NATIONAL QUALITY FORUM

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MEASURE APPLICATIONS PARTNERSHIP
DUAL ELIGIBLE BENEFICIARIES WORKGROUP

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WEDNESDAY
MARCH 4, 2015

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The Workgroup met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 9:00 a.m., Alice Lind, Chair, presiding.

PRESENT:
ALICE R. LIND, RN, MPH (Chair)
JENNIE CHIN HANSEN, RN, MS, FAAN (Vice-Chair)
GEORGE ANDREWS, MD, MBA, CPE, Humana, Inc.
RICHARD BRINGEWATT, SNP Alliance
GWENDOLEN BUHR, MD, MHS, Med, CMD, American Medical Directors Association
ADAM BURROWS, MD, National PACE Association
ANNE COHEN, MPH, Subject Matter Expert
STEVEN R. COUNSELL, MD, America's Essential Hospitals
VENESA DAY, MPA, CMS Medicare Medicaid Coordination Office (Federal Government Member)
KATA KERTESZ, JD, Center for Medicare Advocacy
K. CHARLIE LAKIN, PhD, Subject Matter Expert
THOMAS H. LUTZOW, PhD, MBA, iCare
D.E.B. POTTER, MS, Office of the Assistant Secretary for Planning and Evaluation (Federal Government Member)
SUSAN REINHARD, RN, PhD, FAAN, AARP Public Policy Institute
E. CLARKE ROSS, DPA, Consortium for Citizens with Disabilities

GAIL STUART, PhD, RN, Subject Matter Expert
SHAWN TERRELL, Administration for Community Living (Federal Government Member)
SALLY TYLER, MPA, American Federation of State, County and Municipal Employees
GREGG WARSHAW, MD, American Geriatrics Society
JOAN LEVY ZLOTNIK, PhD, ACSW, National Association of Social Workers

NQF STAFF:

HELEN BURSTIN, MD, MPH, FACP, Chief Scientific Officer
ANN HAMMERSMITH, JD, General Counsel
MARCIA WILSON, Senior Vice President, Quality Measurement
MEGAN DUEVEL ANDERSON, Project Manager*
SARAH LASH, Senior Director
ZEHRA SHAHAB, Project Analyst

*** present by teleconference**

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(9:05 a.m.)

CHAIR LIND: Good morning. So this morning I was the chatter bug who slowed you all up. Apologies.

This is Alice Lind. I am one of the two chairs of the Measures Application Partnership, and welcome this morning.

Megan is going to do our housekeeping tips, I think. Where is Megan? On the phone. Megan is on the phone. So, Megan, do you really want to do the housekeeping announcements?

MS. ANDERSON: I am happy to. Thank you, Alice.

This is Megan Duevel Anderson. I'm the Project Manager at NQF for the dual eligible beneficiary workgroup. And, first of all, I want to thank you all for joining us in the room and on the phone.

I am on the phone, and I just -- just to tell you why, I now work from southern Germany.

I am going to go through some announcements for housekeeping purposes, just so everybody has the information that you need. Hopefully, you are all getting settled and enjoying your breakfast.

The staff in the room are happy to recommend local restaurants where you can get something to eat during the break for lunch. Those of you in the room, we really appreciate your taking time away from your day job. And if you need to take a phone call, just please step into the lobby, and remember to turn your phones on mute at the beginning of the meeting.

The Wi-Fi connection information is available and staff at the check-in can help you if you are not able to get onto the internet.

All of the meeting materials are available electronically. You'll notice we don't have a lot of handouts. We are trying to be green. The meeting materials are downloadable from the NQF website, and have been made available for workgroup members. You can access

them there, and staff will make sure you get them directly.

The people on the phone don't need to worry about this, but the restrooms, for those in the room, are just located beyond the elevators, and then as you get past the elevators turn right and the restrooms are on the right.

In the room, please let us know when you want to speak by raising your tent card, so that the chairs can recognize and call on you. If you're on the phone, please let us know you would like to say something, and we will make sure that you are in the queue. Just speak up. You can also let us know via the chat box on your web platform, if you'd like to make a comment as a workgroup member.

For those on the phone, please do make sure you mute your phone when you are not speaking, and do not place your call on hold. As probably heard from the operator, if you do place your call on hold, the room and everyone else will hear a lot of beeping. So, please, hit mute

and dial back in if you need to pick up a phone call.

We will be using public comment periods throughout the meeting, so public members in the room are invited to use the microphones. And the public members on the phone will have their lines opened during discussion or public comment periods. The public are also welcome to make comments on the web platform.

And last, but also very important for those in the room, if you need to speak, please use your microphone. If the light is green, then the microphone is on. If the light is red, it is off. If the light is flashing, that means too many people have their microphones on. There can only be three. So when you are not speaking, please make sure you turn your microphone off.

And since I and a couple of other people are on the phone, please do make sure you use your microphones, because I really need to catch all those tidbits of information that you're sharing with us. And the Court Reporter

can't, also, get the information if you're not using a microphone.

That's all from me.

CHAIR LIND: Thank you very much. So we are going to go through the meeting objectives first, and then we will do introductions as we update the disclosures. So in case you wondered why we haven't done that step yet, it's coming just immediately after this one.

The objectives of today's meeting is to explore the use of measures in the dual eligible beneficiary population. So I think you would have been able to tell from the web meeting, for those of you -- I think almost everybody participated in the webinar, so you know that the staff has been busy at work doing analytical work to figure out which of the measures are being used in what way. And so a lot of the information that is going to be presented to you is about that.

So moving just from the which measures to the application of measures, so I think you

are going to be thrilled to see that the work that has been done over the first couple of years is really starting to get some play.

Then, we are going to do the annual update of the family of measures, so that is going to be the really hard work, hard because we have many measures to get through and a short amount of time to do so, but as we get to that part of the agenda we will have already gotten your brains completely awakened. For those of us from the West Coast, that is sometimes a challenge.

Then, the final objective is to consider strategies to support the delivery of person-centered care for complex beneficiaries and what is the role of measurement in improving that. So that is something near and dear to all of our hearts, I think. Over the last couple of years we have had many conversations about it, so, again, I think it will be heartwarming to us in the room to move forward from the just thinking about the measures to the how does that

play out in actually improving person-centered care.

So those are the objectives for the next couple of days. Ann Hammersmith is going to do the annual process of updating disclosures, and that will form our round of introductions at the same time. So, Ann.

MS. HAMMERSMITH: Thank you, Alice. Good morning, everyone. As some of you may recall, the disclosure for MAP committees is different from our CDP process. We have two types of representatives on the committee. We have organizational representatives, and we have subject matter experts.

If you're not sure what you are, if you think back to the form you received, if you're an organizational representative you received a one-page form with one question. If you're a subject matter expert, you received a multi-page form where we asked you lots and lots of questions.

So we will do the disclosure in

pieces. First, we will do the organizational representatives, and I'll explain that a little bit more, and then we'll do subject matter experts, and I'll explain that a little bit more. And for our federal representatives, we will just ask you to introduce yourselves at the end of the disclosures.

So organizational representatives, as you might have guessed from the term, you represent your organization. So because you do represent your organization, we expect you to bring a particular viewpoint to the table, a viewpoint that we are looking for and would regard as important for this work.

So in light of that, we didn't ask you a lot of questions about your professional activities. We only asked you one question, which is, do you personally have an interest of $10,000 or more in something that is related to the work of the Committee? So something that will come before the Committee that is directly related to something that you have a financial

interest in of $10,000 or more.

So the example I always give is defibrillators. I don't know why, but that's the example I always give. So let's say you were a Committee looking at cardiovascular issues, and one of the topics was defibrillators, and you have $50,000 of stock in a company that makes defibrillators. We would look for you to disclose that.

Other than that, you wouldn't need to disclose anything. If you have nothing to disclose, just tell us that. As Alice said, we're going to combine introductions with your disclosures. So we'll go around the table; tell us who you are, who you're with, and if you have anything to disclose. And this is organizational representatives only.

So we will start with Clarke Ross.

MR. ROSS: Good morning. Clarke Ross. I am employed by the American Association on Health and Disability. I represent the Consortium for Citizens with Disabilities, which

is a 42-year-old coalition of 113 national organizations. It is a volunteer coalition. I have worked for nonprofits my entire career, and I have no financial interest at all, much less those to report.

DR. BUHR: My name is Gwen Buhr. I represent AMDA, the Society for Post-Acute and Long-Term Care Medicine, and I have nothing to disclose.

MS. ZLOTNIK: I am Joan Zlotnik. I represent the National Association of Social Workers, and I have nothing to disclose.

MS. REINHARD: Susan Reinhard, AARP, Public Policy Institute, and nothing to disclose.

DR. ANDREWS: George Andrews, representing Humana, and I have nothing to disclose.

MR. LUTZOW: Tom Lutzow. I'm with iCare. I have nothing to disclose.

MS. KERTESZ: Kata Kertesz. I represent the Center for Medicare Advocacy, and I have nothing to disclose.

DR. COUNSELL: Steve Counsell representing America's Essential Hospitals, and I have nothing to disclose.

MS. TYLER: Good morning. Sally Tyler. I represent AFSCME, the American Federation of State, County, and Municipal Employees. Nothing to disclose.

MR. BRINGEWATT: Rich Bringewatt. I represent the SNP Alliance, Special Needs Plan Alliance. I don't have anything to disclose.

MS. HAMMERSMITH: That takes care of all of our organizational representatives. We have two people who were not able to attend.

Let's move on to our subject matter experts. Your disclosure is a little more complicated, because your form was longer. So subject matter experts, you are sitting as individuals. You don't represent your employer, anybody you are associated with, any organization that may have nominated you for the Committee. So you are sitting because you are individual experts.

Because of that, we sent you a much longer form, where we asked you detailed questions about your professional activities, whether they're paid or they are unpaid. So what we're looking for you to disclose this morning is anything that is relevant to the work of the Committee that you have engaged in.

