
14 adherence to antipsychotics medications for
15 individuals with schizophrenia.

16 And, again, this is a physical
17 prioritization exercise, so for folks
18 participating remotely, know that we're going to
19 be offline for a few minutes and then we'll come
20 back.

21 And, Julie and Sue, if you would like
22 to place your prioritization ranking via the chat

1 function, we can record it. Put sticky notes
2 here in the room.

3 MS. GORHAM: Don't all run up at once.

4 (Whereupon, the above-entitled matter
5 went off the record at 10:34 a.m. and resumed at
6 10:52 a.m.)

7 MS. KUWAHARA: So staff took count of
8 everyone's rankings, and I will read off the
9 rankings in order of priority. The first was
10 1448, developmental screening in the first three
11 years of life.

12 Next was 1768, plan all cause
13 readmissions. And then adherence to
14 antipsychotics medications for individuals with
15 schizophrenia was tied with NQF Number 0038,
16 childhood immunization status.

17 CHAIR ANTONELLI: Okay. So we are now
18 moving into a different phase of the work today,
19 around the scorecard measures to drive change and
20 overall system performance.

21 Recall that there are three -- Kamala?

22 MEMBER ALLEN: Yes, Richard, I just

1 have one question about the ranking. The
2 prioritization.

3 Is the goal that there not be a tie so
4 is there like another round of ranking that you
5 want us to do or it's sufficient to have --

6 CHAIR ANTONELLI: Very pragmatic
7 question.

8 MEMBER ALLEN: Okay. Because I'm just
9 wondering if you want everyone to now have one
10 dot --

11 CHAIR ANTONELLI: Yes.

12 MEMBER ALLEN: -- and they just have
13 to put them, you know.

14 CHAIR ANTONELLI: So who --

15 MEMBER ALLEN: I don't know what you
16 need.

17 CHAIR ANTONELLI: Yes, ties are
18 acceptable.

19 MEMBER ALLEN: Okay, thank you.

20 CHAIR ANTONELLI: Welcome to our
21 democracy.

22 (Laughter.)

1 CHAIR ANTONELLI: All right, so
2 talking a little bit about this I want to remind
3 people that three pillars, our work is focused on
4 the scorecard, which is pillar one. And these
5 are the discussion questions. Now we're going to
6 be opening this up.

7 So from the state Medicaid
8 perspective, what are the health system
9 performance changes you expect from the measures
10 in the scorecard?

11 Aspects of the health system
12 performance can be impacted, what aspects can be
13 impacted with the scorecard, existing scorecard
14 measures?

15 And remember you have the sheet from
16 yesterday we tweaked to increase the impact of
17 these measures in changing system performance.

18 And then what state level factors are
19 important for maximizing the scorecard impact and
20 overall health system performance?

21 So these are some of the questions for
22 discussion today. We will open this up. And

1 then, Jordan, just assure our members on the
2 phone have -- are they open to voice, or are they
3 raising their hands?

4 They're un-muted, okay. All right.
5 So a moment to reflect and then we can go ahead
6 and get started. And, Marissa, you'll be our
7 lead off and then Sally.

8 MEMBER SCHLAIFER: I just had a
9 question. On the question, how can existing
10 scorecard measures be tweaked, what do we mean by
11 tweaked?

12 I mean, I know we can't change the
13 measures, is it tweaking by prioritizing? What
14 do we mean by tweaked?

15 CHAIR ANTONELLI: Karen, I'm inclined
16 to maybe put that question out for you. Can you
17 think of a way that --

18 MS. LLANOS: I mean, any changes would
19 have to stem from the core set.

20 CHAIR ANTONELLI: Right.

21 MEMBER SCHLAIFER: Okay. So it's --
22 okay. So there may not be an answer to that

1 question.

2 CHAIR ANTONELLI: It may not be but I
3 actually think that the experience we had
4 yesterday with the perinatal measure as a
5 placeholder and operationalizing that, and then
6 quite honestly, I wouldn't mind, for the sake of
7 the creating the public record, to talk a little
8 bit about that developmental trajectory of, we
9 are attached to whatever is in the core sets for
10 recommending addition, or deletion, from the
11 scorecard.

12 What would this group do in terms of
13 prioritizing either gaps or modifications of
14 existing measures to make that better, where does
15 that system feed into each other?

16 Because I, I don't mind being open
17 with everybody, what I've been struggling with,
18 although yesterday's conversation for me was very
19 helpful is, I didn't know how this group fit in
20 with the rest of that ecosystem. I used to be on
21 the group here that curated the core sets. And
22 then this was an additional piece.

1 So there is some clarification coming
2 from me, but I think that that's kind of what I'd
3 like to hear in this conversation, okay. So I
4 have Sally and then Clarke, and then is that Ken
5 or Stephen, I, yes, okay.

6 MEMBER TURBYVILLE: So this is a
7 question. And I don't know that it has to be
8 answered today or maybe it's a call to action.

9 I'd love to better understand not, and
10 learn from the conversation today, about how we
11 can continue to tap into what are the health
12 system performance changes that we might expect
13 from the scorecard. For us it will be very
14 helpful for us to, as we're working with our
15 member organizations, which is pretty much all
16 children's hospitals in the country, to help them
17 prepare to be good partners in what the states
18 need.

19 And so thinking about, in addition to
20 the conversation in the record that goes, what
21 role could CMS or other organizations that we and
22 other like-minded organizations can tap into, not

1 just today but in the next year, again, so that
2 we can do a better job in preparing our member
3 organizations.

4 CHAIR ANTONELLI: Clarke.

5 MEMBER ROSS: Just an observation from
6 a predominant sentiment and perspective and
7 feeling within the consumer family movement and
8 disability. And that is that our quality
9 measures or our regulatory enforcement
10 requirements, the most effective way of impacting
11 change in the Medicaid program.

12 So is accessible mammography for women
13 who use wheelchairs, is that an ADA regulatory
14 requirement or is that a quality measurement?

15 Is re-balancing the system allocation
16 between institutional settings and home and
17 community-based service settings, a policy
18 regulation or is it a quality measure?

19 And a lot of organizations and
20 individuals in a consumer family movement and
21 disability, they're happy that I'm here but their
22 real focus is on using the regulatory mechanism

1 to enforce ADA and related kinds of
2 modifications.

3 And, so we sit around focused on
4 quality measures but a lot of folks who are
5 impacted every day, don't focus on this. It's
6 just, I don't know how to capture that in the
7 discussion but it's a dynamic that I'm faced with
8 every day.

9 CHAIR ANTONELLI: Yes. So I'm going
10 to come back to you. Are you formulating a gap
11 that has a potential solution or are you looking
12 at a dichotomy and after the last day and a half
13 you're not quite sure that you've heard anything
14 here that would help you bridge that divide?

15 MEMBER ROSS: I, I'm not going to
16 recite, re-answer that in the way you've asked
17 it. In thinking about how to impact change, in
18 my case, people with disabilities, particularly
19 adults, we have to look at multiple factors.

20 Quality measures being one, domain of
21 those factors, legal rights under the Americans
22 with Disabilities Act being a second factor,

1 where we spend money in a policy sense is a
2 third.

3 So I think that if adherence to
4 medications and schizophrenia is actually an
5 identifiable quality measure that state Medicaid
6 agencies and others are working with, that will
7 result in significant system change for people
8 with schizophrenia. Our most disabling of mental
9 illnesses, and probably the most disabling
10 condition we face.

11 So I don't know if that's coherent
12 enough to respond, but --

13 CHAIR ANTONELLI: So I'll move on but
14 I just make the observation. I know when this
15 roster was being formulated, there was a very
16 specific focus to bring in enough sensibility and
17 perspective of LTSS and this extra vulnerable
18 populations.

19 And so I think that, what I'm hearing
20 you say is, what's the added value of the quality
21 measures of the promotion thereof and how do they
22 relate to the regulatory environment. Because

1 the answer is clearly, it's a both, it's not an
2 either or. Okay, thank you for that.

3 Stephen, Harold, Carol, Jill and then
4 Amy.

5 MEMBER LAWLESS: To the answer about
6 --

7 CHAIR ANTONELLI: After Amy, Kim.

8 MEMBER LAWLESS: -- the expectation of
9 performance. A lot of work on developing the
10 measures.

11 I hope that the plans will, the states
12 will see this. They realize the power and
13 comparison --- of comparing data but also opening
14 up the discussion about whether system
15 performance is there.

16 There was a hint about how hard it is
17 to collect data. And people spend more of their
18 emphasis on just collecting the data and saying,
19 Ryan, we've finally got it in our EMRs, click,
20 click, click, send it, leave it alone, we have no
21 time for something else, than it's been a wasted
22 exercise.

1 But if it's been more of a, all right,
2 now let's have the discussion with the hospitals
3 about system performance, that would be the
4 trigger of the performance, that would be
5 fantastic.

6 CHAIR ANTONELLI: Harold.

7 CHAIR PINCUS: So a couple of
8 thoughts. One is, if you think about it, sort of
9 the pyramid or triangle of having like a full
10 range of measures up to the core set, up to the
11 scorecards that allows, from the good side of
12 focusing on particular issues that are deemed of
13 high importance.

14 The potential negative of that, there
15 is the ignoring of other things. And so that as
16 things move forward, to keep some kind of
17 surveillance so that you're not just looking at
18 the scorecard but that you're looking at some
19 breath of quality and, sort of across disorders,
20 across different domains and so forth, so that
21 it's not exclusively focused.

22 And that means, obviously, you're not

1 going to have full reporting on all of these
2 things, but there may be other ways, both
3 quantitatively and qualitatively.

