**National Quality Forum**

**Moderator: MAP Adult Medicaid**
**August 14, 2018**
**1:00 p.m. ET**

OPERATOR: This is Conference # 3169159.

Operator: Welcome to the conference. Please note today's call is being recorded. Please stand by.

Erin O'Rourke: Good afternoon, everyone. This is Erin O'Rourke. I'm a senior director here at NQF. Thank you so much for joining the Measure Applications Partnership Coordinating Committee Web Meeting to review the 2018 Medicaid Adult and Child Workgroup and MAP Rural Health Workgroup Reports.

With that, I'd like to turn it over to Yetunde Ogungbemi, our program manager, to take the roll call so we can see how is on the line with us.

Yetunde Ogungbemi: Hello. Good afternoon. Is Chip Kahn on the line?

Charles Kahn: Yes.

Yetunde Ogungbemi: Harold Pincus?

Harold Pincus: Yes.

Yetunde Ogungbemi: Marissa Schlaifer?

Marissa Schlaifer: Yes.

Yetunde Ogungbemi: Shaun O'Brien or someone from AFL-CIO? (Ross Stabta) or someone from AHIP?

Danielle Lloyd: AHIP, stepping in for (Ross).

Yetunde Ogungbemi: We're getting feedback on the line. Could everyone mute their lines until it's time to speak, please. Or, operator, could you figure out that – thank you. That's what it is. May I ask who is on the line for AHIP? I'm sorry.

Danielle Lloyd: Danielle Lloyd.

Yetunde Ogungbemi: Danielle Lloyd. Thank you. Thank you for joining us as well. Is (Barrett Neuwan) on the line? Or someone from ABMS? Mira Irons maybe. Amy Mullins?

Amy Mullins: Here.

Yetunde Ogungbemi: Amir Qaseem? (Ruth Paul)? American Healthcare Association, David Gifford?

David Gifford: Present.

Yetunde Ogungbemi: Welcome. (Maureen Cahn)?

Nancy Foster: This is Nancy Foster subbing for (Maureen).

Yetunde Ogungbemi: Thank you, Nancy. Welcome.

Nancy Foster: Thank you.

Yetunde Ogungbemi: Carl Sirio or someone from AMA? Mary Beth Bresch White or someone from the American Nurses Association? Sam Lin?

Samuel Lin: Here.

Yetunde Ogungbemi: Hi, Sam.

Samuel Lin: Hi.

Yetunde Ogungbemi: (John Vought)? (John Vought)? Derek Robinson? David Baker?

David Baker: Here.

Yetunde Ogungbemi: Welcome. Leah Binder? Joe Baker? Gail Hunt? Rachel La Croix?

Rachel La Croix: Here.

Yetunde Ogungbemi: Welcome. Steve Wojcik?

Steve Wojcik: Yes.

Yetunde Ogungbemi: Thank you for joining us. Mary Barton? Is someone from NCQA on the line? Erin Mackay?

Carol Sakala: This is Carol Sakala here for Erin Mackay.

Yetunde Ogungbemi: Thank you, Carol. (Chris Querim)? Bill Kramer? Jenny Bryant? Or is someone on the line from PhRMA?

Carolyn Ha: Yes. This is Carolyn Ha from PhRMA filling in for Jenny. Thanks.

Yetunde Ogungbemi: Thanks, Carolyn. Is Rich Antonelli on the line?

Richard Antonelli: I am here.

Yetunde Ogungbemi: Hi, Rich. Nancy Wilson?

Nancy Wilson: Here.

Yetunde Ogungbemi: Welcome. (Tesley Richards)? Someone from CMS? And is David Hunt on the line?

David Hunt: Yes. Yes, I am.

Yetunde Ogungbemi: Welcome. Thank you. So, we have to – in order to proceed with the call, we have to continue to have quorum. And quorum is 18 for the Coordinating Committee. So, when we get to objections and voting, we will – I will recount for vote – or for quorum at that time.

Charles Kahn: I'm sorry. How man did you say we had? I missed it. This is Chip.

Yetunde Ogungbemi: Quorum is 18.

Charles Kahn: But, I mean how many do we have right now.

Yetunde Ogungbemi: So, I couldn't count while I was – let me count quickly.

Charles Kahn: Yes. And let me also say that – why do we need to go through that process each time? Once you have a quorum, the meeting is called to order. And I don't know why we'd need to count – we do it every time we have a vote because the whole notion is you have a quorum. I think we could be more relaxed, assuming we have one.

Yetunde Ogungbemi: So, OK.

(Heather Braham-Polsgrove): Hi. This is (Heather Braham-Polsgrove) sitting in for (Sheryl Powell) with IBM Watson Health. I'm sorry if you missed – if I – if I missed when you called her name. But, I'm here as well.

Female: IBM Watson.

Female: (Inaudible) from Ohio. I'm here as well.

Female: (Inaudible) on as well.

Lisa Patton: And Lisa Patton from IBM Watson Health.

Charles Kahn: OK.

Yetunde Ogungbemi: I'm only calling Coordinating Committee members now because those are the people who are reviewing the recommendations and the reports. So, Chip, we have 15 members on the line currently. And if anyone else on the Coordinating Committee has joined after I called roll, please let me know. I will not count again or do another roll call before we ask for objections. But, I do need to make sure that we keep quorum while we are asking for objections.

Charles Kahn: OK. No problem. And, then, the other issue is – I mean, I know about the – the 60 percent rule. We obviously would have a vote count if we did that so that it's – it would work out. OK. Thanks so much.

I guess, for me, I'll welcome everyone to the meeting and, again, thank the NQF staff in advance for all the work that I know has gone into the preparation for the meeting as well as the work that's done by the committee members to get us the three reports that we are considering today. Harold?

Harold Pincus: Sure. And let me add my welcome as well. I think that, you know, while a lot of the focus, you know, traditionally for the MAP Coordinating Committee has been around sort of looking specifically at the introduction of new measures to the various measure sets, the reports from these three workgroups, you know, are extremely important. And it's important that we, you know, focus on this and be able to review those recommendations and give our feedback. So, this is another important function.

Charles Kahn: OK. With that, let me turn it back to Yetunde. And if you'd proceed with the objectives and the …

Yetunde Ogungbemi: Thanks, Chip. So, today's agenda – we will review meeting objectives. Erin will review the MAP and, then, we will go into the recommendations of each of the three workgroups. Our meeting objectives today are to review the public comments for the three workgroups, Medicaid Adult, Child and MAC Rural Health. We will review the recommendations and the reports as well as public comments. On the screen here is the Coordinating Committee. And I will turn it over to Erin.

Erin O'Rourke: Great. Thank you so much, Yetunde. So, to briefly reorient everyone to the charge of the Coordinating Committee, this group is tasked with setting the strategic direction for MAP as well as advising HHS on the coordination – on the coordination of performance measurement strategies across public sector programs, care setting as well as across public and private sector payers. And then, finally, the last bit of the charge is to give direction to and ensure alignment among MAP advisory workgroups.

Moving on to the next slide. So, here, we did want to refresh everyone of the structure of MAP. I think everyone is probably very familiar with MAP, the Coordinating Committee's role in overseeing and finalizing the

recommendations of the three setting-specific workgroups – hospital, clinician and PAC/LTC – to make recommendations for pre-rulemaking.

However, as Chip and Harold were saying, another important focus of the group is to oversee MAP's guidance on rural health as well as the Medicaid Core Sets. So, that's what our goal is here today. And we thank you, all, for taking the time out of your August to join us and review those recommendations. And I think with that, I can turn it over to the Medicaid team to dive right in so that we can go ahead and get started.

May Nacion: OK. Good afternoon, everyone. This is May from the Child Medicaid team. So, we're just going to do a quick over view of the Medicaid Child and Adult charges and, then, dive first into the Child Workgroup discussions and recommendations.

Next slide. Thank you. So, the charge of the – both workgroups is to review states' experiences with reporting the Core Set measures, refine the measure areas and recommend potential measures for addition or removal from the Core Sets to CMS.