This may be research. It may be grants that you have received. It could be consulting that you have done, but only if it's relevant to the work of the Committee. We are not looking for you to disclose everything on your resume. Also, want to -- we'd be here for a long time if we asked you to do that. We also are -- just because you disclose doesn't mean that you have a conflict. A lot of people will say, "I don't have any conflicts," which is great, but you may have something that you should disclose anyway, even though it isn't a conflict.

So we are -- we do this in the spirit of transparency, openness, so that everybody knows where everybody is coming from. So with

that, we will go through the subject matter experts, and we will start with -- we will go around the table. We'll start with Gail Stuart.

MS. STUART: Good morning. So I'm Gail Stuart, and I'm the content expert on nursing. I'm at the Medical University of South Carolina in Charleston. And while I've had lots of professional experiences, at this point in time I don't think I have anything to disclose or anything that is relevant. My grants aren't relevant to this particular topical area.

Thank you.

MS. HAMMERSMITH: Who is our next subject matter expert going around the table?

MS. COHEN: I think that's me. Anne Cohen. I'm a disability and a health policy consultant. And at this point, none of my clients have any conflict; I have nothing to disclose.

MS. HAMMERSMITH: Okay. Thank you. Charlie Lakin?

MR. LAKIN: Charlie Lakin. I'm

retired, but before that was Director of the National Institute on Disability and Rehabilitation Research, and before that the Research and Training Center on Community Living at the University of Minnesota.

During that time, I received a number of grants from CMS, ACL, and NIDRR, that used some of the instrumentation that has been discussed as part of the background paper for this group. And so I do have some interest in that area, but none of it is financial.

MS. HAMMERSMITH: Okay. And we will go to our co-chairs?

VICE CHAIR HANSEN: Hi. I'm Jennie Chin Hansen. I have probably one new development since the last meeting, and that is I am on the Commonwealth Fund's Committee on High-Need, High-Cost Populations.

MS. STUART: I'm sorry. I just remembered, I have just recently been appointed to the National Advisory Board for SAMHSA, have yet to attend my first meeting, so --

MS. HAMMERSMITH: Okay. Thank you, Gail.

CHAIR LIND: Alice Lind. I had, up until 18 months ago, worked for the Center for Healthcare Strategies, and in that role received grants from the Federal Government and other foundation-related work, some of which involved similar measures, the use of measures in demonstrations for dual eligibles.

Now I am on the Washington Medicaid side, and I am a recipient of grant funding from the Centers for Medicare and Medicaid Services to support our dual eligibles demonstration, which does overlap heavily with some of the work of this group.

MS. HAMMERSMITH: Okay. Thank you, Alice.

And is Mady Chalk on the phone? Mady Chalk on the phone? No.

Okay. All right. And now I'd like to invite our federal representatives to introduce themselves. So that's D.E.B. Potter and Venesa

Day.

MS. POTTER: Hi. I am D.E.B. Potter. Since the last time we met in person, I changed agencies in Health and Human Services, and I now work for the Office of the Assistant Secretary. But I am very pleased to still continue to participate here with you all today, and I have nothing to disclose.

MS. DAY: Hello. My name is Venesa Day, and I'm here representing CMS from the Office -- well, the Duals Office, MMCL. I have nothing to disclose.

MS. HAMMERSMITH: Okay. And is Shawn Terrell here? Oh, there you are.

MR. TERRELL: I am Shawn Terrell, Administration for Community Living, sitting in for Jamie Kendall, who is the official member from our organization.

MS. HAMMERSMITH: Okay. Thank you, everyone.

Now I just want to invite you to ask any questions you may have of each other, or of

me, regarding the disclosures that were made this morning. Any questions? Okay. Oh, go ahead.

MS. COHEN: I was just going to ask, as Alice demonstrated, are we -- we are only supposed to disclose from the past year, or the past -- since last time we reported, or are we disclosing back farther?

MS. HAMMERSMITH: The new form is five years. I'm not sure which one you've got.

MS. COHEN: Oh, five years. Okay. Well, then, I actually do have two things to disclose.

MS. HAMMERSMITH: Okay.

MS. COHEN: Sorry. Forgive me, it's West Coast time in my brain. So I worked as a consultant for the State of California and helping develop their dual eligibles program. So, obviously, that's probably something -- I am no longer consulting with them. And then I did do cultural competency training for Health Plan San Mateo, which is a duals health plan.

MS. HAMMERSMITH: Thank you for

updating your disclosure. Appreciate it.

Go ahead.

MS. REINHARD: As an organizational rep, I'm not sure if I'm supposed to say this. But we do have funding from the SCAN Foundation and the Commonwealth Fund to produce long-term services and support states' work, and where we use as much data as we can. Especially around the duals, we would love to. I don't know if that's something to disclose or not.

MS. HAMMERSMITH: Okay. I appreciate your disclosing that. You don't need to disclose that as an organizational rep, but thank you for doing that.

One of the things I want to remind you of before I leave is that we remind -- we rely on all of you to help us make our process work, our disclosure of interest process. So if you're sitting in the meeting, and you think that you may have a conflict, or you think someone else has a conflict, or you think that someone is behaving in a biased manner, we do ask you to

speak up. The process is only as good as everybody who is involved in it is, so we all try to do our part and we ask our Committee members to do their part as well.

If you do think there is a conflict or there is bias, you can always speak up openly in the meeting in real time. If you prefer not to do that, you can go to your co-chairs, who will go to NQF staff, or you can go directly to NQF staff, and we will do our best to resolve it.

So, with that, thank you very much, and have a good meeting.

CHAIR LIND: Thank you, Ann. And thanks, everybody.

So, Venesa, who I can't believe I am finally meeting you in person. We have talked -- Venesa and I have been on the phone together probably 100 times over the last --

MS. DAY: Alice is being modest.

CHAIR LIND: So I'm so delighted to have Venesa here representing the Center for Medicare and Medicaid Services Duals Office, and

please give your welcoming remarks.

MS. DAY: All right. Thank you, everybody, for having me and for meeting so soon after our web meeting.

I will say, first, that I'm super nervous about speaking in public. But when I walked in and the room was set up in this way, which is kind of -- for people on the phone, it's just like everybody is seated in kind of a semi-circle, I was like, ah, okay, I can do this.

So, but a few things. From the web meeting, I really heard that the MAP wanted to hear what CMS has been doing with its work. And there are lots of things that we have been doing with the work, and so I am going to be very concrete and walk through those things and not take up too much of your time because I really would like to do some discussion and question and answer.

When Sarah told me I had to speak, she was so nice to me and she sent me an email. She's so tactful, and it said -- the last thing she

said in her email was, "These people are your partners in this work," and then that kind of brought everything together, because if you know anything about our office, we have a pretty big task from Congress. So I'll have to read these, so I make sure I don't get it wrong.

Improving the quality of health care and long-term services for Medicare and Medicaid enrollees, increasing enrollees' understanding and satisfaction with coverage under Medicare and Medicaid, improving care continuity, and improving the quality of performance and service -- of service and suppliers under Medicare and Medicaid.

And so that is a pretty big task. None of us do it alone. And especially for me, who is kind of new to this kind of setting, your partnership is invaluable.

A couple of folks around the table, like Alice and D.E.B., definitely know that I'm not afraid to say, "I don't know what this is. Can you please -- can you please guide me and

lead me?" And the first document that I read when I came to the Duals Office and started working on quality was the Duals MAP 2012 Report. And that really has served as a road map for what we have done so far in every report since.

And so a couple of things. Right now, we have 12 states operating CAP and managed fee-for-service models, all of which have a core set of measures that come directly from your work and your -- the NQF MAP reports. In addition, and not just in what the states are working together to report, but also in what they are being evaluated on through our independent evaluation contractor.

We also have -- let's see, I have notes. We also have a nursing facility demonstration, which is -- has a fancy name. It's the Initiative -- Nursing Facility Initiative to Reduce Avoidable Hospitalizations Among SNF Residents. And a number of the evaluation measures, the measure concepts, come from -- directly from the work that you guys

provided.

In addition to that work, we have worked across Medicare -- I'm sorry, well, Medicare, Medicaid, health home states, all kinds of programs to make sure that when we do put measures into our demonstrations we are coming up with measures -- well, not coming up with measures, but using measures that you guys have identified for us that we can work with states to try to collect. I mean, that's kind of -- I'm learning -- an imperfect science, but we keep trying, so that we can work across states and across programs, so that we are not overburdening reporters and limiting access to our population.

So we also, in addition to the 12 demonstrations that we have going, there is some other work happening behind the scenes. So CMMI issued a document. It is called The Priority Measures for Monitoring and Evaluating CMMI -- I'm sorry, for Monitoring and Evaluation. And so this document is pretty much -- I think it's maybe about 20 pages, and it outlines measures

that folks should consider when they are putting together CMMI programs for integration or any kind of innovation.

Of those measures, I think -- I just counted the number. I think 18 of them come directly from our work. Many of them are in work that we are already doing in our duals demonstrations.

In addition to that broader document, we work very hard on every CMMI initiative that comes across our desk to make sure that, one, if it impacts duals, it makes sense for our population; but, two, to make sure that we are using similar measures, similar measure concepts. If there are measures that don't directly align, we are asking that they be stratified, so that we can get information on our population from that measure set.

So I think that is two things. Three, let me just say, at first I started -- when I was thinking of how I would do this, I thought David Letterman and, like, the blue cards and the Top

10, but I had so many things that I had to scrap that idea.

(Laughter.)

Top 50, right.

So another thing that we are particularly proud of is the opportunity to really go out to our CMS partners and push them on stratifying the measures that they already collect.

So most recently we had a small success, but we feel like it's a success nonetheless. The ESRD quality -- what is it, quality incentive program, MPRM that went out, we actually were able to convince them to request information at least for stratification of dual measures for ESRD, which, in turn, led to us working very closely with a new program coming out of CMMI that is an ESRD program. I don't think it has hit the street just yet, but their entire measure set really is pretty closely related at this point for what they want to do their -- their concepts are very closely related,

and we are working with them so that we can ensure that measures that come -- that ultimately are included really do reflect our interest and the information and work that we have gotten from this group and what has been developed.