4 The second piece of this is also to
5 begin, as this moves forward, to think about,
6 what are the mechanisms by which change occurs.
7 So that as you're doing this, obviously there's
8 going to be changes that are occurring both
9 within states and across states.

10 And some efforts, and again, this is
11 sort of research kind of thing, but it has very,
12 very practical implications in terms of
13 understand what accounts for some of the changes
14 to understand both the mechanisms involved and
15 what states, what plans, what providers have
16 don't to sort of take action based upon what's
17 being measured.

18 Because we know the power of
19 measurement, and the question is, how was that
20 power exerted and can we better understand that
21 process and then apply sort of a more rational
22 approach to measurement and how we, what are the

1 consequences of measurement.

2 CHAIR ANTONELLI: Carol, Jill, Amy.

3 MEMBER SAKALA: I just realized that,
4 I think were, my comments are more suitable
5 toward maybe the next section, so the future of
6 the scorecard, they're kind of crosscutting, so
7 if that's going to happen, I'll just wait.

8 CHAIR ANTONELLI: Yes, it will happen.
9 Jill.

10 MEMBER MORROW-GORTON: So I think what
11 we have to think about is, we can measure things
12 and then we have to think about, can we fix them,
13 can we improve them. And can we fix them and
14 improve them in a meaningful way that's cost
15 effective and that improves quality of life and
16 improves quality of service as opposed to, can we
17 just put it in the EHR and meet the number and be
18 done with it.

19 And I think some of the, having a
20 measure is great but the real work is underneath,
21 figuring out what's the, sort of what are those
22 things leading to that result, what are the ways

1 and the solutions to be able to improve that.
2 That requires partnerships with research and the
3 literature and other models that have been used
4 in other places and that sort of thing.

5 So I think there's a, you know, it's
6 great to have the measure and the number but
7 there's a lot of work underneath that and I think
8 that's where states and health systems will need
9 assistance to make this successful.

10 CHAIR ANTONELLI: Amy.

11 MEMBER HOUTROW: Yes, I was just
12 reflecting on what Clarke was saying and it seems
13 like we, in the future, have some opportunities
14 for measures that may address the population
15 that's high cost and high need.

16 We know, at least for children with
17 disabilities, the kind of issues around respite
18 care and long-term services are the number one
19 highest percentage of unmet needs. And that if
20 there are some measure that we have, that then
21 little a, big A accountability becomes more
22 important.

1 I think in the disability space, the
2 idea of using the ADA in a regulatory way to say
3 we need access, it seems like the less hard
4 hurdle to climb than it is, in some ways, to get
5 services where you can wait on a wait list for
6 years. And it doesn't seem feasible to climb
7 that mountain.

8 And so I think I really appreciate
9 what you said, Clarke, and wanted to challenge us
10 in the measure development world and really be
11 thinking about how we make measures and really
12 get at some of these important issues.

13 CHAIR ANTONELLI: I totally agree with
14 you guys that's why I'm grateful that you brought
15 that up because we do have to connect these two
16 universes. So I have Kim, Camille, Jeff.

17 MEMBER ELLIOTT: So I think of the
18 scorecards really as quality. Everything that
19 we're working in is focused on the quality of
20 care and services that these are really
21 representing.

22 But these measures that we're

1 including in the scorecard are really indicators
2 of a lot of other things. So really, when I
3 think about the measures that we're including in
4 the scorecard, what that's going to drive down to
5 the state level then down to the manage care
6 level, down to the provider level.

7 And all of those things are going to
8 keep trickling back up to really be that
9 indicator of the quality of the care that we're
10 providing. So that's why I think it's just
11 important to include those measures that will
12 have that kind of actionable opportunity on the
13 provider, the health plan side in particular.
14 Which will be driven by the state.

15 So Dave always talks about the metrics
16 that they include in the paper performance and
17 value-based purchasing and those sorts of things.
18 And that's what's really going to start driving
19 some of this.

20 CHAIR ANTONELLI: Camille. And then,
21 Shayna, is that yours on edge?

22 MEMBER DAHAN: Yes.

1 CHAIR ANTONELLI: Okay.

2 MEMBER DAHAN: Yes.

3 CHAIR ANTONELLI: I can recognize your
4 ponytail, but I can't see that unless I see the
5 letters. So I got Camille, Jeff, Shayna.

6 MEMBER DOBSON: I wanted to piggyback
7 on Clarke's comment. I think it's accurate that
8 the scorecard, this pillar at least doesn't
9 reflect really what a lot of people care about
10 who get long-term services and support. It's not
11 what the consumers really care about.

12 The challenge that we have
13 representing the aging and disability agencies is
14 that we don't have a HEDIS, we don't have, there
15 isn't anything for the services that are
16 non-medical, that people are getting in the
17 community, outside of a nursing home. Because
18 Medicaid is the only payer.

19 And so there hasn't been any push from
20 the commercial sector, private insurance
21 companies, to build measurements. So the states
22 have been on their own in the wilderness,

1 building things as they go along, as best they
2 know how.

3 And so one of the things we've been
4 pushing with CMS, and Karen has been really
5 receptive to it, is adding other aspects not in
6 this pillar or context around this pillar, to
7 explain the LTSS aspects of a state Medicaid
8 program.

9 It is the highest spend, they are the
10 highest risk individuals. Almost, not all, but
11 very high number of them dual-eligibles.

12 So none of these data the state gets
13 for those focus really, unless they're molding a
14 Medicaid managed care plan, Medicare managed care
15 plan in a lot of states. So it doesn't address
16 that sector of our membership.

17 And so we're spending a lot of time
18 asking CMS to put some more qualitative measures
19 in, or at least explaining a little bit of the
20 work that the states are doing to address the
21 quality of care, to work on re-balancing, to get
22 people, transition folks out of nursing homes,

1 the things that are important to our consumers.

2 So this isn't the only, I just wanted
3 to let everyone know, this isn't the only piece
4 that we're working on, others way that are not
5 related to sort of NQF quality measures.

6 CHAIR ANTONELLI: Yes, thank you.
7 Jeff.

8 MEMBER SCHIFF: So I just wanted to
9 make a couple comments from the state point of
10 view because I think all of us and states try to
11 figure out how to leverage these measurements to
12 be effective. And although we report them, what
13 we do after we report them depends on the
14 easiest, not the easiest, one of the things is
15 from the managed care contracts, now we can put
16 them in our ACO contracts.

17 But I think that, to Kim's point about
18 what's an achievable opportunity, it's really
19 about how much energy we can put into how many
20 measures to really make a substantial difference.

21 Because every measure, if you really
22 wanted to do something that involves an adaptive

1 change where people actual adopt a different kind
2 of a behavior versus a technical change, let's
3 calculate BMI in our medical records so we get
4 the ding, the point, that is really the meat and
5 the potatoes of this to me because those are the
6 things that stick.

7 So I think that this scorecard will,
8 I think that a lot of us will use this as the
9 tool to go back and say, see, somebody said these
10 are really important and you ought to do these so
11 let's get on raising our rates around development
12 of screening.

13 And that's how this gets to be useful
14 so then we can do that. But this, in and of
15 itself, is not that adapted change, it just gives
16 you the selling point to be able to go out and do
17 that.

18 And I also want to, I think to the
19 point, to Clarke and Camille's points, there's
20 other things we have to focus on as well. So we
21 want to make sure this is in the proper context.

22 CHAIR ANTONELLI: Shayna.

1 MEMBER DAHAN: So my only, like,
2 blanket concern sometimes, when I look at these
3 scorecards and core sets, is that a lot of these
4 measures that are being measured, come from or
5 fall on the burden of PCPs who have high volume
6 and low resources and low staff. Specifically if
7 they're not affiliated with a hospital.

8 So sometimes I get concerned that when
9 you keep pushing at primary care providers, that
10 eventually it's just going to be about meeting
11 your paid for performance and you're cutting out
12 like the real quality of care because you're just
13 worried about what you're numbers look like and
14 you don't have the resources to actually do it
15 all.

16 So one of the, like, for example, the
17 developmental screening I think is really
18 important. But I also think that there's a lot
19 of kids that are screened through early
20 intervention.

21 So if that's not going to get captured
22 into the managed care plan that they had a full

1 early intervention screen, that there would be no
2 reason at that point to do it in a primary care
3 setting, that it's not going to look like these
4 children actually got screened.

5 So there is things that, I think that
6 when you pull data just from the EHR and claims,
7 that these services are provided from other
8 entities and that those things should be
9 accounted for as well.

10 CHAIR ANTONELLI: So if I'm trying to
11 extract the theme or themes from your comment,
12 the implications for the scorecard are what?

13 MEMBER DAHAN: It's to show where we
14 can improve, and hopefully that the states will
15 provide ways in which those areas can be improved
16 so that these processes can actually happen.

17 But I think that what falls into play
18 is that when this data is collected, the pressure
19 kind of immediately goes to one specific area of
20 health care delivery, which tends to be primary
21 care. And sometimes these services are actually
22 being provided.

1 So I just caution like continuous
2 pressure on one area without collecting the data
3 from all the other community resources that are
4 providing intervention. Such as school
5 counseling. Some of those kids are getting
6 screened for depression in the school, it's just
7 not getting billed out, you know.

8 And so those things I think there's a
9 lot of resources out there that primary care
10 providers are referring out to but it's just not
11 getting captured.