Next slide. CMS has a three-part goal for the Core Sets, which are to increase the number of states reporting on the Core Sets, increase the number of measures reported by the states and increase the number of states using the Core Set measures. Of course, that data is used to obtain a snapshot of quality and inform policy and program decisions.

Next slide. Next slide. So, this is just – this and the following slides are just a listing of our – of our workgroup members. Next slide. So, just a brief background. Greater than 40 percent of births are covered by Medicaid and nearly 35 million children are covered by Medicaid and CHIP. So, Medicaid plays an important role to improve outcomes for children, especially in promoting access to care among children with chronic and special health care needs.

Next slide. So, CHIPRA requires HHS to publicly report the Child Core Set yearly. The initial Core Set was published in 2009, and states voluntarily submit data annually with the most frequently-reported measures being those

that assess access to primary care, well-child visits, childhood immunizations, dental services, chlamydia screening and ED visits.

Next slide. So, this and the next couple of slides are a listing of the 2018 Child Core Set. I'm just going to quickly go through these. Those with the light purple shading indicate that they are newly-added measures.

Next slide. Next slide. Next slide. Next slide. Thank you. OK. So, this slide illustrates the number of states reporting on each measure in the Core Set for fiscal year 2016. And as noted previously, the measures most frequently reported by states are the access to primary care, well-child visit, dental services, childhood immunizations, chlamydia screening and ED visits.

Next slide. So, during the in-person meeting, Florida presented on their experiences using the Child Core Set, specifically on receipt of dental services. Florida increased their dental visits by 15 points since 2010. And this is primarily due to the support for Performance Improvement Plans, intensive technical assistance under federal partners, greater consumer engagement and also targeting their health plan contract.

Next slide. Minnesota also presented during the in-person meeting and focused on the social factors affecting health and receiving health care. They focused on the accountability model, improving health outcomes by ensuring both clinical and community aspects as accounted for. The need for wraparound services to address gaps in services was also discussed.

Next slide. During the measure discussion, the workgroup members considered many factors, including whether measures address the health needs of the population, if they drive improvements in health care quality and reduce or minimize reporting burden. So, consideration of factors helped the workgroup members recommend these six measures listed here for phased addition.

Next slide. And this is regarding the high-priority gaps. So, based on discussions regarding the needs of the Medicaid and CHIP population, the workgroup shifted from just a listing of gaps to really focusing on how a

child's life span needs should dictate the gap areas. The gaps discussion also considered the relationship between health and social risk factors.

The workgroup created two main domains, which is Behavioral Health and Public Health. The subdomains under these domains are actually not mutually exclusive. Overlap exists and actually illustrates the interconnected nature of health as a care continuum. And I'm going to now turn it over to our Child co-chair, Lindsay Cogan, to discuss the public comments received. Next slide.

Lindsay Cogan: Thank you, May. And good afternoon, everyone. So, I'm going to review very briefly some of comments that have – that came in on the Child report. So, as you will see on this slide, there were 22 comments submitted by nine organizations, and most commenters supported all recommendations that were made for the phased addition to the Child Core Set. You will see that several did not support, and you will the number of commenters per measure. And we'll go over in a little bit more generally some of the comments that came in.

Next slide. So, you can see on this slide our overall comments were mostly measure-specific. There were some few strategic or generalized comments that are summarized on the following slides and a, you know, support for evidence-based or evidence-informed measures, measures that are feasible, emphasize prevention and that reflect the diversity of pediatric care were some of the general comments.

Next slide. This slide, the overall recommendations that were provided for CMS, included things that relate back to the phasing in of new measures that are not already in use by state Medicaid agencies and really think about some of the concerns as they relate to the feasibility of data collection and reporting at the state level.

Next slide. This slide is over – gives a general overview of some of the support for general comments. So, there was some cross-cutting themes that appreciated the workgroup's discussion of substance use disorders and its integration with behavioral health during both the Adult and Child meeting.

Next slide. And with that, at this time, I am going to turn it over to Harold to facilitate the Coordinating Committee discussion around some of these public comments that came in.

Harold Pincus: So, why don't we open it up for discussion in terms of any comments that anybody on the Coordinating Committee has with regard to the overall report as well as the public comment feedback? And I guess one way of doing it is by – I don't know if they need to raise their hand or – in some way or whether they can simply speak up.

Female: So, while we are waiting for comments, we want to acknowledge Rich Antonelli. He is also the co-chair for the Child Core Set. Rich, if you wanted to say anything regarding the discussion during the meeting or the comments that we've received.

Richard Antonelli: Thank you. This is Rich Antonelli. I appreciate the opportunity. I guess I also want to thank the members of the Child – Medicaid Child core group and the NQF staff. You will see the presentation was in a simple straightforward approach of "There are the measures; let's go." We really feel the urgency of this alignment between the public health domain and the medical delivery system.

So, in particular, I am – I wanted to emphasize for the – for the MAP this idea of setting a path forward for measures of significant relevance, especially for children with Medicaid. I don't need to make any of the comments right now but will remain available for any questions that come from the MAP.

Danielle Lloyd: Hi. This is Danielle Lloyd with AHIP. I'm not on the Web line, so I can't raise my hand there. So, first of all, we just wanted to say that we really appreciate the discussions around social determinants of health up front, and we're very supportive of that.

But, we are – there's sort of a tension between this idea of increasing adoption of the existing measures and expanding the measures in that, you know, to the extent that you are expanding them, you are – might be sort of driving resources to other measures and actually increasing the disalignment between states by having, you know, more measures available.

So, I think part of our concern is just the magnitude of, you know, continually adding, particularly when many of them are process-oriented instead of outcomes-oriented. And, so, we just – our concern that we're not really, you know, honoring, if you will, the parsimony and alignment concept with these additions and, then, just that we, you know, really share the concern with some of the commenters about this not being a test bed, right, that everything needs to be thoroughly tested and finished with this testing before it comes in to these – to these Core Sets. Thanks.

Amy Mullins: Yes. This is Amy Mullins. And I echo those comments. I was getting ready to make a very similar comment. I was concerned when I saw the – one of the outcomes. And I can't scroll back on the slides to say what it was when it says "To increase the number of measures."

And just that statement alone is one of the outcomes of the – this group or the set here. As a standalone statement, it was concerning to me. I understand that maybe better measures are needed or more relevant measures. But, just increasing the number of measures I don't think is a good goal. I think we need more – more valid, reliable, evidence-based measures that are harmonized and parsimonious across, you know, different programs. But, just increasing the number of measures as a goal I think was maybe not a great goal to state.

Harold Pincus: Hi. This is Harold. I just wanted to sort of ask a question back to the previous two commentators. I guess since this is a voluntary reporting program and states can choose which measures – choose (for their patients) which measures they would want to collect, your sense of what is the balance about sort of having alignment among the states in terms of the measures that are being reported and applying parsimony as compared to having a somewhat larger set of measures so that states would have – be able to make choices around certain measures that may be of higher priority for their states specifically. And just say something – your thoughts about the balance between those two objectives.

Amy Mullins: This is Amy. And I'll go first. And, I think that when you get just too many measures, you get lost in the milieu of measures. And I think that at some point, you know, if we're going to continue to add measures to sets, then we need to start removing measures from sets.

And I think that there are low-hanging fruits to remove. There's a lot of topped-out measures, a lot of process measures that can be removed. But, just continually adding and adding and adding measures – I just think it leads to a lot of confusion.

Danielle Lloyd: Yes. And I would just say, you know, thinking about this as truly a Core Set, I think the priority is getting more states to report on the same measures and not just proliferating measures and then having lots of different combinations so that we can try to get to a national snapshot on some of these things.

And just if there are so many, you know, you might worry – I think providers also get worried, you know, what – how many the state is going to adopt. And, then, you also risk not being truly aligned with some of the private sector as well.

Nancy Foster: Harold, Nancy Foster. Could I jump in on this? So, let me associate myself with the comments that Danielle and – I'm sorry I didn't get the other person's name – but – have made. Getting to the right set where you've really got important things to measure, you are – you are honing in on those issues that are – that are important to deal with and where we have the science to suggest we can actually do better is critical, especially around the child care measures.