We are also working with the in-patient psychiatric facility measure developers at CMS, and encouraging them to stratify measures that they are already collecting for our population.

And I'll tell you a funny story. I don't know if Carolyn is on, but we are sitting down with a gentleman who does this work, and at first he was kind of resistant, but, you know, we come from Medicaid, so we are used to a fight. So he kind of -- you know, he was pushing and pushing and pushing back, and then all of a sudden he just talked himself into it. He just kind of said like, "You know what? This population is going to be a lot of duals," and blah, blah, blah.

And so we reached, like, a zen point

where we were just silent, and then he is like, "Oh, you know, it does make sense for us to do this work." So that's always a good thing when your battle is kind of fought by the other person for you.

And so another thing that we are doing is promoting new measure development, and so we are required -- and I don't know how much I can talk about this, but we are required to develop new measures for GPRA. But one thing we are working on very diligently right now is a readmissions measure specific to duals. So that's pretty exciting.

I have lots of other things here, but let me go through quickly and talk about some things that we are doing outside of the measure development arena. We are also providing data to states. I mean, we have heard very clearly that, you know, data is an issue, and especially integrated data. And so our office actually maybe, I mean, from its beginning I think, started working on the chronic conditions -- what

do you call it -- chronic conditions warehouse data where we, one, got some new flags introduced that made it easier for us to capture codes related to duals; and, two, we were able to develop an algorithm that allowed us to put together a joint or integrated -- right terminology -- integrated measure set for dual eligible available to researchers.

We are also providing Medicare data, not through CCW but through a program that we call the SDRC, State Data Resource Center, that provides Medicare data directly to states. And we have technical assistance available to them now, at least to our demonstration states, and we are working very diligently with Medicaid through the innovation accelerator program, so that we can provide technical assistance around Medicare data for states outside of our demonstration.

And all of this work kind of grew out of what we are hearing from states, what we hear from this group, and so we are pretty proud to be able to take that information and make it real.

So that means that what you give us is actionable. And as much as we can, we are happy to push it and move forward.

Let's see. I just want to make sure I didn't miss anything, because literally I started right -- I mean, I started with 10 things, and then I just -- they just kept coming.

So I think just in addition to the things that we are already doing, there are so many challenges I think that folks hadn't considered. I know for myself, when we put out our -- when we started doing our demonstrations -- and Alice is a saint -- we had this group of measures, and it was kind of like, "Oh, yes. Now we can move forward and measure."

But I promise you that on -- at every step there is something that you -- we didn't think about. So in moving from what you guys give us, which, I mean, you give us a charge and it's a big charge and we take it seriously and it makes sense, and then we go to implement, there are so many different levels and phases and data

issues that we face.

And so, as we work, we are trying to work through them and work through the challenges, and sometimes, quite honestly, working through the challenge of getting Medicare to talk to Medicaid and translate that in a good way to states.

So we keep pushing, and I personally am very thankful to have you all as partners in this work. And I look forward to what comes of it from now on.

CHAIR LIND: Thank you. Any questions for Venesa? Yeah. Go ahead, Clarke.

MR. ROSS: Can you be more precise in this forum in identifying the areas of measure development that you mentioned, what precisely are the measures being developed?

MS. DAY: So we -- no.

(Laughter.)

And not being facetious, but we are working in areas of long-term services and supports and ACDS and measure gap areas. I can't

be more specific, because we are having some bureaucratic issues.

MS. POTTER: I think it's okay to add that there is also work to look at risk-adjusted methods for measures specific to HCBS. How is that?

CHAIR LIND: Any other questions?

MR. LUTZOW: Yeah. I have one. Is your development of measures indifferent to budgetary consequences? Or do you have to take those consequences into consideration?

MS. DAY: I would be lying if I said we didn't. But that's not our particular issue right now. Our group is actually pretty crafty at building alliances and getting things done across programs.

So, for instance, one thing that we didn't mention is that we actually -- I guess we coordinate a group of folks that are interested in HCBS across the agency. And through that group we have been able to really just kind of on a staff level do a lot of work around getting

things done within the confines of what we have to do as far as contracting and budget.

So I don't -- I mean, I can't say, "Oh, we have an endless pot of money to develop measures," but we certainly are crafty at being able to do what we need to do. And I think one area that we are really looking into is how we about this in a strategic way. There certainly are measures that exist, and I think our first thought is always, what is already there? Can we use it?

And a lot of times if the answer is no, then we have to look for some other avenue, which is development. And so right now we are going through that process almost in everything. So, you know, readmissions, what's there? Is it something that we really can use? Well, no, so we have to create our own. So that is kind of our process for everything.

And a lot of it honestly is where not just we are, but like where are states. Where is the data? If you recommend to us a measure, and

I will give you a specific example -- we initially had an influenza measure in our -- in our demonstrations. And so part of the issue there was, well, you -- our population can get a flu vaccine in a lot of different places. Is the data there? Are the data systems caught up and integrated enough so that we can paint a real picture of what this looks like?

And so I know that is kind of left of what you are asking, but those are the types of things that we face more so.

MR. LUTZOW: I think you said no to my question, but my question had more to do with the impact of measures, the potential impact of measures on the cost of Medicare to the nation. And, you know, is that a criteria in the selection? I believe you said no, it isn't, but that was the gist of my question.

MS. DAY: Let me make sure -- let me say it back to you, so I make sure I am hearing you. Measurement costs, you're asking, when we are developing measures, are we thinking about

the impact that it could have on overall costs?

I think -- so that question I think on some levels we have to, but in terms of what we're asking for from this group, we are not asking you to limit yourselves that way. We want -- and my predecessor, Cheryl Powell, like this was her push forward. We want you to give us what you think is the right set of -- the right family of measures. Bottom line. And on our side, we'll work to take that to where it needs to be, so that we get to the optimal place.

Did you want to --

MS. POTTER: In general, when a measure is developed by CMS or the agencies in general in health and human services, those are some of the considerations that go into measure development in terms of figuring out is the measure feasible, its usability, and things like that.

So it is on the table in that respect. When a measure goes through National Quality Forum for endorsement, it is obviously on the

table. So it is thought about. I think the world of quality measurement is a balancing act, trying to balance multiple barriers and constraints simultaneously, but still moving forward.

There is a document on the CMS website called the CMS Measures Blueprint. I think they are up to Version 12. You can like search in Google, and it comes up. This is a two-volume text on how to make quality measures, and it specifies all of the things that CMS and CMS's contractors have to do as they go through the measure development process.

CHAIR LIND: Thank you. Steve?

DR. COUNSELL: I just had a quick question, if there was a summary table or something available of the dual eligible demos, measures that are being put in place to -- for the duals to --

MS. DAY: I think so. I think it's on our website, and I can provide that link for you guys.

MS. LASH: And it is data that we have collected in one place for the alignment tool, which is our next agenda item. So we can explore that together.

CHAIR LIND: Anne?

MS. COHEN: I know that a number of states have been doing homegrown measures, and we are going to talk about that today. What has been the challenges and the positive nature of that, and how is the office kind of adjusting that and --

MS. DAY: I didn't hear the last part of your question. I'm sorry.

MS. COHEN: I was just going to say, how is the office kind of adjusting their measurement plans related to that?

MS. DAY: Well, I think the biggest adventure of all of this has been kind of the state-specific measures. We actually hired a contractor to help states be able to work through how they develop their measures.

I personally am the lead for the

managed fee-for-service model. In our model, what we say to states is, "We want you to collect measures that really matter for your state, for your population," because that was the point of designing it that way.

States have been -- the challenge is really that states look different, like everything in Medicaid. So we have one state where they are just kind of, you know, they run with it, and they are ready to go, they know what they want to collect, they know I think probably how they are going to perform on the end of it. And so that's one state.

But then we have another state where the parties in the state, the players, kind of the politics of what they collect, they ended up having honestly a state -- a set of measures that they really couldn't collect. So then we have to deal with that.

Another challenge I think for us has been in getting just kind of like the process of it, and making sure states have the data and know

how to use the data, and making sure what they want to collect, in the long run isn't too burdensome for what they want to do.

And how have we had to adjust? Like anything else, we want -- we want our -- we want to provide as much support as possible, so a lot of our work has been in, honestly, like learning. Our state leads are very adept at what is going on in states, learning what flexibilities we have, really, those issues and so forth.

CHAIR LIND: Charlie?

MR. LAKIN: I think this is somewhat related. But in the background papers -- and this is my first meeting, so I'm trying to catch up -- there is a great of attention on long-term services and supports and on HCBS.

And I just want to kind of clarify what you mean by "development," because there is a great deal that has been developed and is actively used in the states. But many of these efforts struggle for the resources and assistance they need to really do the validation, the

psychometric testing that is needed, and even help with how do you properly risk-adjust these measures.

And I'm wondering how interested you are in sort of catching up with this rapidly growing effort to use such measures to help them develop the kinds of qualifications that would bring those instruments and the individual measures in them to a forum like this where they really could be endorsed based on the psychometrics and other aspects of validation.

MS. DAY: So the first thing that we do when we look at -- well, the first part of our plan in every phase is to look at what is existing to do what I guess -- I don't know if it's the term that everybody uses, but we do kind of an environmental stand or we require that an environmental stand is done.

And so, for instance, where D.E.B. said there are two volumes about this thick document, that's the requirement. And so we are very interested, so much so that we have

partnered across ourselves and Medicaid to look at some existing work. And we are looking to develop -- or we actually have in the works a strategic plan around how we do exactly what you said, look at what's out there. Looking at what states are already doing is always paramount in what we look to do.

We don't want to, again, create a system where the reporting is a barrier to access. So we are always looking and considering the state is our partner, what data do they have, what are they already doing, does it make sense to make this a broader kind of thing. And so we are so interested that we are looking at resource options for getting that work done.

MR. LAKIN: Good. Thanks.

CHAIR LIND: Any last questions for Venesa? Okay. Thank you very much. Thanks for good preparation and delivery, and your excellent questions, group.