12 CHAIR ANTONELLI: Okay.

13 MEMBER DAHAN: So that's the thing.
14 So to drive health care based on data that's just
15 --

16 CHAIR ANTONELLI: So you would argue
17 that measures in the scorecard need to reflect
18 some aspect of integration?

19 MEMBER DAHAN: Exactly.

20 CHAIR ANTONELLI: Although the point
21 of measurement could be at the primary care
22 level. But I think that that's kind of the

1 spirit of the last day and a half anyway, and I
2 think you're point is really, very well taken.

3 It also resonates with Stephen's
4 challenge to the group about, so what if we're
5 measuring, what are we going to do with the data,
6 how do we feed that back into the system.

7 Okay, so I have Ken, David, Enrique
8 and then Sue on the phone, you're in the queue as
9 well. So, Ken.

10 MEMBER SCHELLHASE: And maybe somebody
11 has already pointed this out and I missed it, if
12 so, I apologize. But the way the scorecard is
13 structured right now, it's really for the
14 consumption of policy makers at a state level,
15 right.

16 If those scores are aggregated and
17 never disaggregated below the state level, then
18 as a health plan medical director, I have no idea
19 where my data sits in that little universe. I
20 could be killing it or I could be the worst,
21 don't know.

22 And even more so for consumers, for

1 patients, members of health plans, all they're
2 going to see is, well, Wisconsin's state Medicaid
3 is marginally better than average in newborn
4 something or other. And it doesn't help them to
5 decide, if they have a choice of I want to be in
6 HMO, Medicaid HMO A, B, C or D, it doesn't give
7 them that information.

8 So on the one hand we talked about the
9 risks, or the risks, the lack of risk adjustment
10 in some of these scores and that giving people
11 heartburn, but that's okay if you've got
12 aggregated state level data, but maybe it needs
13 to be disaggregated for the purposes of people,
14 individual members making decisions at a public
15 level.

16 Or maybe not publicly disaggregated
17 and feed back to health plans who are the ones
18 that might be able to develop programs to improve
19 their poor performance if when you disaggregate
20 it you see that, okay, children's community
21 health plan is really sucking wind on this
22 measure, what are we going to do with it.

1 So if it stays at that state level, I
2 think it's useful for state level policy makers.
3 But I have a hard time envisioning how the data
4 can be used to drive anything else.

5 CHAIR ANTONELLI: David.

6 MEMBER KELLEY: So in answer to the
7 first bullet I'll say that, in the scorecard 1.0,
8 nine of the measures that are on there are
9 measures that we already use in one or several
10 pay for performance programs. And the
11 readmission measure is added to the scorecard
12 that would make it ten.

13 So we're already paying attention to
14 most of these. And what we do is, we take, it's
15 two percent of the premium, to the managed care
16 plans and say, here is your potential upside.
17 Here's two percent.

18 And I think CMS allows up to five
19 percent. But we actually put two percent of
20 premium on the line with our MCOs.

21 So we expect our MCOs to be measuring
22 these. We meet with them quarterly and we want

1 to know, we actually make them run some of these
2 measures, not all, on a quarterly basis. Which
3 they really love doing that.

4 But we want to know why they're not
5 improving or why, what are they doing to move the
6 needle. So as a state program you need to be
7 able to measure, but measuring is fine, but you
8 have to really be able to put some dollars on the
9 table and you need to put infrastructure in
10 place, so that you're actually doing quality
11 improvement.

12 Working, we start by working with our
13 MCOs, but that then goes down into the health
14 systems. And they are, by contract this year,
15 have to get the 30 percent of value-based
16 contracting, which includes many of these quality
17 measures.

18 So from a state Medicaid perspective,
19 it's very important that CMS is looking at these.
20 I feel good that your first round of scorecards
21 was very similar to what we were, are we looking
22 at.

1 So from our perspective, really, you
2 can't just measure it, you really need to put
3 some dollars on the table to incent improvement.
4 And then you need to work with both the providers
5 and health systems to make sure that there are
6 positive incentives, not negative incentives, in
7 place so that folks are focusing, hopefully for
8 the right reasons, and really trying to get to
9 true quality improvement.

10 So I would respect that any changes in
11 the scorecard, final changes that CMS puts out
12 there, we will certainly be paying attention to
13 whatever those additional measures are. And
14 probably taking steps in the future to tweak our
15 programs that we have in place.

16 That takes time and contractually you
17 can't do anything until 2020. As far as any
18 contract changes, but that's how we would
19 respond.

20 So whenever you guys come up with a
21 final list, we might be thinking in terms of how
22 we're going to be changing the contractual

1 arrangements for their MCOs.

2 As far as the LTSS, just a quick
3 comment on that. Increasingly there are, will be
4 LTSS measures, and hopefully CMS will pay
5 attention to this. There are four LTSS measures
6 that are now NCQA starting this year.

7 There is a transition of care measure
8 that's actually now an NCQA measure. Not
9 necessarily specific to LTSS but we are using it
10 in one of our LTSS. We're making our plans to do
11 it around transitions of care.

12 And then I think using leveraging the
13 MDS, which is already there, to look at quality I
14 think would be extremely helpful.

15 We are actually looking at and are
16 developing the re-balancing measure that I think
17 is important to look at, but it has to be
18 interpreted very, very carefully.

19 So I'm going to repeat the concerns
20 about not having LTSS here. Fortunately, those
21 measures are still being newly implemented. I
22 failed to mention that the home and community

1 based CAHPS as well.

2 So it was good, the horizon looks good
3 for LTSS, but hopefully in the future you guys
4 will be thinking in terms of maybe perhaps adding
5 the future scorecards. At least something around
6 LTSS.

7 CHAIR ANTONELLI: Thank you. And,
8 Ken, are you back in the queue?

9 Okay. Enrique and then Sue.

10 MEMBER MARTINEZ-VIDAL: Thanks. So
11 Ken's health plan is one of our members, so he
12 said about two-thirds of what I was going to say.

13 And in my past life I worked with all
14 the Medicaid medical directors and Medicaid
15 agencies, so Dave said about the other third.
16 But maybe just to add one more point.

17 I think it's really important to think
18 about this, not in terms of both publicly, in
19 terms of public reporting, which is important in
20 and of itself, and it drives the policy makers,
21 but at the state level and then down to the plan
22 level, which is where I'm now working, I think it

1 really, it's great to have the P-for-P and
2 contractual issues and all that.

3 And that can help drive dollars and
4 all those things and focus, create focus on what
5 the state wants the plans to focus on.

6 You know, all our plans, they care
7 about all these things. It's not like they said,
8 oh, we don't care about immunizations, they do.
9 They care about all these things. They want to
10 improve quality.

11 A lot of times it's like, but how do
12 we do it. This is sort of Ken's point I guess
13 but I'd like to push it a little further. It's
14 like they do need help.

15 And we do this as an association, and
16 I know other folks are out there doing as it as
17 well. But it's like they need, and Jill
18 referenced this as well, it's like, we need help
19 understanding, what are best practices, how do we
20 redesign our plans, how do we redesign our
21 provider systems, how do we work on quality
22 improvement strategies like Dave said.

1 So, again, from a plan perspective
2 more broadly, I know that in my four months that
3 I've been at ACHAP, that's a lot of what I hear
4 is like, we get it, we want to do it, how do we
5 do it, what are the things we need to do to make
6 this happen.

7 So anything that can sort of push that
8 down to the plan and provider level I think will
9 be extremely valuable.

10 CHAIR ANTONELLI: Okay. Sue, you've
11 got the mic now please.

12 MR. HIRSCH: I'll be reading a comment
13 from Sue.

14 Quick comment to supplement Clarke's
15 point. What I'm hearing is that the measure
16 affects all populations. It may be of value to
17 call out how particular populations may be
18 affected or not adequately represented. For
19 example, if a subset of women are not accessing
20 mammography due to reduced access based on their
21 disability, would it be important for systems and
22 states to evaluate not only the metric, but also

1 root cause of decreased access among populations
2 to drive improvements?

3 CHAIR ANTONELLI: Thank you. That's
4 actually very helpful. So I've got Rhonda, then
5 I think Marissa your card went up again. Rhonda,
6 did you withdraw? Okay. So Marissa, Lindsay,
7 Clarke.

8 MEMBER SCHLAIFER: I was just
9 interested in learning and hearing the discussion
10 and the concerns about how these measures will
11 filter down or push down to the managed Medicaid
12 plans. I think I felt a lot more comfortable
13 today. And I think for those who are on the core
14 set work groups, I was the one that constantly
15 asked CMS, you know, when are we going to know
16 what measures are in the managed Medicaid quality
17 measures set? And are we influencing that in any
18 way? And up to this point, during those
19 meetings, it was well, we don't know.

20 And I think what I heard today that I
21 took great comfort in and it sounds like people
22 here have concerns, but I actually felt much

1 better when I heard that those measures that will
2 go toward the scorecard -- and tell me if I
3 didn't hear this correctly -- but the scorecard
4 for the managed Medicaid set -- for the quality
5 measures for managed Medicaid plans will come
6 from the scorecard. Initially may come -- no.

7 MS. LLANOS: I didn't say that.

8 MEMBER SCHLAIFER: Okay. Okay, but
9 this would be one source of potential?

10 MS. LLANOS: Potentially.

11 MEMBER SCHLAIFER: Okay. Okay.

12 MS. LLANOS: Potentially, but that's
13 not something I said.

14 MEMBER SCHLAIFER: Okay, then I
15 misunderstood. Because -- then I will say it
16 again. But I do think, you know, as everyone
17 said -- And I know, you know right now, it's
18 great to hear what states are doing when states
19 choose to do it. But speaking for -- speaking,
20 having been influenced by my former employer, you
21 know a PDM that works with many Medicaid plans.
22 And also now working for a different PDM that now

1 works with many managed Medicaid plans, it will
2 be so useful to have managed Medicaid quality
3 measures that are similar across -- you know, the
4 same across the country or at least put out there
5 for states to hopefully pick up, that will be out
6 there.