So, fewer measures that are critically important – if indeed there is a state in the country that can claim that they have knocked it out of the park on all of those measures, we all need to know what that state is so we can go figure out what their secret sauce is and emulate it. But, I guess is there's still plenty of work to be done on these measures on whatever forms, a smaller but really important subset of measures.

Richard Antonelli: Harold, Rich Antonelli. Can I get in the queue, please?

Harold Pincus: Sure. Yes. I don't have a queue because there is no way for me to determine whether people are in line.

Richard Antonelli: OK. So, (if I) beg the indulgence of everybody on the line – so, speaking as the co-chair of the Medicaid Child, I just – I want to acknowledge the importance of the comments made around a parsimonious set. Also point out the fact that it's not unique to Child would also apply to the Adult side.

That said, looking over the past several years, the Child Workgroup in particular spent a significant amount of time looking for opportunities – the verb that I like to use is prune or remove measures from the Core Set. Some of the measures that were discussed – there was a message that the workgroup sent to the various key stakeholders being mindful that for a state to turn – to implement the measure or remove a measure is not something that can be done easily and with minimal allocation of resources.

So, I want people to be mindful of the fact that wrapping up measures and sunsetting measures does need to take time. But, speaking as a co-chair of the Child Workgroup in particular, a lot of time was spent thinking about, you know, is a topped-out measure ready to be sunset? Does this measure reflect current science and best evidence?

And I do want to let the folks know that have spoken about parsimony I had a similar reaction to this notion of I don't consider success that we've added more measures. We need to get the right measures, not more measures.

Carol Sakala: Hello. This is Carol Sakala, and I am also on the Child Workgroup. And I'd just like to add an addition to Rich's clarification about our focus on parsimony and focus on what can be retired. A couple of clarifications here.

First of all, the goal is not to add more measures but, rather, to increase the number of states that are measuring measures in the Core Set and to increase the number of measures that are being used for QI. So, it's not specifically to grow the Core Set.

And, also, I'd like to say that it might be alarming to see those six measures. But, they are recommended. It's my understanding. And, typically, toward

the end of the year, CMS will identify one or two that they will select to add to the Core Set.

Harold Pincus: Are there comments from the Coordinating Committee members?

Charles Kahn: Harold, this is Chip. Just in terms of sort of procedure here, so it seems to me there's some concern about the notion of words that say "adding more" that either aren't qualified with, you know, something about – some adjectives or – and I'm just wondering where can we go with the discussion we just had? Or are we just going to go forward with the language that's in there?

I would suggest that we could if the people who are concerned about that language would agree that maybe we could have some qualifying language that – because I understand what you said about this being a menu rather than a prescription – that we have some kind of surrounding language around that that adds some adjectives as to value and purpose and – I mean, of measures.

Now, I have to go back and look at the language, what that is, that maybe they're in other bullets or whatever (inaudible) (that is wondering) – it seems to me that the concerns weren't about measure – doing the measurement or suggesting but, you know, just the notion of more did seem to, I mean, concern a lot of people.

Erin O'Rourke: Hi, Chip. This is Erin. I can take that one. So, we will revise the reports with input from the Coordination Committee. So, we can capture all of this conversation and you will see it reflected in the final report to go along with the recommendations of the workgroup.

So, we can reflect that the Coordinating Committee made a strong call for parsimony, recognizing that there is some need for flexibility, to Harold's point, to allow states to choose measures that are really relevant to them. But, at the same time, we need to make sure (these key sets) have the right measures.

And I think we can echo some of Danielle's points about the value of aligning with the private sector, and I think Nancy raised some great concerns about the value of consistency and making sure that we're – to Amy's point, we're

not getting lost in the milieu of measures. So, I think we can package all of that up and put that in the report with the recommendations to make sure that this balancing voice goes along, that this is not a call just for more measures. It's a call for the right measures.

Male: And I think also to make clear that there is – it's not just the right measures but measures that sort of meet the threshold of quality of the quality measures.

Male: Yes.

(Shekanah): Hi. This is (Shekanah) from the Medicaid team. I also wanted to just reiterate Rich Antonelli and Carol Sakala's clarification that the (real priority goal) for the Child and Adult Core Sets specifically states increased number of states reporting Core Set measures, so not necessarily more but to increase the number of states reporting the measures and increase the number of measures reported by each state. So, there is some clarifying language on the goal.

Male: OK.

Male: I mean, I think – I mean, I think (inaudible) the first part. But, the second part says the same thing that we're raising concerns about.

Female: Yes. Inherently, if you are adding six measures, you are expanding in the other way, too.

Male: Yes. I think, it – where there are no measures, we think there should be measures. Where there are already measures, the question is what's the quality of the additional measures, and could they replace some of the measures that are already being asked. I think that is the question.

Male: Also, there needs to be some, you know, clear justification that there is a gap and the gap is significant, an important gap.

Female: OK.

Harold Pincus: Well, I'm fine, Erin, with what you suggested. Are there any further comments from committee members? So, if there's no further comments from committee members, Yetunde, can we open it up for public comment?

Yetunde Ogungbemi: Operator, may we open the line for public comment, please?

Operator: Yes, ma'am. At this time, if you'd like to make a comment, please press star, then the number one on your telephone keypad. And at this time, there are no comments.

Yetunde Ogungbemi: All right.

Erin O'Rourke: And, Harold, this is – this is Erin. Could I just jump in with one process concern? At the start of the call, Yetunde had 15 in the roll call. So, I did want to see if anyone else joined since then. We are looking for 18 to hit our 66 percent threshold to be able to do the votes on the meeting.

(Ken Schall Hayes): Hi. This is (Ken Schall Hayes). I think I may have joined after the initial. I couldn't call in at first.

Amir Qaseem: And this is Amir Qaseem. I called in a few minutes later too.

Charles Kahn: So, we're just two away – I mean one away.

David Gifford: Erin, this is Dave Gifford.

Erin O'Rourke: Yes.

David Gifford: Just a procedural question. I need to recuse myself on this vote but not AHCA. And we have my alternate here. So, (Catherine) will be voting for me on this Medicaid issue. It's only on the Medicaid measures that I have to recuse myself.

Erin O'Rourke: OK. Great. Thank you, Dave.

Charles Kahn: Well, did Dave Gifford announce himself? I mean is he on the – is he included in the 17?

David Gifford: Yes, I announced – I announced myself at the beginning. Yes, I did.

Charles Kahn: I'm sorry. OK. So, we are at 17. We're not at 18.

Erin O'Rourke: So, since we have …

Male: (Inaudible).

Erin O'Rourke: Since we have 17, we will send you Coordinating Committee members a SurveyMonkey after the call to cast your votes. We will include the recording of this call so that those who weren't able to join have the benefit of the conversation. We'll go forward with discussion and the presentations.

But, we'll be taking the official votes after the – after the meeting via survey since we do not have quorum so that those who couldn't join can listen and also cast their vote. Apologies for the procedural challenge. So, I can turn it to Harold if there's any final thoughts on the Child work. And if not, we can move on to the presentation and discussion on Adult.

Harold Pincus: No. I think we can move on to the Adult.

Miranda Kuwahara: Excellent. This is Miranda Kuwahara with the Medicaid Adult project (scene). We will begin this presentation with a few slides introducing the Adult Workgroup members. The 2017-2018 workgroup was chaired by Harold and Marissa Schlaifer.

Next slide, please. Before diving in to this year's Medicaid Adult Core Set work, we wanted to provide a quick overview of the Medicaid adult population. Medicaid covers the most vulnerable populations, including individuals with mental illness and substance use disorder. I'd like to highlight that beneficiaries with complex care needs account for more than half of total Medicaid expenditures despite representing only 5 percent of all Medicaid beneficiaries.

Next slide. The initial Adult Core Set was published in 2012. The 2017-2018 final report marks the NQF Medicaid Committee (six sets) of recommendations to the Department of Health and Human Services. States voluntarily submit data to CMS, and federal fiscal year 2016 is the most recent data available. In federal fiscal year 2016, 41 states reported at least one Adult Core set measure and states reported a median of 17 measures.