We are going to turn it over now to Zehra and Jennie to do the preliminary alignment

analysis results, which relates quite closely to what Venesa was just talking about, so that's great.

MS. SHAHAB: Good morning. My name is Zehra Shahab, and I am the Project Analyst for this workgroup. And you have received several emails from me, so it's nice to see all of your faces, and nice to meet you.

So I'm going to be giving an overview of the preliminary alignment analysis that we have conducted and review the results. And at the end of my presentation, we will ask you to consider what actions MAP could take that are suggested by the analysis.

So, first, we are going to give an overview of the MAP family of measures, and these are the measures that are identified by you as the workgroup as the best available to address quality issues across a continuum of care for dual eligible beneficiaries.

And the family is intended more of as a resource to assist the field to select measures

for programs in terms of promoting alignment and also defining high priority gaps. Currently, the family has 58 measures. They are largely NQF-endorsed measures, and there is a large -- there is a variety of measure types, care settings, and levels of analysis.

So -- go ahead.

VICE CHAIR HANSEN: I was just going to offer a context for those of us who are the first-time attendees here. When you hear 58 measures, I mean, your eyeballs roll to the back of your head, but one of the things, just to clarify, it is only a subset, you know, and so especially for those of you who are new, even though the materials are there, it's just kind of an important emphasis so that we think about some measures that health plans might use, some places providers might use.

So even though some of the measures look very similar, they are really geared for a different context. I just wanted to lay that as a background.

MS. SHAHAB: Thanks, Jennie.

Yeah. I was just going to add that because of the wide variety of measures, it is highly unlikely that just one entity would use all of them for a similar program. They are more of a starting place, and it is more of a menu or a list to choose from. And so by establishing this family of measures as a resource, MAP seeks to increase the use of these measures in federal programs.

And later today we are going to ask the workgroup to consider updates to the family of measures, and so some things to keep in mind are two questions. Number one, how can the measure set be strengthened? And, number two, how can the alignment analysis and the feedback loops be used to inform changes to the family over time?

So next we wanted to look at the definition of "alignment." And so a measure alignment can be defined as when sets of measures work well across settings or programs and produce

meaningful information without creating extra work for those responsible for measurement. This can be facilitated by using the same measures across multiple programs.

So the goal of the alignment analysis is to document the use of measures across relevant programs, which I'll describe a little bit later, and also understand how the family of measures are uptake and the degree of alignment that occurs.

So one other thing I wanted to add is that measures also need to display a fit for purpose. The design of the measure must match the programs, the features of the programs, that it must be used in. Otherwise, it would be counterproductive.

So, for example, this is -- it wouldn't be wise to use electronic health records where electronic health records aren't really, you know, prevalent or widespread.

So before we dig into the results of the alignment analysis, we wanted to just remind

everyone of why we are conducting this and review the importance of alignment in general. When there is multiple variations -- as everyone knows, when there is multiple variations of the same or similar measures, it is not only wasteful, but it is also a burden. So alignment can help reduce this inefficient use of resources. And the efficiency measurement will help preserve the valuable dollars for care delivery.

Also, when measures are aligned, it helps limit confusion and streamlines information and improves the likelihood that the performance measurement is effective. And obviously this would also increase the stakeholder buy-in about measurement and quality improvement efforts.

So one of the resources we used while conducting the alignment analysis was buying value. And as you can see, the buying value promotes the use of align measures specifically focusing on ambulatory care and to support states with measure selection.

So there is a couple of things that we noted that the buying value data found. The first is that the current state and regional measure sets, they aren't aligned. And there is not alignment, even despite the fact that they use NQF-endorsed measures, Joint Commission, and/or HEDIS measures. And so even when the measures came from these sources, the specifications or the populations were changed.

So another thing that is buying value, as Anne mentioned earlier, was they noticed that many states are using their own homegrown measures. And this is something that we are going to be exploring a little bit later to determine if these homegrown measures have the potential to fill any of the gaps in the family.

So on this slide -- you also saw this at the web meeting -- it reminds you of how the alignment analysis and the feedback loops will result in the workgroup selecting the best available measures for the family.

So on this next slide, this is a

screenshot of the draft alignment tool. It is really tiny. I would recommend everyone who has brought their laptops to pull up the draft alignment tool. This is available on SharePoint, and also in your email.

I will try to read some of the columns for everyone as well. So if you look at the rows -- well, let me give everyone a second to pull it up, and then I'll get started.

So if you look at the rows, it has each of the 58 measures in the family, and on the columns from left to right there is the NQF number, there is measure title, measure steward, data source, and level of analysis.

There is also six columns for the national quality strategy priorities, and these are -- this is all information that you have seen before. The new information we have added to this table is the section shaded in gray, and these are the measures that are in the state financial -- dual state financial alignment demonstrations.

The white columns a little bit further to the right are several federal or national state initiatives, those programs, and there is two yellow columns that are the total number for the state demonstrations and the total number for the national or other state initiatives.

Finally, you see the columns in pink. These are the important subgroups for dual eligible beneficiaries. And there is four subgroups -- complex older adults, behavioral health, cognitive impairment, and people with disabilities is the last one. So if a measure applies to one of these specific subgroups, then it is marked in the pink column.

MR. ROSS: I am requesting a paper copy -- one of the staff go out, just on this, not on the whole presentation, because what I see on my screen looks like this and I can't read it.

MS. SHAHAB: Yes. Clarke, I'm not sure, unless we had poster-sized paper, printing it would be any better. I can let you borrow my laptop and you can scroll left to right, if that

would be helpful.

MS. LASH: The spreadsheet that was sent out is a little bit easier to read, if you zoom in on it.

VICE CHAIR HANSEN: For those of you who are looking over their shoulders, I think expanding it to 100 percent or 120 percent helps a lot. But you have to scroll.

MS. LASH: And Zehra is going to go on to talk about what the results are, so it's not necessary to, you know, view all the data right now for purposes of the conversation, but to understand that this is, you know, here as a reference, if you want to dig into it in more detail and find any more patterns.

MS. SHAHAB: I will go slowly through the results, so we can -- you can crosscheck if you want while I go through them.

Okay. So in addition to this main tab, there is also two other sheets in the draft alignment tool. And the first is -- the second is the potential gap-filling measures and the

quality measures tab. And we are going to look at these a little bit later, but I just wanted to point out when you see the alignment tool that they will be there.

So while I am going to review the preliminary results in the upcoming slides, I wanted you to keep these two questions in mind. Number one, how well do you think is the family working to promote the use of measures? And, number two -- do you have a question? Okay.

So I've gathered -- I've gathered the results and kind of combined them and shown you some of the trends, and then you can ask questions at that point if you would like as well.

Number two is, can the experience of applying measures in the field inform MAP's updates to the family?

So now I am going to review the preliminary results. First, we have looked at 11 state financial alignment demonstrations, and nine were capitated payment models, and those are

the states listed here -- California, Illinois, Massachusetts, Michigan, New York, Ohio, South Carolina, Texas, and Virginia.

VICE CHAIR HANSEN: D.E.B. had a comment.

MS. POTTER: It is really sort of a process question. The second question you asked us was, could the experience of applying the measures to the field be informative to MAP updates? Was that MAP to the duals group, or was that to all of the MAP, or both?

MS. SHAHAB: The duals group. Just the duals group. Sorry. We should have been a little bit more clear on the slides, but it is for the duals group, the MAP updates to the duals group. And we are going to dig into it a little bit later. There is going to be side by side of each of the new measures. Does anyone else have any questions?

Okay. So we looked at 11 state financial alignment demonstrations, nine capitated, and two that were fee-for-service for

Colorado and Washington.

So out of the 58 measures in the family, six -- approximately 10 percent -- are in all 11 of the state duals demos; 17 are in nine or more; 18 measures are in four or more; 25, which is approximately 43 percent, are in two or more; and 25, which is, again, 43 percent, are not in any of the state duals demonstrations.

So what do these results mean? Which states' demos have the greatest uptake from the family of measures?

So we noticed that the capitated demonstrations included between 18 and 25 measures, while the fee-for-service ones only included six to eight measures. So should we be concerned that approximately only 40 percent of the family of measures is not included in the demonstrations? We thought not quite, because the demonstrations are designed to measure integrated care that is delivered by health plans.

And many measures that are in the

duals family are outside of the -- outside the scope of the demonstrations, and they are designed for different levels of analysis and care settings.

Venesa wanted to add some background.

MS. DAY: Well, I -- just so you have some insight into the thought process on this. For the plans, a lot of the plan -- for the capitated model, a lot of the measures are HEDIS measures, measures that plans are already used to collecting. On the managed fee-for-service side, we felt like a lot of the -- what we were asking states to do was new and on a different level and on a level that they hadn't really done before.

In addition, on a level that they had being asked -- that they are being asked to collect across maybe like three different programs, so us, health homes, and the Medicaid adult core. So in considering all of that, and talking to states, we've really gotten to the question of, what's the burden on the state here versus the -- you know, what we are really trying

to get at.

So we don't want to measure just for the sake of measuring. We want to have something that states can actually collect, so that they are not in a place of, you know, just spinning their wheels, and so a lot of that is reflected in this.

MS. SHAHAB: Thank you, Venesa.

So our team was generally happy with the level of uptake in the state duals demonstrations, and we are curious if you all feel the same way when we get to the discussion portion a little bit later.

So in addition to the 11 state demonstrations, we also looked at 43 national or other state initiatives. And some examples of these are the CMS health home measure set, the CMS Medicaid adult core set, CMS nursing home quality initiative, and the Medicare Parts C and D ratings programs.

And one other thing we noted is whether they were in the comprehensive primary

care initiative, the SIM population level measure, or whether it was a Joint Commission accountability measure as well.

So out of the 58 measures in the duals family, approximately 12 percent were in 12 or more of these 43 programs, 19 percent were in nine or more, 41 percent were in four or more programs, and 67 percent were in two or more, and 22 percent were not used in any of the national or other state initiatives.