7 Because at least for the prescription
8 benefit side, there are nationwide firms that are
9 working with the different managed Medicaid
10 plans. So if that wasn't, I obviously
11 misunderstood. Because I think the more we can
12 do to get the quality measures the same across
13 the country would be helpful to allow
14 prescription benefit management companies to
15 really help push the -- at least the pharmacy,
16 potentially the schizophrenia measure and really
17 emphasize that.

18 MS. LLANOS: I'll just add, I think,
19 certainly alignment is one of our biggest
20 priorities at our agency. There is multiple
21 reporting programs that states and providers are
22 participating in. And certainly by leveraging

1 the core set, we're trying to not create yet
2 another set of metrics. Right? So to the extent
3 that the core sets influence measure selection
4 across other programs. And we always start with
5 what we already have states reporting. And
6 certainly there's really an emphasis on trying to
7 align.

8 CHAIR ANTONELLI: Lindsay, Clarke,
9 Carol.

10 MEMBER COGAN: So a lot of my comments
11 have been covered. The use of a scorecard at a
12 state level, in New York, we then take that,
13 apply it to each managed care organization. And
14 then they in turn will push that down and do a
15 similar scorecard to their provider network of
16 practices.

17 But again, just to emphasize, because
18 we've been doing a great deal of work with
19 practice transformation and getting better
20 insight into the practices and how they receive
21 that information. Without technical assistance
22 of what that scorecard actually means, it doesn't

1 go anywhere. In fact, it goes into the garbage
2 can most -- I would say most of the time.

3 So I just would emphasize that, that technical
4 assistance of this is what it is, this is what it
5 means, this is what you can do about it is
6 probably the most important thing.

7 And the other area that we struggle
8 with in a state level, not even bringing it to a
9 national or federal level is well we push similar
10 measures down, health plans will then choose
11 which measures they are wanting to work on
12 because of you know, maybe one lacks -- or has an
13 issue with child immunization. Another doesn't,
14 but they have some the provider network. And
15 then that provider is being asked to work on as
16 many as eight different measures based on -- I
17 mean they could have 14 different contracts.

18 I mean this is how complicated it
19 gets. And then there's no cohesion at the
20 practice level. They're being asked to work on,
21 you know, this panel. We have to worry about
22 child immunization. This panel we need to work

1 about anti-depressant medication management. And
2 then at the end of the day, we're not really
3 moving the dial on any one of those things
4 because resources are spread way too thin.

5 So if we could think about -- and I
6 don't have the answer, but if we could think
7 about again, that cohesion, alignment. And I
8 don't know -- I don't know what the answer is,
9 but you know, it goes back to that issue of
10 resources and you know, not being able to work on
11 everything. So I'm seeing the scorecard get
12 bigger and bigger and I'm having some angst. And
13 you know, it's important to address these issues,
14 but I feel like it we don't just pick just one
15 thing to work on, then no one's going to be able
16 to do everything. So that's just my thoughts.

17 CHAIR ANTONELLI: Clarke, then Carol.

18 MEMBER ROSS: I just wanted to build
19 upon Amy and Shayna's and Karen's observation
20 about other agencies. So there's the universe of
21 all these other agencies dealing with special
22 populations. But maybe there's a couple more

1 natural starting points. So the first thing that
2 the Commonwealth of Pennsylvania and the state of
3 Virginia did after the American Revolution was
4 establish a state mental health authority. Every
5 state has a state mental health authority. The
6 first thing most states did after World War II
7 domestically was pull out ID/DD population from
8 the state mental health authority and create a
9 state ID/DD authority.

10 So every state has a state mental
11 health authority and a state ID/DD authority.
12 And Camille might want to comment on aging and
13 disability. These are large consumers of
14 Medicaid dollars, particularly LTSS and HCBS, but
15 also acute on the mental health side. And some
16 of those state agencies are actually granted by
17 the state legislature, the administering
18 authority for targeted population and target
19 service. So they actually are quasi Medicaid
20 authorities in selected states.

21 So this might be a way to start the
22 dialogue about the potential of the scorecard and

1 what the state initiatives and ID/DD and Mental
2 Health are doing as a pilot to try to see how we
3 can get early intervention and maternal and child
4 health and special education and developmental
5 screening related too. But you need to start
6 somewhere other than the abstract. And so I
7 would state the state mental health authority and
8 the state ID/DD authority.

9 CHAIR ANTONELLI: Carol?

10 MEMBER SAKALA: So picking up on a
11 different set of comments in the room. I just
12 wanted to reiterate what I said yesterday that
13 the notice of proposed rulemaking comments due on
14 Monday are for the Medicaid managed care
15 organizations include the quality rating system
16 that they will have. And the proposal is there
17 to align with the scorecard among other
18 proposals. So if you want to weigh in on that
19 quickly you can do that.

20 And secondly on the how do we do it?
21 How do we get help? I don't know about other
22 fields but there's a pretty good national network

1 of perinatal quality collaboratives now. And I
2 know for that field at least, you can contact
3 your state folks and that they identify priority
4 projects and work on them. And you can get
5 technical assistance that way.

6 CHAIR ANTONELLI: Karen, would you
7 like to make any comments? And I'll give the
8 last word to you and then we'll move on to the
9 next agenda item.

10 MS. LLANOS: So Lindsay made a lot of
11 my comments, so I won't -- I think that I was
12 just going to react to the earlier comment about
13 whether or not the scorecard would ever provide
14 other levels of data than states. And that is
15 something that because these are data from
16 states, that there is an expectation that states
17 are -- and let me just step back -- I don't think
18 CMS thinks that the scorecard is the only public
19 reporting tool ever established or that we just
20 came up with this idea. So I think we are -- we
21 acknowledge that states are using their own data
22 to do a variety of different things; monitoring

1 behavior performance or public reporting. And
2 have done so with their providers and health
3 plans for many, many years.

4 This is an opportunity for us to
5 provide or highlight on a more national level,
6 the data that everyone's been submitting to us on
7 quality. Which has also been available
8 previously, but this is probably going to give it
9 a little bit more emphasis than before, in
10 addition to administrative level data that we and
11 our state partners have been collecting for many
12 years. So this is a compilation of data in terms
13 of how states work with their providers and
14 health plans. And certainly we want them to
15 continue the great work that they've been doing
16 on provider profiling and best practices and QI.

17 So I think we see the scorecard as one
18 of many steps that we are taking to help our
19 state partners and to help ourselves get on this
20 path to quality improvement. And to better
21 understanding how to use data. And it is the
22 natural next step based on all of our collective

1 efforts to start eight years ago on doing
2 standardized reporting. So I think we see this
3 as a continual evolution. And know that public
4 reporting on the national level is just one
5 piece. And that it has to be tied to better
6 understanding how to -- what does this -- what do
7 these data represent in helping our state
8 partners and ourselves understand how to move the
9 ball forward for everybody.

10 CHAIR ANTONELLI: Thanks a lot. All
11 right, so we're going to transition now to the
12 next and I think final agenda item. And you get
13 to listen to Harold now.

14 CHAIR HAROLD PINCUS: Rich has been
15 sort of doing the heavy lifting of this meeting.
16 And I really appreciate his leadership there.

17 So this is -- actually there is a lot
18 of overlap with these discussion questions and
19 the ones we just had. This is taking it more
20 from a future perspective to get us to begin to
21 think and assist CMS to think about how we
22 foresee or how we would like to see the scorecard

1 move in the future and you know, in the
2 discussion questions before. But actually Karen,
3 I was wondering if you could remind us about the
4 timeframe because I think that would be helpful
5 in sort of setting some stage for how we think
6 about -- what do we mean by the future.

7 MS. LLANOS: Yes.

8 CHAIR PINCUS: And what's your
9 timeframe in sort of thinking about the next
10 steps?

11 MS. LLANOS: Yes, so our -- so we've
12 got kind of short and long-term horizons. The
13 shortest horizon is finalizing the measures
14 that's across all three pillars for the fall
15 release. And that will happen in the next
16 several months. So this is certainly a vital
17 conversation to have now.

18 In terms of the longer term horizon,
19 there are, as you mentioned many, many factors
20 currently at play including a lot of what we
21 discussed. And having also just had our NAMD
22 meeting with our state partners, a lot of the

1 same similar themes came up in terms of what
2 needs to be defined at a CMS level? How will the
3 scorecard look like in the future? So we think
4 of this as kind of multiple next steps.

5 The first one is how to get to the
6 finish line for the fall release because we know
7 that has -- is already set in motion. While
8 we're doing that, we have the ability to take a
9 bit of a step back. So we'll have almost two
10 releases under our belt. We'll have enhanced
11 functionality, which is one of the biggest pieces
12 of feedback. We'll have a process or a timeframe
13 for having more recent data, because that was the
14 other piece? Right? So because of the fall
15 change, we'll now have the ability to leverage
16 the latest core set data that would be available
17 publically.

18 But we're also taking a step back at
19 this time in trying to understand what do we need
20 to define from the CMS perspective in order to
21 give the scorecard a tighter shape than it has
22 before? And a lot of the questions that we're

1 struggling with are ones that certainly we've
2 posed and we've heard here. Do we include --
3 continue to be a small parsimonious set? Or do
4 we include all of the core measures and highlight
5 keys areas of focus? Right? There's pros and
6 cons to all of this. How do we better or best
7 create efficient ways of connecting the scorecard
8 and the core set initiatives so that it is a more
9 seamless process, particularly for Pillar 1?