Next slide. Reflected on the following four slides is the 2018 Core Set in its entirety. Measures shaded in light purple were newly added to the Core Set this year.

Next slide, please. This slide illustrates the number of states reporting on each measure in the Core Set for federal fiscal year 2016. States most commonly reported measures assessing women's access to primary care, prenatal and postpartum as well as behavioral health care. More information is found in – can be found in CMS' chart pack regarding the number of states reporting each measure and descriptions and trends of each measure. That chart pack can be found on CMS' website.

Next slide, please.

(Joe Baker): This is (Joe Baker). I'm sorry. I've been on the call the whole time but – I've been trying to chat. So, if it – I think I'm the 18th person. I was online but not on the phone. So, I just dialed in so that you could know that I was here. I've been trying to chat and say I was here. So, I just wanted to let you all know that.

Charles Kahn: You're our hero.

(Joe Baker): Yes. Well, that's why I wanted to – that's why I wanted to do it now so we can avoid SurveyMonkey. I didn't have any comments or questions about the previous presentation.

Charles Kahn: Super. So, now we wait – we now have a quorum officially, and we can proceed with the meeting and the voting.

(Joe Baker): Well, we have had it because I've been on the – I've been on the computer and listening to the discussion. But, I thought I could speak through the computer, but I guess I'm technologically deficient and I phoned back in.

Charles Kahn: Right.

Yetunde Ogungbemi: We do not have quorum because the – one of the people who said that they were – they had joined is not on the Coordinating Committee. So, we are still short one person.

(Joe Baker): OK. If you are on the – on the Web platform and not dialed in, could you please let us know somehow that you are on the line?

Charles Kahn: How would they do that if you're not (inaudible) on the Web platform?

(Joe Baker): I tried to do it – I tried to do it by chatting, and the chat function isn't working, I guess, on the online.

Yetunde Ogungbemi: So, I see you in the chat. It's just not coming to the leader messages. I'm sorry about that. But, we would still require one more person on the Coordinating Committee to be on the line in order to …

Charles Kahn: Right. But, how could they inform you of that so we know that?

Yetunde Ogungbemi: They can e-mail the Coordinating Committee inbox or e-mail me personally.

Charles Kahn: And e-mail me means what's the e-mail address?

Yetunde Ogungbemi: It's yogungbemi@qualityforum.org or mapcoordinatingcommittee@qualityforum.org.

Erin O'Rourke: And if you have access to the phone – this is Erin – it might be simple as – if you're able to join in. Apologies. Our Web platform doesn't allow you to speak by phone like some of the other – or speak via the computer via some of the – like some of the other platforms do. So, if you're a Coordinating Committee member and we aren't able to get your chats up, please dial in so you can participate in the conversation. Apologies for some of the confusion there.

But, while – we do we go back? Miranda, do you mind continuing with your presentation. And if there is anyone we missed for the purposes of quorum, please dial in or reach out via e-mail or chat to let us know you are on the line. And apologies for all the technical difficulties.

Miranda Kuwahara: Thank you, Erin. During the Adult in-person meeting held on May 9 and 10, Dr. David Kelley, chief medical officer for the Pennsylvania Department of Health and Human Services, presented on Pennsylvania's experience reporting on 21 Adult Core Set measures. He concluded with three recommendations presented on this slide.

The first is Core Set stability is critical for managed care organizations. Second, population-based measures with national benchmarks are useful tools to gauge performance across states. And, finally, Pennsylvania views reporting burden as one of the principal reasons to exclude a Core Set measure from its portfolio.

May reviewed this slide previously during the Child section. But, to reiterate the high points Dr. (Jeff Sheffs) presented during the joint Adult-Child meeting and focused on presentation on social risk factors and accountability models that encompass both clinical and community-based efforts.

Next slide, please. Using state-reported data and state presentations from Medicaid representatives to inform their decisions, the Adult Workgroup supported all but two of the 33 measures in the 2018 Adult Core Set. The workgroup recommended the removal of NQF #0476 PC-03, Antenatal Steroids, and NQF #2082, HIV Viral Load Suppression, due to concerns about reporting burden and reporting challenges, respectively.

The Adult Workgroup also recommended eight measures for phased addition, which are presented on this slide. These measures include quality and high-priority areas such as home and community-based services, substance use and behavioral health.

Following the review of the 2017 key priority gaps, the workgroup members expressed the need to highlight a subset of the existing priority areas with some additions and clarifications, which are reflected on this slide. We'll now hand it over to our Adult Workgroup co-chair, Marissa Schlaifer, to review the public comments received.

Marissa Schlaifer: All right. Thank you. And, first, I want to make sure and acknowledge that Harold Pincus is the other co-chair of this workgroup. He's just playing multiple roles today – so, the reason why I am presenting. And also that the additional background that I am going through some high level on the public comments – but, all of those public comments are in Appendix J on the report.

And I'm just going to take this opportunity to back up just a second. Just based on the earlier conversation, I do want to make sure and emphasize – although it's already mentioned – that we did remove – we did recommend for removal two measures due to, as people had talked about, you know, making sure that we did think about duplication and not have unnecessary measures.

So, I didn't want anyone to miss the two measures were recommended for approval. And of the eight measures that were recommended for addition, one of them, you may note, is conditionally recommended. And that condition was that it replace another measure.

So, I just want to mention just based – in response to some of the conversation that we had earlier that the "real estate" within the measure was definitely an issue that was discussed extensively during the discussions of the Adult Workgroup. So, everything that was said earlier was something that we definitely took into consideration as we were making our recommendations.

So, to jump to the public comments, there were 34 comments submitted by 13 organizations. This slide has been updated with some additional detail. NQF staff provided the number of commenters who didn't support each measure. Obviously, with 34 comments, there was just one or two on each measure that had some concerns with the measure addition.

Next slide. Most comments were measure-specific, most in support of the measure for phased addition or removal. There were a few strategic and general comments that have been summarized on this slide.

Moving to the next slide. Commenters' requested actions or recommendations for CMS are presented on this slide, some of the specific ones requesting standardization for the assessments and screenings that can be used to satisfy certain measures, requesting more technical assistance for

states and clarification and, also, the caution of addition to the Core Set that are not yet specified at the state level.

Moving on. Finally, most commenters expressed support of addressing existing gap areas and movement towards population-based cross-cutting measures in future Core Sets. And just to go back and note, that was how measures (did come) – gaps were identified and workgroup members did recommend measures to address the gaps that had been previously – in previous years identified. So, all the gaps that were recommended were to address previously-identified gaps. And with that, I'll turn it to Chip for discussion.

Charles Kahn: OK. Thanks. So, just as we have the last discussion, is there anybody – I guess everyone has to speak up when a – when a – person finishes because we don't have a way to queue. So, I entertain discussion. Hearing a lot of (thoughts). So, is there – I guess – I assume (there is concurrence) with the – with the report on the phone.

Nancy Foster: Chip, it's Nancy.

Charles Kahn: OK.

Nancy Foster: I'd be happy to provide a couple of comments (inaudible).

Charles Kahn: Sure. Yes. Thank you, Nancy.

Nancy Foster: So, you know, I appreciate the struggle here to get to the right Core Set. And I'm curious because as I look through the report, it appears that part of the reason for – that the workgroup considered for excluding some measures was the difficulty in reporting, the difficulty in identifying an appropriate data source and so forth but not clear that that same criterion was applied to the measures that were recommended for inclusion because, seemingly, there are some data source issues that need to be addressed.

For example, the Adult Major Depressive Disorder Suicide Risk Assessment measurement, which is absolutely an important topic to be measuring but is e-specified only – and to date, at least in the hospital world, we've had a great

deal of difficulty getting to any kind of valid and accurate eMeasure reporting. So, I'd be curious to hear a little bit more about that.

I also want to re-emphasize something we said in the Child health set, which is that the structural measures are really not I think where we need to be holding ourselves accountable. So, I guess starting with a measure of "Did you administer a CAHPS or not?" But, we had a point where we can push beyond that to actually include topbox scores and make that the recommended measure set for folks.