So, in this slide, we wanted to once again look at which programs now show the greatest uptake of the family. And the measures were most recently used in the physician quality reporting system, which included 23 of the measures in the family, and the physician value-based payment modifier program, which included 22.

So in addition to the ones that were most frequently used, we looked at the programs that had the fewest measures. And these included only one to two measures in each program in the

nursing home quality initiative, long-term care hospital, and the health home quality -- CMS home health quality reporting program.

And please note that there were a variety of other programs that we -- that don't contain any of the measures, but we excluded from this analysis.

So in this slide we also wanted to look at the most aligned measures, and there were six that were the most aligned, and by "most aligned" it means that they were used in nine or more state financial alignment demonstrations and eight or more national or other state initiatives.

And these are the six measures that are listed here -- initiation and engagement of alcohol and other drug dependence, controlling high blood pressure, colorectal cancer screening, antidepressant medication management, and preventative care and screening, screening for clinical depression and followup, and the last one was the plan all-cause readmissions.

So in addition to the top six measures that were the most aligned, we also wanted to see the distribution of the top 15. And these -- this means that the measures were in three or more state financial alignment demonstrations and three or more national or other state initiatives. And we wanted to compare them with the national quality strategy priorities that are listed here, and also how relevant they are to the dual eligible subgroups.

So in the next slide -- in this slide, I have two pie charts that we have created to show the distribution of the top 15 most aligned measures. As you can see, the pie chart on the top left is the comparison of the priority areas.

So out of the six priority areas, we have five of them. The only one missing is affordable care. And you can see the distribution; 28 percent is the highest percentage, and that is focused on effective communication and care coordination. Next is 24 percent each for health and well-being and

prevention and treatment of leading causes of mortality.

So the second pie chart on the bottom right is the population subgroups, and they are the four population subgroups I mentioned earlier. As you can see, there is a pretty even distribution here between -- ranging between 23 to 26 percent of the population subgroups of people with disabilities, complex older adults, behavioral health, and cognitive impairment.

So in addition to the most aligned measures, we also wanted to look at the measures that are not included in any state duals demonstrations or in any national or other state initiatives. And we found 10 measures -- they are all listed here -- that weren't found in either.

So I am not going to read each of these 10 measures, because you can see them in the slides. But when you consider the updates to the family, keep these in mind, that these were the 10 measures that were not found in either the

duals demonstrations or the national or state initiatives.

But that doesn't mean that they shouldn't be in the family. It just means that they just haven't gained the traction in the field, and they need -- we just need to do more to promote their use in federal programs.

VICE CHAIR HANSEN: Joan has a question.

MS. ZLOTNIK: I just had a question. Looking at some of these measures that haven't been used around transition in care, when you go back to the earlier slide one of the areas of -- you know, effective communication and care coordination is sort of one of the major areas where there is alignment with the NQF's priorities. So it is just kind of interesting.

It would be important to know more particularly when so few of them hit at the person- and family-centered care piece, and those happen to be measures that are about transitions and making sure that people -- that their needs

get communicated. So that is an interesting observation. I don't know what it means.

MS. SHAHAB: Yes. That's a great point. There is actually two other transition care measures. They are slightly different. One is with different elements, so what -- so there is two other measures in the transition of care. This one was just the only one that wasn't used, but the other two were in the state duals demonstrations.

Are there any other questions?

MR. LUTZOW: I certainly have taken note of your nursing home quality initiative and the fact that some of them -- their measures don't overlap well with the duals MAP measures. But aren't you struck by, I don't know, the weakness of -- I mean, the nursing home measurements need a lot of work.

They are on an island by themselves, it seems. The measures have to do with staffing ratios. They have to do with bed sores. It is almost as if the nursing home community is not

part of the larger health initiative. And, I mean, how to get at that I don't know, but I would like them to join the world and to think of themselves as part of the larger health continuum.

And, I mean, my interest in -- as a plan is how -- how do we, you know, as a plan support and advance the performance of the nursing home community. But the measures that affect a plan are so different from the measures that affect the nursing home that the foundation for communication isn't there.

So I don't take this as a fault of MAP. Who is in charge of the metrics for the nursing home community? It seems -- you know, let's invite them to join the free world.

VICE CHAIR HANSEN: Tom, that's an excellent point. You're bringing up a much broader one, and I see that -- other tent cards. And just as a reminder for those of us who are here for the first time, we try to use the tent cards to make sure that we recognize people in

order.

I think the suggestion I have been given is to ask to hold some of these larger points, unless it's a specific point to one of the measures that is on the slide that needs clarification right now, that we can kind of go through them and please jot some of these broader questions and comments of a way for us to bring the whole piece together.

So if we could just do that for process, so that we can have a little bit of flow. Clarification, I think, on the individual slide is a broader discussion that we will actually have ample time for. Okay? Anything to clarify this particular slide that Zehra can offer? So I still have two, three, four tents up here. So let me start with Anne, on down, and then we'll come back to George.

MS. COHEN: I mean, it's -- I think it was Joan that brought this up. I think, you know, it's interesting that these ones that aren't being uptaked by the states, and in

particular the current programs, are actively using these measures.

And a lot of them were care transition staff, medication reconciliation, which I know I read in the stuff there are some problems with that measure. But then the one that really struck me was the pain management one is used only by a little bit of people. I know we struggle with that measure, but we wanted the concept of it.

And then the other one that I thought was a good measure, and maybe there is something wrong with it, was the smoking cessation measure. And later in the slides the states and the plans talk -- I guess it was the plans -- talk about wanting smoking cessation measures. So it's just interesting.

I think one of the challenges that I have had as a MAP member the last couple of years is we have so many options to choose from. But given the fact these are clustered around a theme of ones that the states had issues with, maybe we

need to specifically look back on those measures that weren't uptaked and say, "Is it the measure? Is it the area? Do we need to dump that area out completely and replace it with another family group of care coordination, or whatever it is?"

So that's I guess my priority for this meeting is to kind of figure those pieces out.

VICE CHAIR HANSEN: Again, that is a significant, you know, suggestion of cluster. So if I could just take the prerogative to be able to I guess clarify the slide, and we will continue on.

So, okay, D.E.B.?

MS. POTTER: A couple of points on Tom's point. The last measure, the antipsychotic use, there is a very similar measure that is a CMS measure that is used in national programs. This is the pharmacy alliance measure, which is slightly different than the CMS measure. But they are really both getting at the same -- the same domain.

The second point I wanted to make is

maybe we, as a group, should also revisit or talk about the measures that the other MAP groups have put forth around nursing home measures that go into Medicare shared savings, because we, I think, have more expertise in that than the other groups, and maybe we could add things to our portfolio that would align up with those kinds of things.

VICE CHAIR HANSEN: Thank you, D.E.B. George, and then Shawn afterwards.

DR. ANDREWS: Yes. To D.E.B.'s point, you know, I was looking at this, and I was concerned particularly when I saw two of them -- the reconciled medication and transition record -- both of which from -- whether you look at it from the health plan perspective, whether you look at it from the patient perspective, whether you look at it from the ideal care perspective, it is something that should be in use, yet it's not.

So, again, to D.E.B.'s point, I know that it's probably something else or the other

measures that are in use, so the question that I have is, do we know -- do we have any insights from the states or from -- in terms of why these particular ones are not being used that we can then step back and say, "Okay. Now we understand where you're not using it. Let's then modify and replace with what makes sense."

VICE CHAIR HANSEN: Again, building some momentum for the body of work that we'll do. Shawn? Thank you, George.

MR. TERRELL: Thanks. And I just ran across the JO report from January 2015 that reports 61 percent of people in nursing facilities are prescribed antipsychotics for dementia, and 14 on Part D were not in nursing facilities -- 14 percent.

And so there is -- you know, there is -- this is -- they are using a different measure, I'm guessing, than the one here. But it would be worth maybe perhaps looking at that and using that as a potential springboard for, you know, promoting this particular measure or something

similar.

VICE CHAIR HANSEN: I see a very strong theme developing from this that will come from our recommendation. Steve, and then Susan.

DR. COUNSELL: I share some of the concerns that have been voiced around the lack of use and uptake of some of the measures and just wanted to kind of make the corollary. You were looking at the six measures earlier on Slide 21 that are, you know, most broadly aligned or are just the same old measures. They are really not measures that were specific to our group or our work per se. I mean, everyone was doing all -- maybe the initiation and engagement of alcohol and other drug dependence, I think that was something we certainly felt strongly that was maybe a little bit new to the -- kind of the run of the mill, you know, measures that everyone was already using.

So the impact of this group I guess on changing and getting new measures, you know, so far at least in the results that you are showing

here today are very discouraging, I think.

VICE CHAIR HANSEN: It's the raison d'etre for this group.

MS. REINHARD: I agree with the last two comments, last three comments in particular. I find -- I know you're excited about having progress, but I don't really see progress. I think the comment that you just made is showing the most important things we've worked on are not being picked up, and I didn't hear an answer to George's question.

That's what I'd first -- like, do you have any insights? Are we going to get there, or do you have any qualitative -- has anyone done any -- asked anybody why they are not using these? That's -- I didn't hear the answer.

MS. LASH: We have a little bit of general information about measure use that Megan will be talking about later on in the meeting related to the feedback loop. So it's the hand-in-hand data of what are the measures in the programs, and then actually talking to the

broader stakeholder community about how it is all working for them on a day-to-day basis.

We don't have measure-by-measure information at this stage about a particular care transition measure. But we do plan to continue the stakeholder outreach. So the group can consider if there are particular measures without a lot of use, if you would like us to kind of vet those in the process of having those conversations, that could be something we could pursue.

MS. REINHARD: I do think we need that granular level, though, that we are asking for.

MS. LASH: Right. You are unable to go through 58 measures with every interviewee to see what --

MS. REINHARD: Well, what is on the -- we need that. We really do need what you've put up there and which you so kindly shared with us, because it is easier, for me at least, to eyeball it and see what is going on than to hear six measures are doing -- this one is doing that. It

just isn't making sense to me.