10 And certainly as we think about all of
11 the collective feedback, because we've used many,
12 many approaches this year, how do we ensure that
13 we're getting the broadest set of feedback across
14 all the pillars? So we've got a lot of questions
15 to define in the next, I would say six months,
16 that would impact releases that go past this next
17 Fall release.

18 CHAIR PINCUS: Just to follow up on
19 that. So we have -- So in six months, roughly
20 somewhere in October, November, September, you're
21 going to be actually formally releasing--

22 MS. LLANOS: Yes, so --

1 CHAIR PINCUS: -- with the expectation
2 --

3 MS. LLANOS: -- November is our
4 tentative release timing for the next scorecard
5 release. And that would reflect changes to -- or
6 potential modifications to all three pillars, as
7 well as enhanced functionality. And then we
8 would go on an annual release thereafter. So as
9 you can imagine, we're almost always in the cycle
10 of development.

11 So a lot of what we would be
12 discussing in the weeks to come are what is --
13 based on everything that we've heard so far and
14 all our collective conversations in terms of the
15 content changes that we've already shared with
16 you guys in terms of additional measures, what is
17 most viable for this next release? What needs to
18 be phased in for a future one based on data
19 availability or data accuracy. As well as taking
20 into consideration, kind of this big versus small
21 and all these other changes that we're defining.

22 CHAIR PINCUS: So two other just

1 questions again in terms of thinking a timeline.
2 So do you see this kind of annual release going
3 on sort of until 2024, which is sort of the -- we
4 see these sort of qualitative changes in how you
5 would do things once you get to that point?

6 MS. LLANOS: Yes, I think 2024
7 signifies -- Well I would say I think any changes
8 that's tied to the mandatory reporting would
9 probably need to happen before 2024, right, in
10 terms of that. I think we have initially thought
11 of the scorecard as an annual release. Because
12 we are not tied to statutes, certainly I think
13 we're flexible of terms of what that would mean.
14 So we don't necessarily have to do an annual
15 update or change statutorily. So for now, that
16 is the plan, is to go into an annual cycle. And
17 that could go well beyond 2024.

18 CHAIR PINCUS: And I guess the other
19 thing is the, you know, the continued discussion
20 we've had about the relationship between the core
21 set and the scorecard. And I just sent you like
22 actually literally last night -- I don't know if

1 some of you got an email, I guess from
2 Mathematica about today being the deadline for
3 making suggestions for the core set.

4 MS. LLANOS: Well so it's nominations
5 for --

6 CHAIR PINCUS: Yes, nominations --

7 MS. LLANOS: -- the CMCS core set
8 update process. So that's the process that we
9 have talked about that is set in statute. And
10 our center has the ability to choose whoever they
11 want to, to lead that process. And Mathematica
12 is the folks that are leading that process this
13 year.

14 CHAIR PINCUS: So that will be a
15 continual process also on an annual basis and
16 that's in statute?

17 MS. LLANOS: That isn't -- there is a
18 requirement that our agency releases annual
19 updates on the adult and child core set. So that
20 is base and statute. I would not want to go into
21 detail because I'm not the one leading this.

22 CHAIR PINCUS: Okay.

1 MS. LLANOS: I certainly encourage my
2 co-workers if they're on the line and want to
3 make a comment -- but that is -- that is the
4 statute. And I will say I think certainly from a
5 historical perspective, we have used various
6 different entities from the beginning. I don't
7 know if any of you were part of the AHRQ process
8 back in -- So we've tried different iterations of
9 how to get to this annual update cycle. And this
10 is the latest one.

11 CHAIR ANTONELLI: Okay. Does anybody
12 else from CMS want to make a comment about the
13 future schedule and their perspectives that are
14 on the line?

15 MS. RANEY: So this is Gigi Raney.
16 Hi.

17 CHAIR ANTONELLI: Hi, Gigi.

18 MS. RANEY: Can you hear me? Hi. I
19 think Karen got it exactly right. We continue
20 our annual review of the adult and child core
21 sets as required by statute. The information
22 that you got yesterday is about our core set

1 review process that we're going to be doing,
2 which will be updating the core set for 2020. So
3 nominations are due by the close of business
4 today. And we'd like to encourage you guys to
5 think about applying or sending it on to someone
6 that you think might be appropriate.

7 But we are required by statute to
8 review the core sets annually. We are not
9 required to update them, but we are required to
10 review them and take a look at them, which is
11 what we've been doing under previous years
12 through an NQF contract vehicle. And now it is,
13 as you stated, a new contractor is working with
14 us on that process.

15 CHAIR PINCUS: Okay. Thank you, Gigi.
16 So comments from around the table with regard to
17 the future? How you would -- suggestions you
18 would have with regard to -- you know,
19 particularly from let's say Medicaid perspective,
20 what do you see the scorecard involving in the
21 future? How one can maximize the functionality
22 of the scorecard? How can we sort of think about

1 the development of the scorecard and ways that
2 maximizes its impact? And also to maximize the
3 input from not only states, but also various
4 stakeholders in that process.

5 MS. LLANOS: Can I put a little bullet
6 on that? I would -- Because we are having lots
7 of conversations on the size, it would be really
8 helpful if folks wanted to share their feedback
9 in terms of keep it small, it would so much
10 easier if you'd just all of the core sets. I
11 mean if there's any initial reactions, I think
12 that would be super helpful for us.

13 CHAIR PINCUS: So Carol, David,
14 Rhonda, Jill, and I can't see which -- okay, I
15 couldn't see the depth perception of who -- okay,
16 and Judy and Lindsay.

17 MEMBER SAKALA: Great, so I have some
18 proposals for building out the framework moving
19 forward. I think that the domains are great.
20 And I'm proposing -- this can be literal, but
21 also figuratively, thinking of a grid. So you've
22 got your domains and the measures that fall under

1 them. And then across the core populations that
2 you're serving. So LTSS, children, child-bearing
3 women and newborns, women of reproductive age. I
4 think these are all large key groups in there.
5 And I'm sure I'm missing some.

6 But anyway, I think that this would be
7 a kind of a check on what is in the core set and
8 what would be available that would apply to those
9 various populations. I really liked what Jeff
10 said about a kind of signal -- sending a signal.
11 That I think this is really important to the
12 people in the field about that.

13 And some thoughts about possibly
14 changing the rules and the parameters. One would
15 be to have maybe -- if it hasn't reached 25, to
16 have a developmental category saying in two years
17 we'll be, you know, going in this place in terms
18 of filling gaps. And I think this is going to be
19 a little harder to move forward. But I just want
20 to suggest that it's possible to say if it's not
21 in the core sets, we should look at this.

22 And the reason I think of that is

1 because we, on the core set groups, have made
2 recommendations that we support. But CMS,
3 because of the pressure to go incrementally, has
4 not taken those up. So there are other measures
5 that we have supported that potentially could
6 fill glaring gaps in this grid that would be out
7 there. And I think we can also look at that in
8 the core set work or whoever's involved with that
9 moving forward.

10 And lastly, I would think that the
11 North Star -- I mean I love what I've heard from
12 the Secretary, states should be leading
13 transformation. We're going to drive outcomes.
14 We're going to drive value. I mean I think that
15 should be the North Star here of whether the
16 items that populate that grid, conceivably can do
17 that.

18 CHAIR PINCUS: Rhonda?

19 MEMBER ANDERSON: I like Carol's
20 comments here about how to develop a grid. But I
21 want to go back to Lindsay's comment earlier
22 about so many measures that it sometimes is

1 overwhelming. And I know we had this discussion
2 on the map about what are the basic foundational
3 measures that are going to begin to help us make
4 the major changes that we need to make?

5 And so I just want to caution us that
6 maybe it's not about the question, large numbers
7 or small numbers, but it's more on the
8 foundational side of what will make and bring
9 major change to the improvement of health and
10 well-being of individuals in the Medicaid space?
11 And then build on those, almost like Maslow's
12 Hierarchy if you will, cautioning us though to be
13 sure that we're not adding measures to just add
14 measures.

15 And I know we all believe that, that
16 shouldn't happen. But we also sometimes get very
17 excited about oh, this measure or that measure.
18 And so I just want to be sure that we're looking
19 at the scorecard side of this. That we really
20 ask ourselves the question. Are these
21 foundational measures as implemented going to
22 really make a major difference in the health of

1 our population?

2 CHAIR PINCUS: Dave?

3 MEMBER KELLEY: A comment on the size
4 of the scorecard. I think we're close to just
5 about right. When we've developed our program,
6 we try to keep it around ten or less. Because
7 otherwise plans, providers either get burned out
8 or lose focus.

9 So I'd like the size of where we're
10 at, even with some of the additions, probably
11 okay, like I'd say lump all the well-child visits
12 into one measure when I look at it. Because
13 providers should be focusing on the well-child
14 visits across all of those age domains. So I
15 think the size of where we're at is good to
16 expand too far.

17 I think if you look at the entire core
18 set, we do look at the entire core set, but it's
19 easier to have our plans focus. We focus on the
20 core measures -- the performance measures. We
21 also look at other measures where our plans are
22 let's say underperforming. So I think staying

1 focused on a smaller subset is very useful.

2 I would like to see, I think, in the
3 future, some of the measures that we talked about
4 are not perfect. I'd like to see the postpartum
5 measure be updated down the road per where the
6 direction that NCQA is headed.