And, then, one final comment I'll offer up – a question, actually, is, you know, opioids have become the topic of greatest importance in health care in many a discussion these days. And they are incredibly important but not to the exclusion, I think, of dealing with and appropriately assuring the assessment of major depressive disorder and other psychiatric issues.

So, I – how did the committee think about creating that right balance between the measures of substance use disorder and the treatment thereof and the measures of other psychiatric disorders and the treatment thereof?

Marissa Schlaifer: Harold, this is Marissa. I can start, but you probably are the one that (inaudible).

Harold Pincus: Yes. Can you say a little bit more about that last point?

Nancy Foster: Sure, Harold. I guess the concern is as we're striving for parsimony, don't want to overload the measure set with measures of substance use disorder forcing out or diminishing the importance of some of the measures of psychiatric issues.

Harold Pincus: OK.

Nancy Foster: So, how did you think about and address that to get to the right balance?

Harold Pincus: Well, I think there was a lot of discussion about it. Certainly, the – the – prioritizing the issue of opioids. And I think that was, you know, (the biggest

area). And, you know, the measures that were added are trying to address the opioid crisis from different perspectives.

So, one has to do with focusing more on the prescription of opioids and the other focus is more on the continuity of people who are under treatment for opioid use disorder in terms of assuring that there is sufficient length of time that they are sort on sort of medication-assisted treatment.

So, that's – so that was the reason for the two – for the two additions, both the importance of, you know – and the degree to which (they are) trying to address it – the opioid issues and also the fact that they were addressing two different dimensions of the – of the – of the problem.

Marissa Schlaifer: Harold, this is Marissa. I was just going to add one or two things, if that's OK.

Harold Pincus: Sure.

Marissa Schlaifer: I think one thing just for the Coordinating Committee to know, especially as Nancy brought up the challenges in using some of these measures, we were very fortunate this year that we had a larger representation of Medicaid, whether it's Medicaid medical directors or quality program directors or Medicaid directors, on the workgroup this year. So, there was a lot of discussion and a lot of opportunity for input in that area.

On things like the suicide measure, you're exactly right. There was a trying to figure out the balance of the importance of a measure versus the challenges of a measure. But, that was an area where, you know, definitely we look to the Medicaid plan – Medicaid programs on the workgroup for input and, you know, may have, in some people's opinion, erred one way or the other. But, I think it was trying to figure out that balance with something we've spent considerable conversation doing.

Charles Kahn: OK. Any other thoughts? Recommendations?

(Catherine Omendinger): This is (Catherine Omendinger) from the American Healthcare Association. We had some questions about clarification for the CAHPS

Home and Community-Based Services Experience measure. We wanted to make sure that the scope of this was explicitly confined to home and community-based services and not going to be recommended for use at (ALs) and skilled nursing facilities since it's not validated in those settings and there are NQF-endorsed measures that are specific to those settings.

Clarke Ross: Hi. This is Clarke Ross. I'm a member of the Adult Measures Workgroup. And the CAHPS HCBS Instrument is a copyrighted CAHPS instrument and it's targeted exclusively to the home and community-based services and support settings. There is need for greater clarity of the slideshow on the precise home and community-based service population being measured for comparative purposes. But, this is exclusively HCBS. And if you read the instrument in detail, you will see that.

(Catherine Omendinger): All right. So, one – I guess the concern we had is that many states consider (ALs) to be home and community-based services. We would like to make sure that's reflected in the clarification that – in states where they are considered, that there needs to be some discrimination between those populations.

Charles Kahn: How does the staff respond to that? This is Chip.

(Bajani): So, the way this works is, one – this is (Bajani), by the way – is once we recommend – make recommendations for measures to CMS and HHS, they will have their own internal – go through own internal process to pick up measures that they think they would benefit from being added to the Core Set.

Once they are added to the Core Set, then it is CMS that works on the technical specifications and stipulates – and will, at that point, stipulate what should be included or not included. So, that is actually outside the purview of sort of our Core Set here. Our work focuses on recommendations for addition and removal and they are merely recommendations.

So, the final decision always lies with CMS. And it's here in the comments and we have captured that the public at large would like to see more specificity with regards to the technical specifications of settings, what's

included, what's excluded – things like that. So, that will be captured in the report.

Male: I'm sorry. I want clarification of the last thing you said. So – I mean, this is just a recommendation anyway. But, are you saying that we could have language that says that things have to be setting – we recommended that measures be setting-appropriate? Is that what you are saying?

(Bajani): Yes. We will capture it and say that during the MAP Coordinating Committee discussion, the recommendation was made that measure specifications be setting-specific and explicit.

Charles Kahn: OK. Is it – so, that – is that OK with everyone?

(Catherine Omendinger): (Inaudible). Thank you.

Male: OK. Other comments?

Danielle Lloyd: (This is Danielle). Go ahead.

Male: Go ahead.

Charles Kahn: I'm sorry. Who wants to speak?

Danielle Lloyd: Well, this is Danielle. I think there were two of us at once. But, I just – I wanted to ask a clarification. The tobacco screening is the one that one would come in and one would go out. Right? And – which is – would be – (if that) – so, yes or no to make sure that's true.

And, then, on the opioid one, it talks about 2940 having been added to the Core Set in 2016 and that we'd be recommending that there'd be three measures that sort of gets at Nancy's point of kind of doubling down in one area. But, I don't see 2940 listed in that list of the existing measures. So, that would potentially be a little bit less overlap on the opioid issue. So, can someone clarify those two points?

Female: On the opioid – sorry. I'm trying to go back and look at the …

Danielle Lloyd: It's page 14 on the report. CMS added 2940 to the Core Set in 2016 but did not accept 2950 and 2951. But, maybe it came out in '17 or '18. So, maybe there is less overlap than this might suggest. Well, we can – we can move on to other people's comments while folks are looking. But, I got a little bit confused by that.

Miranda Kuwahara: Hi, there. This is Miranda from NQF. So, 2940 is included on the 2018 Adult Core Set. It's Use of Opioids at High Dosage in Persons Without Cancer

Female: Which slide is that on?

Female: It's slide 39. And it's listed. It says NA for NQF number because it didn't have an NQF – it had not been NQF-endorsed at that time it was recommended for addition (inaudible).

Danielle Lloyd: OK. So, it's the one with the NA. OK. Thank you.

Female: Right. Sorry. Yes.

Danielle Lloyd: Got it.

Female: And they are two different opioids – two kind of opioid measures that are often used in conjunction. But, they do measure two different things.

Charles Kahn: OK. Any further – anything further?

Nancy Foster: I'm sorry, Chip. Can I get some clarification on my question around the CAHPS survey? Did the committee talk about whether we can push beyond just peer administration of it and to actually having a Core Measure Set that includes results? And this is Nancy. Sorry.

Charles Kahn: Because it – Harold, do you or your co-chair have a comment on that?

Harold Pincus: I don't have (easily accessible to the) specific sort of measure operationalization. So, I'm not sure about that.

Male: (Inaudible) from Pennsylvania Medicaid. I was on the Pediatric Committee but also advised the Adults Committee. (Inaudible) that – (I mean), community-based CAHPS survey is more than just to administer. It actually has (movable) domains with the results that are specified.

Harold Pincus: Right. You might – the assumption was that it was the – the actual results (are there) and not simply being administered.

Rachel La Croix: Yes. This is Rachel La Croix. I am also on the Adult Workgroup. And we had talked in the meeting, if I recall correctly, that at present, CMS has only been able to capture whether folks are administering the survey or not and that I would be an additional step for them to be able to actually analyze the data and provide topbox scores or some of the global ratings from individual survey items. So, I think that's more on the operational side for CMS.

Charles Kahn: Well, Nancy – I mean, can we put – I mean, do we have a sense of the group that – I mean, we can be aspirational here. Then, an aspiration would be for CMS to move in that direction. I mean, obviously, they are going to do what they are going to do and if they don't have the capacity, that's – answer the question. But, can we have that aspiration here in our language?