VICE CHAIR HANSEN: Anne, Rich, Gail, and then Steve. And, you know, I'm picking up a sense that the granularness of this is so important. I know we will check here to see whether this is something -- there is any adjustment that we can do in the schedule to spend a little time at it tomorrow after people maybe have something physical to look at tonight. But it is beginning to come to that level of discussion that -- how much people will add on as new thoughts about system design versus the individual area.

So let's do this. Let me say that we will do these four comments, and then we're going to go back to Zehra to see if we can move through. We originally had time set until 10:45 for this segment before we had some external comment. So I just wanted to ask the group's indulgence in keeping -- having us keep moving on.

Okay. I think I started with Anne.

MS. COHEN: Yes. So the comment that I have to make, I wanted to give folks background. I work for a state duals program as a consultant. I have been a disability manager responsible for implementing quality measures, and then also I have done a grant project developing quality measures.

And so what this list says to me, based on that experience, is that part of this could be pushed back from the plans that are contracted with the state, because they don't want to do anything in addition because of the administrative burden of just implementing a duals program in and of itself.

And in my experience working with a plan and developing a grant project, the way to get uptake in new measures is by having a pilot program with grant funding behind it, because part of the challenges from many of these plans, their administrative people that are doing the analysis, that are doing the quality work, is like one person in the plan, maybe two tops.

And I know a number of particularly the nonprofit-making plans that were stretched really thin trying to implement everything, so I don't know whether that's in NQF's purview or CMS's purview, but it might be something to look at, to take a close look at these measures, particularly the ones that take a lot of time, like care coordination and medication reconciliation and outside contacts and nursing home measures, take a group of those and say, "This is our priority as MAP, and let's figure out a way to get a number of folks to test these measures to implement them."

MR. BRINGEWATT: Yes. Jennie, you'll have to tell me if my comments here should come later or whether they are appropriate here. But what is striking me now relates to a question about what the purpose of alignment is.

You know, it seems to me like it's -- I don't want to discount the importance of people adopting new measures and adopting measures that we think are important. But it seems to me like

the analysis that we have going here is about alignment. And there is a couple of things I think that are important. I think this is very helpful, useful data, and I've got some thoughts about pushing it to another level of analysis.

But it seems to me like the alignment issue -- the first set of alignment issues is simply, where do the dots connect or not connect for Medicare and Medicaid? You know, whether they're the right measures or not, you know, that seems to be an important factor.

And then, secondly, is to drill down in terms of what is the process of data collection, and do those processes connect or not. You know, it's clear to me that we have some measures, particularly in the HEDIS measure area, where they are the same measures.

But if you drill down in the stack a bit, we have separate processes for data collection, for the plan, for the state, that they don't necessarily -- you know, if you have to have a separate draw of a sample on the same

measure, one for Medicare, one for Medicaid, and the analysis is done at different points in time, that's a major burden for plans, it's a major burden for states and the federal government as well. But it's an alignment issue that I think this group can help elevate.

Then, if we drill down a little bit further to what are the alignment issues within the plan provider community, it seems to me like it's necessary for us to define major population sets as to why that is important. You know, if somebody has the flu, it really doesn't matter in some cases, particularly if it's an acute short-term event, you know, you can go to the doctor's office and get something prescribed, and that particular problem is resolved.

But that doesn't happen, you know, for frail elders and for adults with disabilities and people with complex medical conditions. And that is -- you know, that is where you need -- we need to look at primary, acute, long-term care data sets as it relates to people within defined

populations, you know, as to whether the dots connect, because you can't have continuity of care for a frail elder or an adult with disability or people with complex medical conditions, and those are very different population types, you know, unless you focus on what their problems are.

So, you know, again, this is kind of a first-time analysis of this kind of thing. It hasn't been done before. It's important. But I would caution us to not move too quickly to the solution being let's have adoption of more measures before we fully vet here the question of alignment as to whether it is helping in terms of efficiencies for us all working together across time, place, profession, across program components, and whether it supports continuity of care for defined populations across primary, acute, and long-term care.

VICE CHAIR HANSEN: Well, Rich, I think you did go beyond, but it was a good beyond. It is the reality I think we are in the

midst of struggling with. I think you are absolutely -- we had some really good discussion this morning about, again, how these things, you know, match. And I'll hold off my -- with my comment there, but -- so I see two more tent cards up, and so Gail, and then Steve, and we're -- we'll go back.

MS. STUART: So this discussion reminds me that what we're really looking at is we are stuck in the medical model. And early on in these deliberations we talked about population-based health care and how we really needed to move beyond that, and we have not moved beyond it. We are locked into that medical model, because if we were looking at population health we would look at the continuum of care. We would look at long-term care where the population is clearly moving to more rapidly than anyone can even anticipate.

And so -- and I think the other failure is patient- and family-centered care. It is not represented here. And so I know we had

early discussions about that, but somehow I think that is core, because the model upon which we make decisions obviously will influence everything down the road.

VICE CHAIR HANSEN: Steve?

DR. COUNSELL: Yes. Just further maybe astonishment at this, but wondering if we would -- could narrow it down, especially looking at what have been used in the duals demos, and what has not. I mean, that has got to be our sweet spot, right? And so if it's not, you know, aligned with some of the other programs, it may be for good reasons.

But if we could look -- at least look at what is being used in the duals and what's not across the states, and then -- and then maybe learn at least what we know is out there about which ones are not used and why. You know, the point brought up by D.E.B. around whether there's another similar measure that -- and that is used, and so that would help us.

But, you know, you look at this, the

middle one, 1902 on health literacy practices, well how are they doing that, then, if they are not, you know, measuring whether plans are addressing health literacy in the dual eligible population. I mean, is that because there is another measure that is doing that, or is it because it's just ignored, or it's just too hard? And we could understand that, but I think that's where we need to go next.

VICE CHAIR HANSEN: There's slides, and then we'll have some added discussion here.

Thank you.

MS. SHAHAB: Okay. So we talked about this earlier, about the innovative homegrown measures. And this is an area where you can excuse the lack of alignment because there are new innovative measures that are created to fill a gap. And if you look at the potential gap-filling measures tab in the alignment tool, there are -- there is a list of several measures, several examples of measures that different states are using.

So we picked out three examples. One was from the Massachusetts patient-centered medical home. And that is the percent of patients who have been seen in the emergency room with a chronic illness problem, and have had clinical, telephonic, or face-to-face followup interaction with the care team within two days of their ER visit.

Another example is the Texas delivery system reform incentive payment, and this is to improve patient satisfaction and/or the quality of life scores in the targeted population with the identified disparity.

Finally, the last example is the New York Department of Health's disruptive intensive daily pain where a low rate is desirable. So while these measures are not being used outside of the programs that have created them, if they are found to be effective, we can use these to fill some of the gaps and use these to further test them and replicate them as national standards. However, the states that are

currently using them are probably not thinking about these big picture ideas.

So we -- finally, in this last slide, we have described some potential actions for MAP that are for the MAP duals workgroup that are suggested by the analysis, and they are listed here in this slide.

One, you can retain the measures with a high level of alignment within the family of measures, or you can explore reasons why some measures in the family are not used in national or state programs and/or consider dropping the measures with no usage from the family if the pattern is persistent, or you can evaluate the potential of the homegrown measures to be further developed, tested, endorsed, and used in other programs.

Does anyone have any questions about the MAP actions? I know we have, you know, had some questions, and I'll ask Jennie now to facilitate the workgroup's discussion on this section.

VICE CHAIR HANSEN: Sure. I think we have had a robust start in some of the discussion. It was one of the comments that I also made, I think we are very close to what Rich brought up in talking with Zehra and others earlier this morning.

There is what -- in reading these materials I think all of us saw the slide, who had a chance to go through the slides, to see that there is a process here of -- at NQF by virtue of the role that it has played. You know, it is about the science of measure development.

So when we started two and a half years ago together, we had no pallet at all. We did a lot of brainstorming about what were all these other kinds of things related to population health and the duals work that was being done. So it was really so different, as you know, from moving from provider kinds of measures that have been tested over time and the relevance of them to our population. We all agreed to go or start with a starter set.

My observation is that we are at a different stage now two and a half years later. There are the dual demonstrations that are going, and states are doing some of their things -- areas of relevance. We talked on the phone this last web meeting about the gaps that we had identified as to where was this going to show up in the course of this.

So this reflection in some ways is kind of where the train has been going by virtue of our -- you know, the importance of the science and the methodology, the tweaking that we ended up doing for a while, and then, really, where is this new space of person-centered care, the ability to think about care continuity, transitions and all that are part of the national quality strategy.

So this is a bit of an inflection point, I sense, for all of us, and one I think is the rigor of the method, and then what is the real "there" there, what we're trying to do.

So I sense that, you know, the

suggestions done by the analysis of, you know, are there still some core things that are useful? Do we need a different method of connecting the dots of this with the stratification issues as well as with risk adjustment? Which is also fairly new.

And then, you notice that we had this discussion on the phone about the whole aspect of disparities and some of the work that NQF is just really starting to do that.

So, you know, there was some discussion and some guidance. I certainly turned to Sarah and the NQF staff, as well as Alice, who has been living with this for years relative to this, whether or not, you know, again, the raison d'etre for this group getting together is different. We build on what we knew. We know that it was not perfect. We then realized that the machinery of measure development goes on, that -- some of which are relevant, but have we asked the real question of what this multi-segmented population is -- in different settings

is going to be?

So what is the work for us as a MAP in this case? I'll turn to Sarah just for a staff reaction, and then I see tent cards up.

MS. LASH: So the work for us today is multi-faceted, as usual. I think right now we are interested in this group's guidance and dialogue about how to take its standing body of recommendations to this next level. How can we promote greater use of the measures that are the best fit for the unique needs of the dual eligible population? We have had some great ideas already surfaced over the course of the conversation, and I think we just want to keep that thread going right now.

VICE CHAIR HANSEN: Okay. And then, I'll take the prerogative to turn to Alice, and then Vanesa, and then go to --

CHAIR LIND: So it's not really fair, because I'm going to take off my chair hat, which I am so happy to be able to do, since you're chairing, and just, you know, give the context of

-- I'll give a single example of Washington State has a duals demonstration that is not based in managed care.