7 I think similarly, I'd put a plug in
8 for NCQA and/or others to maybe take up either
9 stewardship or look at the developmental delay
10 and help to work with that current steward to
11 make it happen, so that it gets NQF endorsement
12 and maybe gets tighter and better developed so
13 that there is consistency.

14 And around readmissions again, I think
15 NCQA finally got their Medicaid readmissions back
16 up and running and functional, which I think
17 should really help considerably in standardizing
18 how that's measured across plans. So I think
19 those are some specific things that hopefully
20 will get better over time.

21 I also think that we need to think in
22 terms of CAHPS survey and really looking at

1 consumer experience. And we have some measures
2 there now. I did propose both smoking and
3 immunization be looked at. I guess they just
4 missed the threshold. But those two things,
5 smoking kills, you know, almost a half a million
6 people every year. And depending on the flu
7 season, between 20,000 and 50,000 people die from
8 influenza. So I think we need to think in terms
9 of what are things that we should focus on that
10 are simple things that hopefully prevent --
11 improve the population health and prevent
12 mortality?

13 And then I'll reiterate my previous
14 comments about the LTSS measure set to also
15 include in terms of something from the community
16 based CAHPS survey or the MDS. I like the
17 population grid. In my grid, I would have kind
18 of populations. But I would also be thinking in
19 terms of what are some of the high cost issues
20 within some of those populations to focus on?

21 And then I think certainly looking at
22 -- being able to look at outcome measures. We're

1 always looking for that -- the holy grail but we
2 haven't found it yet. Think in terms of
3 mortality as an outcome. What are some of the
4 quality measures that we need to look at that
5 would reduce mortality within our population?

6 And then lastly I think being able to
7 look at social determinants in health. And
8 looking at how that may or may not impact any of
9 these scorecard measures.

10 CHAIR PINCUS: Ken, Jill.

11 MEMBER SCHELLHASE: I'd echo a lot of
12 what's been said already. I guess a couple
13 additional thoughts. I've heard that, you know,
14 if you've seen one Medicaid program, you've seen
15 one Medicaid program. And so I recognize that
16 what I'm going to suggest may take more bandwidth
17 than exists in the programs that do this. But
18 talking in as much detail as possible with state
19 Medicaid leadership and as many states as you can
20 possibly talk to, to find out what they think
21 would make the scorecard more usable for them and
22 for their constituencies. I think that, that

1 would be in an ideal world, a really helpful
2 thing to do.

3 And at the same time, I think that
4 would be help you to avoid -- I'm not sure
5 exactly how to characterize, sort of measures
6 that are very close, but not quite the same as
7 what the states are already doing. Which can
8 make people tear their hair out in trying to, you
9 know, develop programs where it might work for
10 one nuance of a certain measure, but doesn't work
11 for another one. And that's just -- that's a
12 head versus banging the wall experience that most
13 of us want to avoid.

14 So it would potentially -- those
15 detailed conversations might lead to discovering
16 ways to tweak our measures or the states can
17 tweak their measures. And not have sort of this
18 close call duplication, which really isn't quite
19 the same thing -- quite the same measure.

20 CHAIR PINCUS: Jill?

21 MEMBER MORROW-GORTON: So I agree with
22 David around a number of things. I like to think

1 about a scorecard as a report card. But I also
2 like to think about it from kind of the business
3 world as a balanced scorecard. So I think it
4 should include measurements from across your book
5 of business -- sorry for the business world
6 language -- that reflects how you're doing in
7 various areas. You can't measure everything
8 you're doing, but it should be a signal. It
9 should be a sentinel number that will tell you,
10 are you doing well? Are you not doing well?

11 In terms of evolution, I think that
12 balancing what's there is important. I think
13 that getting rid of measures when you've gotten
14 close to them being pretty good across the board
15 needs to happen. And that requires kind of
16 regular evaluation of the measures. And I think
17 that it might be worth -- you know, so David
18 talked about lumping all of the well-child visit
19 stuff. Well it might be interesting to think
20 about is there a way to sort of make a composite?
21 Because is there a difference between a visit for
22 a 10-year-old and a visit for a 12-year-old?

1 Well, probably not that much. Right? Whether
2 they get -- and sometimes they get put in
3 different groups.

4 So I think -- I think that's one way
5 to think about it. And I think the other thing
6 to think about is -- NCQA goes through their
7 improved -- measure improvement process, right,
8 as measures get evaluated, get redone to improve
9 them after people have learned. Then we can
10 incorporate that improvement into the scorecard.

11 CHAIR PINCUS: Okay. Lindsay and then
12 Judy and Jeff.

13 MEMBER COGAN: Yes, my comments relate
14 back to the overall number of measures on the
15 scorecard. So in New York State, we used to do
16 -- We've done pay for performance and
17 incentivizing plans for, you know, well over 20
18 years. And when we first started, we started
19 with a very small set, five, ten. And what we
20 found was a lot of sort of teaching to the test.
21 And they only care about those ten measures.

22 So we tried something a little

1 different and we expanded it. So then we made it
2 like 30, which if you -- We do have composites,
3 so actually it's much more than 30 if you break
4 out the individual components. And our infinite
5 wisdom was, you know, to have that flexibility
6 and not just have people teach to the test. And
7 some plans maybe that would give them the
8 flexibility to focus and hone in on those areas
9 where they're not achieving a high performance.
10 But now we're coming back the other way.

11 So what we found was again, everyone's
12 spread too thin. They hated that, especially the
13 providers. So now we're kind of coming back to a
14 much smaller focused, tailored, you know, curated
15 list. And so we're thinking about the Super Six
16 to get, you know, fun with it. And we're
17 thinking about aligning that Super Six across
18 pairs. So in our multi-pair commercial, going to
19 Medicare and taking more of a MIPS approach, you
20 know, high priority measures. They can't all be
21 outcomes because we don't have an outcome measure
22 for everything at this point. So those

1 evidence-based process measures that are very
2 closely tied to an outcome. But we've really --
3 you know, done through measure prioritization
4 exercise over the last year. And that's where we
5 think we're driving is to again.

6 So our recommendation would be with
7 the scorecard, don't put them all in. Unless the
8 scorecard is really just a way to help visualize
9 or show some things that are different than the
10 core set, I would say stay away from putting
11 everything in. And again, like Jill mentioned,
12 sort of those high level indicators for certain
13 things and again to echo that the best or the
14 most important things. And that's incredibly
15 difficult to do. But that would be, I think in a
16 forward -- looking forward, that would get us
17 where I think we all want to get is to see that
18 system level change. And if we don't narrow and
19 focus, we're going to stay in this world of we're
20 all looking at different things and not get a
21 collective drive forward.

22 MEMBER ZERZAN: So yes, I think my

1 preference would be to keep the scorecard on what
2 CMS really wants to focus on. As others have
3 said, the core set of adult and child measures is
4 great, but it's way too many to focus on. And
5 some of them are hard for states to do. There's
6 also quite a bit of state variability, having
7 come from one state to another where Colorado
8 didn't do any hybrid measures. We just did
9 administrative measures. And I know that other
10 states do that also. Versus hybrid measures,
11 states have different eligibility things.

12 So the core set is a little hard to
13 interpret. And I think there's some opportunity
14 with the scorecard set to try and get around
15 those or focus on some that perhaps might be a
16 little more similar. That being said, I know
17 there will be plenty of states that will say mmm,
18 I don't really care about my performance or I'm
19 just doing this because I have to. Other states
20 will actively be in competition because
21 Washington is way better than Minnesota or
22 Pennsylvania.

1 MS. LLANOS: That's right. Bring it.

2 MEMBER ZERZAN: So I think that the
3 value of the scorecard is that it more focused
4 and can get people together. The larger set is
5 helpful so that if you're going to pick measures,
6 you can pick measures off of a set, so that
7 you're not making up too many extra measures.
8 And there may be some alignment. But I think if
9 you really want to put a focus on something,
10 having the scorecard at about the level that it's
11 at now is enough measures to make an impact.

12 And then I'd also say that not
13 changing it a lot, sort of slowly tweaking it
14 over time is also very important because these
15 are all very hard things to change. And practice
16 transformation is very hard. So I'd say it takes
17 two or three years to really start to see the
18 impact of some of this change. And I think you
19 need to allow for that. And showing some of the
20 trends over time is going to be where some of the
21 value is at.

22 CHAIR PINCUS: Actually I had myself

1 in line too. So let me step out of the chair
2 role for a moment. There were three points I
3 wanted to make. One specific to a particular
4 domain and then two broader comments.

5 One is you know, we have fairly
6 limited focus in terms of alcohol and other drug
7 abuse problems. And the one that we have from
8 the core set that's in the scorecard is
9 initiation and engagement. And I came very close
10 to recommending that being removed. But I didn't
11 because I thought it would be sort of a useful
12 place-saver.

13 But there is some clear problems with
14 that measure based upon a project that we had
15 done several years ago where we did a national
16 evaluation of the VA mental health system. That
17 you're actually penalizing providers that screen.
18 Because if you're screening people, you're
19 finding people who are less motivated and less
20 likely to follow up.

21 And so it's -- and initially going
22 back, you know, years ago, this was part of

1 Washington Circle measures that included
2 identification, initiation, and engagement. The
3 identification one was left out because it's not
4 really a quality measure. But it does -- it's
5 sort of a balancing measure. So I think it's
6 good to have something for -- something other
7 than opioids as a place-saver. But I think some
8 work on getting something in there that
9 incorporates some screening element to it, would
10 be important.