Marissa Schlaifer: Chip, this is Marissa. And someone on the committee can correct me if I'm wrong. But, we – I believe we had that discussion with CMS. And I'm not commenting on putting it into the report because you're probably very correct there. I believe CMS acknowledges that they have that aspiration.

But, it wasn't something where they would be getting in the next year or so – year or two but that they did – they do also have that aspiration. Someone of the committee can correct me if I'm not remembering that accurately.

Clarke Ross: Hi. This is Clarke Ross. And you're correct. We specifically discussed this and asked CMS. Sixteen states currently implement this. And three to five additional states say they are going to be implementing this calendar year. So, the issue of CMS data infrastructure and collection is one that the CMS director said she would be convening a team to respond to.

Charles Kahn: OK. So – but, can staff make some adjustments here? Is that acceptable? That's what I'm basically asking for.

Danielle Lloyd: Yes. And this is Danielle. I think just overarchingly, we are concerned about, you know, putting things in that aren't yet ready or doable just in general, whether it's scientific testing or operational issues. You know, I understand the aspirational concept.

But, sort of as a matter of course with all of these measures, I think we should really be trying to only put those forward that are ready. And certainly just saying whether or not your collected the CAHPS survey is I don't think very – a substantive process that's really going to yield any information.

Female: I agree with you, Danielle. And, Chip, I like your suggestion that in the report we have something that urges CMS to make this happen and move it forward.

Female: Yes.

Female: Agree.

Female: (That's great).

Charles Kahn: OK. So, can we do that and – can we do that? OK. So, that will be done. Now, I guess – are we ready for the public comment or are there other comments from the group? OK. So, I'm going to open it up to public comment.

Operator: OK. At this time, if you would like to make a comment, please press star, then the number one.

Charles Kahn: Hearing anything – going once. Going twice. OK. So, why don't we return back? And now, I guess we don't have a quorum. So, we'll have to vote on this by the SurveyMonkey. So now, I guess I'll turn it back to staff to go to the next item. Is that what I do now?

Erin O'Rourke: Great. Thank you, Chip. So, with this, we are actually going to review some new topic for the Coordinating Committee. And I'll turn it to Karen Johnson

and the NQF Rural Health team to provide an overview of MAP's new work in that area.

Karen Johnson: Good afternoon, everyone. I'm Karen Johnson. I'm one of the senior directors at NQF and I've had the privilege to lead our MAP Rural Health Workgroup work. So, very quickly, I wanted to give you the background and, then, we have one of our co-chairs from the workgroup on, Ira Moscovice, who will walk us through the (inaudible) of the report.

So, first of all, just very quickly, in 2015, NQF took on a project funded by CMS to look at rural health issues regarding measurement in (rural health) providers. So, as part of this project, we looked to provide guidance on performance measurement issues and challenges and really wanted to make recommendations regarding measures that are appropriate for use in CMS (P for P) program for rural hospitals and clinicians, make recommendations to mitigate measurement challenges, particularly the low case volume challenge and also identify gaps in measurement.

Just as an FYI, as part of this work, we focused not only on small PPS hospitals and clinics but also critical access hospitals, rural health centers and FQHC. The last three, of course, are not paid through the PPS system and, therefore, typically do not participate in CMS programs. (When they do), it's on a voluntary basis.

So, this slide just reiterates some of the key issues that that committee at that time talked about in terms of challenges that really impact measurement for rural providers. These are – they don't operate in a vacuum. They are very much inter-related. But, you have geographic isolation.

So, for example, that can impact your IT capabilities, which impacts data collection activities. Transportation difficulties can happen. That can impact specific measures. You know, a small practice size oftentimes – not always but sometimes.

And one of the big takeaways from that is that you have, you know, limited time and resources for QI overall. And that's the whole gamut of QI from data collection all the way through improvement activities. And you also kind

of – goes with this, you know, a small staff means that often one person is doing, you know, the medical/clinical activities as well as being the IT guy and the plumber, as we heard from one of our members of that committee.

You also have heterogeneity in rural populations. So, you know, when you think of rural, rural is really – you've seen one and you've kind of you've seen one, in a way. Rural southwestern Virginia where I am from is a very different animal than rural Alaska in many different ways in terms of challenges that people face, cultural background – that sort of thing. All of these things do have implications for measurement.

And then, of course, there is the case volume. And that really can affect reliability and validity of measures and even applicability of measures. So, if you don't have obstetrics care in your hospital, then measures of obstetrics care may be – obviously you can't report on. So, these were some of the major issues that were identified back then. Of course, they still hold true now and we kept those in the back of our minds as we did our work with the Rural Health Workgroup.

The next slide, please. The next – the overarching recommendation of that committee was to actually make participation in CMS measurement programs mandatory for all rural providers – again, not just the PPS providers – but do it in such a way that it's a phased approach so that people who aren't used to doing that would have time to ramp up and learn and be able to effectively participate. And, also, we wanted to make sure that low case volume was explicitly addressed.

The – if we go to the next slide. The committee at that time also made several additional recommendations that would help ease these overarching recommendation of migration to mandatory participation. And one set of those recommendations had to do with measure selection.

So, I put those on the slide for you. One was to use guiding principles for selecting quality of measures that are relevant for rural providers. And they actually articulated those guiding principles. Another one was to use a Core Set of measures along with many optional measures for rural providers, again,

when you are selecting measures for particular programs and then, finally, to create a MAP Workgroup to advise CMS on the selection of rural-relevant measures.

So, fast forward two years to today. We are very excited that not only do we have an empaneled MAP Rural Health Workgroup that came together in September of 2017. But, one of the first projects of that group was to identify a Core Set of rural-relevant measures that could be used in various programs.

So, the next couple of slides I am not going to read for you. And you're very happy about that. I just want to make sure that you guys know who was on our roster. So, you see those there.

And, then, if we go to the next slide and then the next one. Our key activities of the workgroup were, again, to identify a Core Set of best available rural-relevant measures, identify gaps in measurement and provide recommendations on alignment and then, finally, make recommendations regarding measuring and improving access to care for the rural population.

That last one – we were actually charged to address a measurement topic. And it became very apparent even from our very first meeting that access to care is something that is a big issue for rural providers and rural residents. So, that almost by default became our measurement topic.

Let's go to the next slide. So, just very quickly so that you know our process, we were very busy. We did five webinars in which we identified our Core Set of measures or at least the draft Core Set, two webinars to discuss to care. We did two draft reports, the second of which was release for our 30-day public and member comment. From that commenting period, we received 14 comments from eight organizations.

As part of our work, we updated an environmental scan of measures that we had actually done initially for the 2015 work, identified first of all initial measure selection criteria. And to do that, we harkened back to the guiding principles that the 2015 committee set out for us.

So, we did use that work. We did some quantitative work to tag measures and try to narrow down the number of potential measures for the Core Set (inaudible) (a lot of) discussions about the various measures to finalize the Core Set and to discuss access to care.

So, the – let's go to the next slide. In terms of our comments, again, we have 14 comments, eight organizations. Our comments were pretty much supportive of the work overall, agreement with our initial selection criteria which were to look at cross-cutting measures and try to choose for our Core Set cross-cutting measures, measures that are most resistant to low case volume and then transitions of care measures. There were also some other criteria – or some other areas that we wanted to bring in, for example, measures related to blood pressure and diabetes because they are just so prevalent in the rural population.

In terms of the focus on access and the three domains – that also was supported by commenters. Commenters did really reiterate the need for measure development that would – for measures that would work for the rural residents and providers and/or modifications to existing measures. So, people always have ideas about how one might modify a measure to make it a little different than maybe (inaudible) providers (inaudible).

And then, finally, there was a comment to create measures specific to major categories of provider type. That one was an interesting comment because it kind of alluded back to some of the work from the 2015 group where not only did that committee suggest that we identify Core Set of measures, but they also said you want to also think about a menu of optional measures. Our workgroup this year did not do that work. We only concentrated on the Core Set. But, there, I think, is a need to think about optional sets as well.