It's called a health home -- it uses the health home model. And so the number one reason that Washington has such poor alignment among the other states who have the duals measure -- so, you know, there is 10 measures where all of the other states that are based on capitated model are in alignment with our recommendations, and then Washington does not have a checkmark, and the reason why is for the most part that those are health plan measures.

A second reason, though, is if you also compare what is in the duals demos to the health home requirements, health home also does not align well with the duals demonstration, and we are also on the hook for the health home.

So a lot of states -- and individual health plans have to wrestle with these questions all the time. If you have a choice of aligning with one or both, or a third, so, you know, for

us it's the duals demonstration is our first set, the health home requirements is the second set, and going to the NQF family would be our third.

And we would look at the NQF family to fill those holes the state -- you know, where we have the state flexibility, and where the holes are is exactly what you said, is around social -- the social models of family and caregiver role, the how are we going to train folks, and it doesn't have anything to do with the list of measures that were on the list that are, you know, shown here as not being used.

So a medical home system survey where we thought, oh, maybe there is one opportunity where we would be able to see this communication and coordination happening doesn't really fit. It's not in -- it's not in the realm of the health home model of care where you are out in the community and you might have a navigator or somebody else, you know, a community health worker who is out there trying to do the coordination. It fits pretty loosely in the --

does the medical home system meet the standard?

So just offering my own perspective that when I look at the list of things that are not aligned with any duals demonstrations, my reaction to it is, maybe we have, you know, put these on the table long enough, and some of them could go ahead and be discarded at this point.

MS. DAY: Wow. So I think that -- I'm a policy person just by nature, and that's my work.

So none of this happens in a vacuum. When you give us recommendations -- and this -- please hear me, this is not an excuse; it is just -- it's realistic. So when you give us recommendations about what we should be measuring, we take those recommendations and we move forward.

Within -- so this is one piece of the puzzle. Every other component in CMS and every -- I mean, every place that we touch in ACO, everybody is talking about or around the idea of measurement, how we improve quality, and so as

things move, everybody is kind of moving, and we are trying to, at least as I've seen, our best -- doing our best to kind of keep things aligned and in the right order.

So, for instance, when you give us our family of measures, we take those measures and we say what makes sense for where states are -- or where folks are otherwise aligned, like ACOs, health homes, Medicaid adult core. And then we say, okay, even after we do our best scrub of how do we align across all of these programs, then we go to states and say, "Okay. States, what are you collecting? What does it look like for you? What data availability do you have?" And that is -- that changes -- that makes the body look completely different.

So, for instance, in the Washington situation, Washington is one of our states. They had a different set of issues than -- with what we were collecting or what we were trying to collect than maybe another state like New York. And so all of this is work that continues and

happens and isn't a perfect science at all. And that is just the reality of it.

Like, I feel kind of disappointed that you guys are like, oh no, we have all failed, and my -- I mean, I wrote to myself, "Where did you think you would be by now with this work?" Because, I mean, you know, it's really hard -- like our -- our team works hard at -- in every meeting. One, we are always raising our hand saying, "What about Medicare or Medicaid?" Because, quite honestly, you know, they don't -- they don't -- you know, it's like the other one doesn't exist.

And so, and then added to that, this work where we're saying, "Okay. And then what about the duals?" I mean, we literally have programs that are like, "Oh, you mean we have 50 percent duals in our population? Oh my. How" --

(Laughter.)

MS. DAY: You know, and so -- and then when we raise our hand and say, "Oh, but you should be using -- at least aligning with the

measures we are using for our demonstration," we get -- we still get pushback.

So, I mean, I almost feel like I've got to take up for my team and say like, "No, no, no. We're really working hard." But, I mean, I think it would be helpful, because, I mean, I -- in my mind, I have an optimal place for where we'd be, so -- I mean, ultimately.

So, in my mind, one day a dual will present, and that will mean something very real to a provider, and that provider will say, "Okay. This is what I need to do for this person." Not -- the response won't be, "Oh no, you know, like how am I going to make sure I can talk to this person and coordinate his care and do all this extra work just so I can get a measly -- you know, the little bit of money I am going to get from Medicare and Medicaid."

So I have a very real vision of what I would like this work to end up being in total. But I would really like to understand, like, where do you think we should be by now?

VICE CHAIR HANSEN: Venesa, let me just respond to you. It's -- I hope you don't think that this is a failure. I was hoping to kind of put a context of -- when you start with nothing, how do you begin to do this? But I think the awareness and the fact that we have so much more experience, you know, the -- the SNPs have really been affected in the past I'd say couple of years by some of the changes, just -- there is just more texture here.

So I think that I just wanted to have you -- and this is your first physical meeting with us. So, you know, this group has been going on for two and a half years or three years. And so we are in a -- both a learning and acting mode at the same time.

So this is where the real experience that is out in the field that implements policy comes together in our -- that's part of the beauty I think of the structure of the MAP. So, yes, we recognize you folks started with nothing as well. And so I think we are on this journey

together to do the best work that we could possibly do and to incorporate the learnings and the feedback that are going on.

So that's why we -- I think we are looking at a bit of a pause button here to think about this may be an inflection to frame up the discussion once again somewhat differently than we may have started with, say, three years ago.

All right. And we do have 15 more minutes than we have allocated.

MS. ZLOTNIK: I think the dilemma here is one that has surfaced at every meeting and every discussion that we have had, which is if part of our goal is to make sure that there are measures that will measure better outcomes for people who are dual eligible beneficiaries, so that it reduces the cost of health care and the -- you sort of work in more of a sort of preventative way, and the reality is there just aren't a lot of those measures.

And, you know, I think Steve's point about -- or Susan's or someone's that they're the

same old measures that are the ones that are most used, because that is the structure of how things are set up.

So I think part of our discussion has to be, how can we be most useful and clever to really figure out a way that we could develop a strategy to promote the use of measures that are not going to be onerous, but that would really get at some of these issues, or otherwise we are going to continue to measure the extent to which people get flu shots that work in hospitals rather than person-centered interventions. However, I am not that clever.

MS. REINHARD: So, Vanesa, I really appreciate where you were laying it out and saying, "Look at -- what do you expect, guys, you know?" And that is what I was trying to say before, that it's okay to say we're not where we would love to be. I think it's better to just say, you know, we're just starting, and it's disappointing in some cases, and it's positive in others, but not to overemphasize it is really

great because it's not yet. That's all I'm trying to say.

And yet I think -- I love your point about there is advocacy to be done here. Once we have the science, which is what this group is trying to do, I mean, I can speak for the AARP state offices, since I have my org hat, right? So I can speak for that, that they are always calling us up. They are at the table in a lot of these states, as you know. And they are asking me personally, what should we be doing? What should we be pressing for, you know? And I'm like, "Hold off, we don't really know yet," because we shouldn't be just running out, "Oh, we want this, we want this, we want this," right?

So from the inside you are trying to do it. You're inside government and you're trying to do it. There is external -- these organizations, in particular, have an ability to have influence, quite a bit of influence frankly, but we don't want to exert influence until we know what we should be doing, right?

And so my question was -- you had a list before that said, should we do this or this or this, right? I would appreciate -- and I don't know if it's in this form or another one -- more direct input, or insight maybe is the right word -- that Alice just gave, for example, like this is the way it is, and this is why we're not, but this is what we're looking for. That would help a lot, and is what I was trying to get to. I think it was your question, too, do we know why these are being rejected?

And then, D.E.B. said, for example, I think it was the antipsychotics, which we all know is really important -- and you brought that out, too, Shawn -- that this is big. This is in our scorecard, as a matter of fact, you know, so is this the right measure? Should we be doing this? Is there a different one? I don't know that. I don't know that there is another one that is competing with this. I don't know where else that is.

So when we look at the ones that we

might be disappointed weren't picked up, some of the care coordination or -- is there a competing one? Is it -- as Anne said, it's just too hard? We don't have enough -- at least I don't, I'll speak for myself, I don't have enough insight to know that. So to say, "Well, retain the measures with a high level of alignment," and it goes back to what Steve was pointing out in that slide I keep pulling out.

Okay. Controlling high blood pressure -- yes, I guess we should keep that. I don't particularly think that's amazing alignment for this group. Yes, you should be controlling blood pressure. I think that was Steve's point. Okay. But that's not really a victory for us. That's good.

Colorectal cancer screening -- not really -- it's almost like you should put those to the side. Yeah, they should all be doing that, but it's not, in my view, alignment that has anything to do with what our passion is of trying to really focus on some of these other

issues, that it sounds like, Alice, you're looking for. How can we do that?

So I don't know where to take that, Sarah. I don't know what group does that or how we get that insight, but I'm there. I'll do whatever I can to help.

MS. LASH: We are talking more later today about what we have learned about measure use experience. And the rub is I think it really varies by who you talk to, but, you know, those challenges are totally unique. But we do it as a sample, so we can begin to unpack those.

VICE CHAIR HANSEN: Okay. I think next I had identified -- Rich, I think you were on this one.

MR. BRINGEWATT: Yes. I've got a couple of comments, but I first want to just join the chorus of support for duals office and all of the work that CMS is doing and that, you know, National Quality Forum is doing. This is tough stuff.

You know, if you look at alignment

issues in a much bigger historical context, there is, you know, people who have been at this for decades, you know, sitting in this room. And, you know, I am -- while I think we are probably only, I'm going to say 10 percent of the way there where we need to ultimately be, we are a whole lot further along than where we were before.

I think, you know, just the mere fact that this is the topic of the day in some circles is to be celebrated, and so that there's a readiness to do something about that that can help expedite the process. And so, you know, don't get discouraged.

The second thing I wanted to mention here is just while I agree, our fertile ground is the dual demonstration, and there are some things to mine there, to sort out, given my role here in terms of the SNP Alliance, I would be remiss if I didn't say that there are some other things that are going on that are important to look at as well. One is Minnesota has a dual alignment

demonstration outside of the formal demo authority that is specifically looking at performance measurement for duals and alignment. And it is important to fold that work I think into this particular study.