11 Two broader issues, you know since
12 we're looking at a timeline that at least extends
13 to 2024, there's a couple of other things to
14 think about as one moves along that timeline.
15 Number one is we've talked a lot about having
16 sort of the importance of different domains and
17 different populations. But I think one thing we
18 haven't talked a lot about is the actionability
19 as a criteria in terms of what are the leavers
20 that states and states through plans have? And
21 to think about that in a very specific way in
22 terms of learning from what has been done in

1 terms of the more actionable elements and
2 mechanisms for that.

3 Number two is this is actually
4 something that Shayna had brought up earlier on a
5 side conversation is that you know, around here
6 we have all, you know, different stakeholders.
7 But one group of stakeholders we don't have are
8 information system vendors and people with
9 expertise in informatics. By the time, you know,
10 we get to 2024, there's going to be a lot of
11 changes in terms of the availability of
12 technology. And that ought to be anticipated as
13 things move forward.

14 You know, I came here from a meeting
15 that I co-chaired with Bill Galley from Calgary.
16 The Quality and Patient Safety Committee for WHOs
17 ICD-11. So people, when I say ICD-11, people
18 will say what are you talking about? We just put
19 in ICD-10. Actually the rest of the world was
20 using ICD-10 for over two decades before we got
21 to it.

22 So ICD-11 is actually approved by the

1 World Health Assembly. And it's built on more of
2 an informatics framework, so that quality and
3 patient safety activities can be pulled in, you
4 know, through the ICD-11 in a much more specific
5 way than in the past. And I'm not saying that,
6 that's a be-all and end-all, but we ought to be
7 anticipating all of the different opportunities
8 that might exist as technology evolves over the
9 next, you know, five to ten years. And they
10 should probably involve the stakeholders in the
11 process.

12 CHAIR PINCUS: Jeff and then Pamela.
13 And, Candy, is yours still up or is that
14 residual?

15 MEMBER SCHIFF: I think I'm breaking
16 into a cold sweat about ICD -- what was that
17 number again, 12?

18 CHAIR PINCUS: Eleven.

19 MEMBER SCHIFF: I just had a -- I feel
20 like this is a lumpers and splitters conversation,
21 you know about -- that we're having. But I
22 wanted to -- And some of the work on social

1 determinants is about this, but I think that if I
2 thought about where the set could evolve
3 potentially, it may be around sub-segmenting some
4 of the populations for some of the measures. Not
5 creating new measures, but you know, the
6 developmental screening is an issue, you know,
7 for different kids with different race and
8 ethnicity.

9 Same thing you could say for some of
10 these measures around disability. So I think
11 that's a place where the measures could evolve
12 that would be helpful. And I know that some of
13 the core set measures, there's a request to
14 submit them by subpopulations, although I can't
15 remember the details right now.

16 The other thing I was just going to
17 say is that some of the work I presume in the
18 other two pillars could relate to -- or
19 inner-relate to the quality here. And I'm not
20 sure what's going to be in the other two pillars,
21 but I'm thinking about things like continuity of
22 enrollment for example or things like that, that

1 may have a big impact on whether or not people
2 get their vaccinations.

3 So I think that some interplay of the
4 pillars may really be an important way to move
5 state systems and quality forward. Because if
6 every -- if systems specifically for example
7 don't have continuity of enrollment for whatever
8 reason are less so, they may have poor results on
9 these. So I'm just suggesting that we look at
10 that.

11 And then I just want to say one other
12 comment about the -- every state Medicaid system
13 is unique and perfect in its own way. But I just
14 want to say that we use -- we use social proof a
15 lot in our state systems to get our states to
16 move. So I can look at Dave's measures and say
17 look at all they're measuring and including it
18 with programs in Pennsylvania to get Minnesota to
19 think about whether we're using our withholds
20 most effectively. So I want to -- I just want to
21 be clear that that's part of the leverage we use
22 is to go talk about what our other colleague

1 states are doing.

2 CHAIR PINCUS: By the way, with regard
3 to segmentation, we actually did a project with
4 the Commonwealth Fund that came out of it a
5 recommendation that there be -- that people with
6 severe mental illnesses be considered a
7 disparities category and that it would be
8 relatively easy to sort of segment, sort of
9 general health measures by that category to look
10 at their disparity. And that's something -- a
11 strategy that adds very little additional effort
12 --

13 MEMBER SCHIFF: Right.

14 CHAIR PINCUS: -- that can identify
15 areas where you can change things.

16 MEMBER SCHIFF: And like the health --
17 Similar to that, the health home measures, which
18 a lot of our -- most states are related to
19 behavioral health conditions are some segment of
20 -- some of those measures overlap and they're
21 reported specifically for the people in that
22 population.

1 CHAIR PINCUS: Exactly. So Kamala and
2 then Rich.

3 MEMBER KAMALA ALLEN: Thank you. And
4 I apologize. I have a long list of comments.
5 I'm making up for being somewhat less verbose
6 yesterday.

7 So to Karen's question about core set
8 measures or not, I think I would agree with
9 what's been said now by several people, not in
10 terms of pulling all of those into the scorecard.
11 I think the -- at least what I understood
12 yesterday about the intent and value of the
13 scorecard was that we want to elevate certain
14 levels for public reporting. And it's not just
15 about what we're collecting and working on within
16 our states and within our systems. But from a
17 policymaker perspective, what do we want to put
18 forward as a parsimonious set of measures to
19 really provide a comprehensive picture of health
20 of the population. And so from my perspective,
21 that would not be consistent with the inclusion
22 of all core set measures.

1 As I think has also been said, I think
2 it would be really helpful to have a better sense
3 of the CMS priority when we come into this
4 discussion. Because I think as we saw today,
5 there's several measures that could be related to
6 a particular topic. Some already on the
7 scorecard and some that are proposed for
8 addition. How do we as a group make a decision
9 about the -- you know, in the context of there
10 being a tension between not including all core
11 set measures and including those that we really
12 want to elevate and focus on.

13 I think what was also said was -- I
14 think Joe mentioned the fact that we want to --
15 when measures get to a certain level of
16 performance, thinking about rotating those off.
17 Hopefully we won't then kind of drop in
18 performance once they are no longer on the
19 scorecard as we then prioritize issues that are
20 maybe at that particular point in time, more
21 pressing. That there's more energy or concern
22 around. And some guidelines and guiderails

1 around how to do that.

2 I want to actually say that there is
3 kind of tension here as well because when we
4 rotate off, then we lose the ability to continue
5 to look at those trends. And so thinking about
6 the value of trends and how we do that in that
7 context.

8 And then the last point -- Actually
9 Harold, you made some things -- made a point very
10 similar. We talked about on the child core set
11 discussion, the gap area of adolescent substance
12 use being one that required attention. And so I
13 just would like to kind of put that out there
14 again that, you know, as NO CHCS, we are about to
15 embark on a process to work on that. But that as
16 we think about what the gaps are, having some
17 discussion or feedback loop from the scorecard
18 group.

19 And I know, as Karen said, that we're
20 really looking at the core set as the feeder into
21 the scorecard, but making sure that there is
22 feedback from any discussion that might happen

1 here around gaps that then gets translated back
2 to that process. And I know that, that process
3 is no longer here in QI with Mathematica and just
4 making sure that there is some mechanism for that
5 connection. Thank you.

6 CHAIR PINCUS: Rich.

7 CHAIR ANTONELLI: So in the last six
8 years in this room, I can count on one hand the
9 number of comments that I've made that actually
10 is coming as a pediatrician. So that's the frame
11 for what I'm about to say.

12 CHAIR PINCUS: I thought everything
13 you say comes from a pediatrician.

14 CHAIR ANTONELLI: It applies to frail
15 elderly, as much as it does the NICU graduates.
16 But this one is actually going to be as a
17 pediatric observation that I want to make.
18 And I would probably have asked Sally to make
19 this comment representing CHA, but I am concerned
20 about the results of yesterday's discussion.

21 I want to come to the discussion
22 around the hypertension piece measure, just as an

1 example. So this is not about that measure, but
2 that whole notion that many of these measures
3 start at the age of majority without any
4 biological underpinnings at all or even often
5 times socioeconomic or psychological dynamics.
6 And really there is a population that is very
7 analogous to the population that Clarke and Amy
8 and Camille have talked about as well. And these
9 are youth and young adults and adults that have
10 complex needs that aren't a big enough prevalence
11 population that I can make a meaningful argument
12 to get them onto any individual Medicaid
13 director's radar screen.

14 And so in Massachusetts in the land of
15 RomneyCare and I'm proud to be there, patients
16 that are 18 plus, I call medical home refugees.
17 They're attributed to ACOs. Getting them into
18 any semblance of an adult care model is -- it's
19 challenging. I'm a pediatrician and I take care
20 of women up to the age of 50 that have
21 significant neurodevelopmental disabilities. And
22 it's not that Boston has a dearth of providers.

1 And so I really need to call out this notion that
2 there are youth, young adults, and adults with
3 pediatric or childhood onset conditions that
4 don't fall under really any of these measures
5 very well.

6 Now the collective wisdom might be the
7 scorecard isn't the place to put them and that's
8 okay. And maybe that would be the core set. But
9 even that's a bit challenging. So in this room
10 in May, we promoted to sickle cell measures,
11 antibiotic prophylaxis at the time of diagnosis
12 and cranial ultrasound. And if you're not
13 clinical, trust me those are two very important
14 ones. And the first one actually is a lifesaving
15 one that costs about 19 cents a day.

16 But yesterday the comment was made on
17 the opioid measure about, you know, gee patients
18 with sickle cell, are they in or out? And I --
19 that put a bit of a stake in my heart because we
20 don't have a way of getting measures into the
21 discussion here if they don't find the way to the
22 core set. So we don't have any quality measures.