Let's go to the next slide. In terms of feedback on the Core Set itself, generally the feedback was positive. There was a desire for some specifics about how the Core Set (inaudible). That was a little tricky because we are – we've built and identified the set of measures but not for any particular program, unlike some of the other work in the MAP.

There was a little bit of concern about the decision to limit Core Set measures to those that were endorsed not so much (inaudible) a suggestion that in the future perhaps we should consider going beyond just NQF-endorsed measures. And then, finally, there were some measure-specific comment. They're going into the – our final webinar with the workgroup.

There have been some kind of back-and-forth seesawing about Measure 1789, the All-Cause Readmission measure. You know, some workgroup members wanted to include it, others not so much. So, there was quite a bit of conversation about that. And commenters – we had some comments who – commenters who wanted to include it and some who didn't want it, and they kind of balanced out.

There were also some recommendations to remove or at least consider removing or at least to talk about a little bit more before you finalize eight measures. Most of them were on the hospital side – all but one. And, really, the rationale for these considerations were because of the potential for low case volume and/or lack of services – and those go together, of course – and some risk adjustment concerns.

So, we did discuss, as usual, all of these things on our post-comment call and finalized the recommendations. There was also some feedback from commenters about access to care, again, in general, supportive of the recommendation, again, encouragement for development of access to care measures, again – and this came up a lot in our discussions – the utility of telehealth for improving access to care as kind of a different mode of delivery.

People liked the approach that we had. Access to care is a huge, huge, huge topic and we only had two webinars that we could devote to it. So, basically, what we tried to do was talk about what are the key domains for rural residents in terms of access to care, what are some of the key challenges to measurement within those domains.

And, then, going a little bit more on the ground, what are some ways that providers can start to address those challenges? So, I think all of the – I think that was appreciated by the commenters. There was also an appreciation of

the announcement that providers can effect access even if they aren't held accountable. And they might not be able to effect every facet or every domain of access, but some things they can influence. And then, finally, there was a comment that the domains that we considered aligned with the priorities of other agencies.

So, I know I talked very, very quickly. I'm going to hand the call over now to Ira Moscovice, who was our co-chair for this workgroup. And he was also the co-chair of our 2015 workgroup. So, we had great continuity there. Ira, do you want to walk us through our recommendations?

Ira Moscovice: OK. Thanks for the opportunity to present the recommendations of the group. On the first slide related to recommendations, overall we had 20 measures that were identified for the Core Set. Nine were for the hospital side, 11 measures for the ambulatory setting. But, we also identified seven measures for the ambulatory setting that are currently are endorsed for the health plan or integrated delivery system level of analysis rather than the individual provider analysis.

And the measures apply to majority of rural patients and providers. As Karen mentioned earlier, they are NQF-endorsed measures. So, we started by looking at the NQF measures that existed. We wanted them to be cross-cutting and, when possible, not to focus on individual diagnoses, for instance, although diabetes came up to be an important area that we did focus on.

And we wanted them to try to be resistant to low case volume, which is always a challenge. They include both process and outcome measures. And we've included measures that are based on patient report (to group health). That was really important to get to the patient input into this. And the staff tracked down and the majority of the measures were already used in multiple federal quality programs. In our final report, there is an outline of that.

So, if we go to the next slide. The next slides contain the individual measure. I won't go through each measure in detail but just give an overview. And if you have questions about individual measures, Karen and I can try to address that.

But, for the hospital setting, you see that there are two infection measures, CAUTI and – one related to CAUTI and one related to CDI because infections – once again, we could try to do with the volume issue here in terms of these infections across all patients coming into the hospital.

HCAHPS including 11 performance measures were included. And that brings the patient input into the picture. We have falls with injury, and people felt that that's a particular problem for the (inaudible) population is more prevalent in the rural areas than in urban areas.

The one care coordination measure is the Emergency Transport Communication measure, which just looks at the this information being related in appropriate timeframe from emergency rooms to hospitals where patients get transferred. A measure on DTE prophylaxis and a measure on caesarian birth rates.

And what it really is – (brought down) – we are aware that there a lot of rural hospitals that have lost their OB services. So, this is one is applied, obviously, to all rural hospitals. But, we felt it's important enough in terms of being a key measures that we would apply to the hospitals that do currently provide OB services.

Interest in a measure (inaudible) and alcohol use screening also. And then, finally, the last measure is hospital-wide all-cause unplanned readmission measure, which we include. And there was a vibrant discussion of the pros and cons of including that. But, we came down (inaudible) on trying to (include it).

Next slide that – some of the ambulatory care setting measures. And as you can see, a lot of them are prevention-oriented. We get this patient input from the CAHPS clinician and group surveys where we have several preventive care and screening measures for tobacco use, for influenza immunization, for clinical depression and follow up – all those being important issues, (we believe), in rural environments.

We had a measure on comprehensive diabetes care, particularly control or lack thereof of A1C, medication reconciliation which is felt to be really

important post discharge. Advanced care planning just came up and it was just felt in terms of end of life environment that it was really important to have a measure related to whether the patients have insurance care claim.

If we go to the next slide, it presents the final four measures for the ambulatory care setting. Once again, two preventive care and screening measures, one related to BMI and another related to unhealthy alcohol use. And, then, we look at outcome measure depression remission six months and then, finally, a measure on optimal diabetes care, whether optimal care in terms of five or six different areas are being provider for patients with diabetes. So, those are the ambulatory care setting measures.

And the next slide looks at the ambulatory setting but where the health plan or integrated delivery system level of analysis is appropriate. And there are seven measures here, once again, prevention or screening-oriented, trying to control high blood pressure, weight assessment and counseling related to nutrition and physical activity, cervical cancer, colorectal cancer, breast cancer.

The feeling of the group was that cancer was really an important area for us to recommend some screening measures. Childhood immunization status and then, finally, contraceptive care in terms of the most and moderately effective methods. And, once again, all of these are NQF-approved measures.

So, if we go to the next slide, that – those are the recommendations for the existing Core Set and the additional seven measures at the end. But, in terms of measurement gaps, the workgroup identified five areas that were important, and they're discussed in the report.

One is the access to care area that Karen mentioned earlier with the feeling that if you don't have access to care, then the whole issue of quality can't be addressed, the notion of transitions in care being really important. The cost issues, which we have not so much information on, also is identified as measurement gap, particularly the focus now on alcohol and opioid and all areas of substance abuse measures is just felt to be a measurement gap. And then, finally, outcomes measures, particularly patient-reported outcomes, with

the feeling that there has been a lot more focus on the process than the outcome side up to now.

But, as Karen mentioned, as we go to the next slide, if we look at those measurement gaps, overall the group really said "Let's take a dive into access to care." And the group identified the facets of access that are particularly relevant to rural residents, documented key challenges to access to care measurement from a rural perspective and identified ways to address those challenges.

And what was discussed was the difficulty of decoupling access and quality and a really good conversation about who should be accountable for access issues. Should it be at the clinician level or the higher level accountability? And the belief was that it really should (be just at all) levels, that we shouldn't just say it's a higher level (inaudible). Clinicians do have some accountability here. As mentioned earlier by Karen, always distance to care and transportation issues are really vital issues for rural environment and certainly affects the access to care issue.

And, finally, telehealth certainly has been – start to be expanded for use. But, it still has some limitations in terms of whether it's reimbursement or individuals having to go to provider sites to participate et cetera. So, it's a start in telehealth, but it got ways to go.

And, then, if we go to the next slide, the three domains that were looked at in terms of access to care was broken down into the domains of availability, accessibility and affordability. On the availability side, clearly specialists are not readily available in most rural areas. But, the whole issue of appointment availability and timeliness came into play.

And there was a good discussion on this in terms of the tradeoffs. You know, we were saying we want the referral or the appointments to be available. Yet, in terms of the current supply out there in rural areas, it's a challenge and this is sometimes a tradeoff in terms of being able to do things in a timely fashion and being able to provide high-quality care.

What the group did was talk about ways – how can we address that? And one was overall workforce policy that's certainly appropriate and team-based care and letting (all providers practice) to the top of their license, telehealth, as we mentioned before. And whole issue of coordinating and improving referral relationships was important.

The second domain was accessibility. And as I mentioned, transportation. But, it's access also to health information certainly related to health literacy, language interpretation issues and just physical spaces and the lack of availability. This could be addressed – suggestions were by tele-access to interpreters, by building strong community partnerships between the rural providers and key community organizations, by remote technology and by enhancing clinician-patient communication.

And the final domain was affordability. And that focused on out-of-pocket cost and really delays due to out-of-pocket cost. And the committee discussed at various points in time the notion of it's important to have appropriate risk adjustment if rural providers can be treated fairly, that a policy insurance opportunity needs to be expanded, issues related to how we're going to protect the safety net and, then, trying to understand how we can monitor the patient balance after insurance.

So, those are the three key domains that we've broke the access to care issue down into. And, then, on the next slide, which is the final slide, you know, overarching recommendation. We really would like CMS to continue funding the MAP Rural Health Workgroup. What we have done in terms of the Core Set – it's certainly a starter set. But, it needs to be refined over time.

There are some measures that we know are under refinement right now. And there's always going to be new measures that come up. There are going to be modification to existing measures and we need to monitor unintended consequences to make sure we're not causing some issues with the kinds of measures we are saying need to be monitored.

And it'd be great if NQF and the group – the workgroup – Rural Health Workgroup can continue to have opportunities to offer our perspective on

other topics that will be coming up in the future. We think it's really important and really helpful both in terms of getting rural provider engagement and also just highlighting the need at times to make sure that measures that are being collected are relevant and applicable to rural providers. So, I'll stop there. And, Karen, I don't know if you have any final comments before we open it up.

Karen Johnson: No. I'm going to stop now and I guess – I'm not quite sure. Do we hand it over to the co-chairs of the Coordination Committee?

Charles Kahn: Yes. It goes to Harold. Yes.

Harold Pincus: Yes. So, are there comments from members of the Coordinating Committee regarding the Rural Health report?

Nancy Foster: So, Harold, it's Nancy. I'll get it started again if you like.

Harold Pincus: That's be great.

Nancy Foster: So, first of all, if I failed to mention it before, I apologize. All three of these subject matters have been challenging. And I actually do applaud the workgroups for taking on these very challenging issues and coming up with successful recommendations.

I am particularly fond of the – this particular set of recommendations and the report here. It illuminates some really challenging issues that – and helps us take steps forward. So, kudos to the workgroup for putting this report together.

I would like to suggest a friendly amendment somewhere near the beginning of the report that acknowledges that even with this set of recommendations of measures, that does not create a sort of shovel-ready set that we could just go out and start implementing in some sort of pay-for-performance program because I think, as Ira started to talk about, you know, this is complex.

And how you put it together so that you create the right incentive built into such a program and recognize that not all rural providers are identical is really

challenging. And, so, just some sort of acknowledgment that it's the design of the program as these measures that would be implemented that really needs to continue to reinforce some of these critical issues that the workgroup has brought out would be appreciated in my perspective.

And, then, a couple of comments on some of the specific measures when – around feasibility really. I am really glad to see both of the infection measures in this report. But, I think it would be helpful and an appropriate cautionary note to those who might choose to pick up this report and use it for implementation that both the CAUTI and the C. diff. measures are not a light lift in terms of data collection. So, they are – they are more on the intense side. And that I think would be helpful as people are trying to put together a balanced portfolio.

In a slight different vein, the HCAHPS measures – important to include here – always want to have the patient perspective. But, I think there's a little more work to be done to figure out what exactly is the minimum set of responses that are needed and how can the HCAHPS survey be improved and the – and the methodology for administering the survey be improved to increase our yield from administering the survey. Can we move into, you know, a Web-based or an app-based kind of response to HCAHPS surveys that would help to create a better response rate?

So – and just one final note. I really would like to even further emphasize the workgroup's call for the need to identify some substance use measures in additional to the alcohol screening measure that has been recommended here and the critically-important issue in the rural communities, and it would be great to be able to tackle that. So, again, kudos to the workgroup.

Harold Pincus: I have a comment. And, by the way, could people please – if you're not speaking, please mute your phones. There's some background noise. Other comments from the committee? So, I have a couple of comments. And people can gather other comments as well. So, two comments.

One is I was surprised that – which I think – I think it's a terrific report and really raised important issues and I particularly applaud that focus on access.

But, I noticed that nothing is called out around behavioral health services access because that's a huge issue in rural areas. And I think developing ways to better measure and assess behavioral health access I think is critical. And I'm talking about both mental health and substance abuse services.

Number two is I have a little bit of concern about the recommendation around depression remission at six months. That's a very high bar and it's also, you know, a measure that requires – that people have access to registries for measuring the PHQ-9.

But then also having remission alone can have some unintended consequences in terms of pushing people who may be satisfied with a PHQ-9 slightly above remission to sort of push providers to add additional medications that may not – that may not be as – may be sort of a burden for the – for patients when they might be quite satisfied with the level of response they have. And, so, that – what most people are recommending is that combination of either remission at six months or 50 percent clinical improvement as a joint measure.

And, number three, I was kind of surprised that there are – I mean I – given the degree of attention being given to opioid issues, that there are measures that could be employed now that are available both on the prescription side and on the treatment side that – and I was surprised that there weren't any that were included in the Core Set recommendations. So, I just wanted to add those comments. Are there other comments as well?

So, hearing none, I guess we can open it up for the – for public comment.

Operator: And at this time, if you would like to make a comment, please press star, then the number one. And there are no public comments at this time.

Harold Pincus: So, let me turn it back to NQF staff to talk about what are the sort of follow-up issues in response to this event.

Erin O'Rourke: Sure.

Charles Kahn: And, then, they can turn it back to us to adjourn.

Erin O'Rourke: That sounds good. This is Erin from NQF. So, since we did not have quorum on the call, we will be e-mailing you a survey to take – to cast your official votes. Please keep your eye on an e-mail from MAP Coordinating Committee box so that we can get those completed as soon as possible as this set of reports is due to HHS on August 31. So, we very much appreciate it if you could take that survey as soon as you receive the e-mail.

That will conclude really the work here. We did send an e-mail a few weeks ago for key dates for the upcoming pre-rulemaking cycle ion November and January. So, please get those on your calendars. Otherwise, thank you for your time today. And I can turn it back to you, Chip and Harold, for any closing remarks.

Charles Kahn: Well, I guess I – one, I want to express my appreciation to everyone who spent time on the phone this afternoon. And we came close to a quorum. But, I think we really accomplished a great deal in terms of reviewing the reports and the great suggestions and observations.

I guess before I pass the baton, I'd just like to thank my co-chair for all the time and effort he has put in. And I think he just showed in his comments on the last report how important a contribution he has made and will be making as a continuing Coordinating Committee member but not as a co-chair. So, with that, I'll pass the baton over to you, Harold, to close out the meeting.

Harold Pincus: So, thank you, Chip. You know, I really appreciate your comments. It's been a delight to partner with you on this and I've enjoyed my term as co-chair and I am delighted to continue in the role as being the – I guess the sort of the expert in behavioral health. So, I look forward to seeing everybody at our next meeting. And, again …

Erin O'Rourke: And this is Erin. Just to …

Harold Pincus: … a great appreciation to the NQF staff who always do such a terrific job.

Erin O'Rourke: Harold, thank you so much for that. And from the NQF staff, thank you so much for all of the effort you've put into the co-chair role over the years. It's been wonderful working with you and we greatly appreciate how much time

you've dedicated. And we're so thankful you are staying on as a subject matter expert and will be back for the next pre-rulemaking cycle.

We're also excited to work with Dr. (Bruce Hall), who will be taking over the co-chair hall. And to all the Coordinating Committee members who are cycling off, again, thank you for your time. And for those continuing on, we look forward to continuing to work with you.

So, again, thank you everyone for your time today. And we'll be in touch with the survey to cast your votes and next steps for pre-rulemaking.

Female: Thank you.

Male: Thanks a lot.

Female: Thanks.

Female: Thank you.

END