1 In the case of antibiotic prophylaxis,
2 potentially a lifesaving measure isn't in scope.
3 But we can talk about patients with sickle cell
4 disease and whether they're going to fall into
5 the 120 equivalence of morphine per day, you
6 know, opioid dependence measure.

7 There is a chasm there that I find
8 deeply disconcerting. I think there are some
9 administrative issues that we need to think about
10 in terms of these sort of, we'll call them
11 special populations -- it could be schizophrenia.
12 I think about children, youth, and young adults
13 with these complex needs. So it's really very
14 much a plea.

15 So to bring this home to something
16 positive, which is why when I was on the
17 coordinating committee at the MAP, people used to
18 think that I was a geriatrician. In the space of
19 integration and measurements -- and performance
20 measurements, what is a patient engagement around
21 a co-created plan of care? What does the handoff
22 look like from one provider to another one,

1 setting to another?

2 I'm very comfortable riding the
3 coattails of predominantly adult-focused
4 measures. I really am when it comes to care
5 integration. But there will be times -- and I
6 think that patients with schizophrenia is one
7 population and neurodevelopmental disabilities in
8 general. These are left-behind folks. They
9 really are medical home refugees. And I just
10 felt the need to share that.

11 CHAIR PINCUS: Thank you. So any
12 other comments, questions? Oh, I didn't even see
13 it. It's sideways.

14 MEMBER OKRANT: Elisabeth. Sorry.

15 CHAIR PINCUS: Okay, Elisabeth.

16 MEMBER OKRANT: I just wanted to also
17 kind of make a plea also around substance use
18 measures. I also almost put the IET measure up
19 for removal, but because it's really the only
20 measure in there, I didn't want to do that. So I
21 think it's really important to start thinking
22 about measures that measure substance use as a

1 chronic disease and getting those kinds of
2 measures into the scorecard.

3 I also think that some of the
4 information that can be extracted from IET in
5 terms of actionability is really about
6 stratifying that measure from OUD and AOD, and
7 where that person was identified or indexed. So
8 really the rich data in terms of IET comes from
9 stratifying it. So it's really a shame to just
10 have one rate or, you know, a numerator and
11 denominator.

12 I also just also wanted to put out
13 there that patient-reported outcomes, I hope are
14 a way that we're moving toward as well on the
15 scorecard developing performance measures around
16 patient-reported outcomes as well.

17 CHAIR PINCUS: Any other last
18 comments? So I want to turn it over to Miranda
19 to tell us sort of what are the next steps but
20 first there has to be -- I guess at first there
21 has to be a public comment. Correct?

22 MS. KUWAHARA: That's right. So this

1 is our last opportunity for public comment.

2 We'll begin with any participants in the room.

3 MS. STOCK: Hello. Oh, that's better.

4 Hi, my name is Kyle Stock and I'm a senior policy

5 analyst with Community Catalyst. We are a

6 national health advocacy organization who works

7 with individuals and communities throughout the

8 country to make sure that their voices are heard

9 about decisions affecting their health.

10 We work with children, families, and

11 people with complex health needs, including

12 behavioral health and long-term services and

13 supports. And first of all, I'd like to thank

14 you for your work on addressing quality of

15 healthcare.

16 We would like to talk a little bit

17 about a couple of the gaps and the future of the

18 scorecard. We are interested in seeing measures

19 related to the long-term care and services and

20 supports, particularly because Medicaid is one of

21 the largest payers for those services. We would

22 ask you to consider adoption of some of the CAHPS

1 home and community services survey questions,
2 which has been endorsed by NQF.

3 We are also concerned about the gaps
4 and measures for mental health and substance use
5 disorders. And would urge you to look to the
6 CAHPS experience of care and health outcomes ECHO
7 survey, which includes several critical outcome
8 questions.

9 We would also ask you to consider the
10 SAMHSA National Outcomes measures, which are
11 currently being used in New York. These measures
12 track improvements in critical life activities
13 including education, employment, and stable
14 housing. These are a couple of examples of
15 measures that are truly meaningful to consumers.
16 And we hope the committee will prioritize these
17 types of measures.

18 As a final note, I would also say that
19 we would support disaggregation of data by race,
20 ethnicity, and disability. I appreciate the
21 opportunity to speak with you all. Thank you so
22 much.

1 MS. KUWAHARA: Thank you. And we will
2 open up the lines for folks joining remotely in
3 just a moment. Are there any members who would
4 like to offer comments?

5 MS. TUFTE: Yes, this is Janice again.
6 I really -- I just want to say hello and I really
7 appreciate this discussion this morning. And I
8 remember we had a similar discussion last May.
9 And something I think that's very important that
10 somebody had brought up about what is of interest
11 to different states. And I think that -- I know
12 that we have information on what states report
13 what for the core set. But there might some
14 easier graphics where I've recently been engaging
15 more consumers with meaningful measures. Sort of
16 teaching them from a peer level to engage them in
17 one state in particular.

18 And if I was able to explain to them
19 on a basic level like how -- what states are
20 interested in what, it would really help. Like
21 we have to go to different charts. So if we
22 could click on the link like you know, for Pap

1 smear or whatever and it would show what states
2 are reporting, rather than having to go to a
3 different graph would help.

4 And I think what was mentioned about
5 ICD-11 is actually very important because the
6 infographics really are able to give opportunity
7 to a lot of people to be able to understand a
8 little more about their health, rather than just
9 reading a measure. And I hope that we do take
10 that sooner than later. And I just want to say I
11 agree with other people that it's important to
12 have placeholders like in the perinatal, I had
13 mentioned.

14 And I appreciate Harold, what you had
15 mentioned about as a mental health measure, then
16 it's true -- it's important to be there. But I
17 guess to look at the outcomes of it, why are we
18 measuring some of those? So I hope to
19 participate on some of the other calls. And
20 thank you very much for your work.

21 MS. KUWAHARA: Thank you, Janice. Are
22 there any other commenters? All right. I'll

1 turn it over to Jordan to review next steps.

2 MR. HIRSCH: Thanks a lot. Important
3 upcoming dates next week, Wednesday, January
4 16th, we will have our post-meeting web meeting.

5 MS. KUWAHARA: Which will be cancelled
6 because we have -- because we have covered all of
7 our agenda items.

8 MR. HIRSCH: Okay, strike that then.
9 February 25th to March 27th, we will have public
10 comment period for the draft report. In the
11 summer, we will have a series of strategic
12 considerations web meetings. And finally,
13 September 9th, the final report is due to CMCS
14 and made available to the public.

15 In the meantime, please contact us
16 with any questions or concerns that you have.
17 Email us at maxscorecard@qualityforum.org or call
18 NQF at 202-783-1300. As well as please view the
19 project pages that we have posted here. And
20 thank you for joining and participating.

21 CHAIR PINCUS: Well, it's been a
22 pretty intense day and a half. And I really want

1 to thank all of you for sticking with us. I mean
2 this is an enormous committee. And the range of
3 contributions -- the full range of people have
4 made contributions in important ways and we
5 really appreciate that.

6 I think what we've come through is
7 going to really helpful to CMS as they move ahead
8 with this very ambitious process that they want
9 to do. And of course, I can't go without, you
10 know, thanking NQF staff who really have set this
11 up so that we can be maximally productive.

12 So thank you all. And I especially
13 want to thank my co-chair, Rich.

14 CHAIR ANTONELLI: Thank you. And I am
15 thrilled that I've had limited media exposure in
16 the last 36 hours. And the fact that so much
17 positive energy could come out of this city. I
18 am just thrilled and that's a lot to do with you
19 guys. So thank you, thank you, and thank you.

20 I want to start by recognizing Karen
21 and the CMS team. This is a challenging time.
22 And I don't mind the fact that you said, we're

1 not quite sure what the stuff is with the TBD,
2 but trust us. You have my trust. And you have
3 my sweat equity. And I think you know that this
4 committee, all 32 of us, we're here for you. And
5 just thank you. Thank you for maintaining that
6 energy and focus for us.

7 And then the NQF staff, as hard as it
8 may appear for the co-chairs, these guys do all
9 of the work. I don't -- I think they live here.
10 And I just -- every single one of them -- Jordan
11 is new to the team. I don't know if he left. I
12 was about to say something complimentary to get
13 him to blush. But I think he did a great job
14 for, you know, just sort of coming on board. So
15 again, NQF staff, thank you very much. CMS,
16 thank you. And to each of you guys.

17 MS. MUKHERJEE: Of course from the
18 staff perspective, we definitely want to thank
19 our chairs. They help us, guide us, and sort of
20 make this meeting a success. Committee members,
21 thank you for agreeing to be part of the
22 committee. And of course, CMS, thank you for

1 giving us the opportunity to do this work. And
2 definitely my team members. Without them, and
3 especially with people like Jordan who are very
4 new and jumping into this, this would not be a
5 successful meeting.

6 MEMBER MORROW-GORTON: And we would
7 like to thank our rock-star co-chairs and all of
8 the staff.

9 MS. GORHAM: So we changed the lunch
10 reservation to one o'clock since we're ending a
11 little early. So if you plan to join us for
12 lunch, the reservation is at 1:00. And we can
13 all walk over together. And you can leave your
14 bags here.

15 (Whereupon, the above-entitled matter
16 went off the record at 12:31 p.m.)
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C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Medicaid and Chip Scorecard Committee
In-Person Meeting

Before: National Quality Forum

Date: 01-11-19

Place: Washington, DC

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