Secondly is there is over 100,000 people now who are served by fully integrated SNPs, plans that have been certified by CMS as fully integrated. That subset grew 29 percent in the last year, more than any other segment of MA. And in the midst of the dual demonstration moving forward, you know, that has been in an environment of one by one marketing, bringing them in, as opposed to passive enrollment where you can move quickly.

And all of those plans have the same kind of issues, the same kind of problems, the same kind of interest, self-interest, business self-interest, of alignment between Medicare and Medicaid. And I think it's -- and then, you know, there is all of the DSNPs and all of the other SNPs where there is about two million duals

that are specifically where -- you know, are choosing to be part of a plan that has the intent of serving duals as a specialty category and looking at Medicare and Medicaid as alignment.

So then the third thing I wanted to mention here is, you know, where do we focus? And I'd like for us to just -- to step back a little bit before we move too quickly with a specific focus, and reask the question, what are we really trying to do here? What is the primary interest that we are trying to achieve?

And it seems to me like one of the primary interests we want to achieve through alignment, keeping that focus, is empower continuity of care for important subsets of this dual population, and I think there are two. You know, I think primarily there is three, but frail elders and adults with disabilities, that's where all of the money is, that is where all of the complications are, that is where all of the alignment complications are, from a person-centered perspective. That's where all the

disconnects are.

And so where can we -- as a group of organizations that care about dual measurement, where is our high leverage intervention pushing alignment to empower continuity to connect the dots between primary, acute, and long-term care providers who serve the same people, either at the same time or in sequence to one another.

You know, performance measurement can either help or get in the way of doing that. And with -- and also with disabilities, it's medical, behavioral health, medical mental health, medical physical disability. You know, there's dots that need to be connected between systems that have deep roots in historical structures that, you know, are going to take a while, but it's important to I think look at those connections.

And then, and I just moved out ahead of Medicare and Medicaid in terms of an alignment issue. But I think we have to, you know, then clearly look at Medicare and Medicaid and drill down in that stack. So it isn't simply using the

same measure, but it's a process.

VICE CHAIR HANSEN: Great. Thank you, Rich. I think there's a significant amount of substance that you captured in terms of the thoughts of some of the previous commenters.

I still have -- at this point, I have Tom, and after Tom, Shawn.

MR. LUTZOW: So, yes. Vanesa, I don't need to remind you that Michelangelo's David looked roughhewn at one point, and thank God he didn't stop chipping away. So don't -- you know, you need to think of yourself as Michelangelo, I think.

You know, this issue with alignment I think is -- should be concerning, because unless it's resolved, health care will suffer in the national debate. It will look disorganized. And, you know, this concept of force multiplier, we have an opportunity to introduce this concept and make it work for health care, maybe in the same way that it works for the military.

But unless all components of the

health care resource community are working in the same direction, toward the same ends, we aren't going to get where we need to go. We are going to look inefficient. The outcomes that we need to see produced in health care won't be produced.

So whether it's our fault that we're creating measures that the larger continuum can't adopt, and we do need to listen to that larger community, if they're not using measures, if they're inventing their own, that is sort of evidence of their voting by their -- they're voting with their feet. And so attention needs to be paid for that.

But this whole concept of, you know, alignment, does it really have the value and is it getting traction? Is it moving the needle? There is one measure that is shared across the continuum, and that is -- right now that is readmission prevention.

And so we have a test case. We have a test case where the entire continuum, hospital physician, nursing home, home health agency, has

one measure that has created alignment and resources. And how is it doing, by the way? Are we moving the needle there? Because if we are, then we need to do more of that. And however we, you know, engage and sell and design, we do have a test case.

VICE CHAIR HANSEN: Good point, Tom, and especially since Vanesa pointed out that this is something CMS is also looking at in terms of measure development.

I next have Shawn, and then Clarke.

MR. TERRELL: Thanks. So on your -- the last slide, the bullet here, the last bullet on the homegrown measure idea is I think a good one. Just as a reminder, so we have this new home community-based services MAP -- no, not MAP group, NQF group. It's not a MAP group. That one of the things is an environmental scan of all of these measures that might be out there, and I know you guys have looked into a ton of resources on some of those.

And I would bet that there is at least

a couple that might be worthwhile looking at for this group as you review those. I mean, I don't want to be too disruptive here, but it might be worth, you know, thinking about, you know, if you find something, use it here, if it's useful, and don't wait. I mean, this is a two-year project, this HCBS group. So it might be worthwhile there.

And then, the other thing I just want to mention is -- ask, really, is how much of the group -- in this group is there emphasis or discussion around what you do once you have -- or you measure something, so what? So now there's -- you know, how do you improve things?

What is the, you know, CQI plan to study or process that -- or, you know, how is that being implemented and looked at here? That is as important as the measurement, right? I mean, we do have a focus on that in our HCBS group, but those -- so that's another thing that I'd be interested in learning.

Oh, and one other thing is, how -- if

there is a -- some people out there who have homegrown measures that may want to get sort of them considered, do they need to wait for HCBS group to finish its two-year work and start another group? Or can they -- you know, can measures be submitted that might be useful in this context?

I mean, people are talking -- Rich, you mentioned person-centeredness is a key thing. That's a foundational component, right, of HCBS. And so there is -- I think there are some measures out there that might be useful. So is that -- that's not a question. We don't have to -- we can talk offline about it, but I just want to ask.

MR. ROSS: I wanted to make an observation about what is missing. Every state in the country has a state intellectual and developmental disability administered system. Every state in the country has a separately administered state mental health authority that focuses on people with serious mental illness.

Frequently, those two authorities are designated by the state Medicaid agency to be the administrative agent for Medicaid for those distinct people in those systems. We have had, over the last few years, presentations on the national core indicators and the personal outcome measures. We have a few million people being measured. Those systems do not apply to the National Quality Forum, because they view their system as a totality of 40 different measures, not each discrete element.

So we just have to continue to recognize -- and I would argue those two systems are leading the nation in person-centeredness, because they start with the individual situation and build out. So I think any discussion of frustration or big concepts, we just need to make the constant observation -- we have made it in other reports to CMS -- that these two systems exist, and we have a lot to learn from them. And there is a mismatch between how they think about wholeness, whole health, and the National Quality

Forum approach on distinct measure by measure.

And so when we think we are losing -- I mean, ACL just invested a lot of money to expand the national core indicators from 35 to 50 states, and to pilot in-state agencies, and three pilots are complete, and now there is the next round. So there is a lot of important activity for people who are severely disabled and dually eligible that are not reflected in what we are talking about.

VICE CHAIR HANSEN: I think this is reflective of I think the desire originally at that last meeting to have examples that we may have, and I think this richness of discussion has popped up, you know, more that we can really think about the environmental scan in a whole other particular manner.

Okay. I next have Anne, Steve, and then Vanesa.

MS. COHEN: So I am kind of echoing off of different folks' comments. And, you know, Susan said that I mentioned about it being hard,

and I think it's not so much that I thought that it was hard for the plans. I think from what I have seen, plan states tend to replicate what other folks are doing.

And so to echo what Clarke said, if we could elevate those critical models, I mean, that is going to serve us really well. And I think part of our charge as workgroup members is to go back also to our individual constituencies, whether it's AARP or, you know, the SNP Alliance, or whatever, to go back and try to get those other folks to have buy-in.

And, you know, for Steve, I think you are doing the heavy lifting, and I want to use one example that has taken 10 years to replicate and that's the disability activist community really pushing for ADA accessibility for health care.

And using the example of disability site reviews and then also accessible medical equipment, that is something that the State of California and others were really focused on

doing, the advocates in California, and that -- from one lawsuit to Kaiser has now been replicated across the country to the point where now in the health care reform bill, and now in the regs, there is work around accessible medical equipment. And so it's incentivizing the equipment manufacturers to develop equipment, and then the health plans and the providers to uptake that equipment.

And so I think it really shows that when a group of people get around a very specific issue, that will be uptake rather quickly, but we have to be very methodical about how we choose that area, and then how, as individual members, we go back and incentivize our folks to try to uptake that issue.

VICE CHAIR HANSEN: Steve?

DR. COUNSELL: Yes, thanks. I want to a make sure, first, just to communicate that my comments are in no way a reflection of what -- an impression of a duals office and the work and the passion and the perseverance and the skill that,

you know, is emanating out of that office, which is just so refreshing and gives us all great hope that we may do -- may see some change down the road.

I want to second Rich's comments about, you know, in addition to looking at what is used in the duals demos, really looking at the dual special needs plans. They have been out there a long time and have a tremendous amount of experience in this field, so we should look at what measures are being used there of the set that we have come up with.

And then, there is a third point. I just wondered if it might help to take a two-prong approach, maybe look at, okay, what is being used in the Medicaid, or what is being recommended in the Medicaid health homes, which is sort of Medicaid.

And then, what is used in -- maybe in the Medicare Advantage plans or on the Medicare side is Medicare. And then -- so the first prong is looking from those two sets, okay, what should

we really be saying that -- okay, for the duals population, you've got to use these -- you know, from those general sets.

But then, the second prong then is, okay, here is a separate set that is specific to the duals that we need to be looking at that aren't in the health home, you know, as that's a different kind of population and it's -- and that's not in the Medicare run of the mill that need to be considered. It may help us maybe leverage some of the things we've been talking about.

Thanks.

MS. DAY: So I have questions about the idea of the measures that are being taken out being kind of the same old measures. So thank you for putting together that -- I mean, we have one, but it's not as great as yours.

So, I mean, thank you for putting that together. And as I look at this, I'm thinking well, of these measures and all the places that they are being used, I know for a fact that a lot

of them aren't using them for the purposes that we would like them to be used. So they aren't stratifying, they aren't providing a picture of what duals look like in these different programs and areas.

And so as I look at this, I guess I'm asking you guys, as we go forward, because this is definitely something that we are going to use in this information -- as we go forward and we are looking at kind of the same old measures, because that's what people are measuring more broadly, is it valuable, at this point, for us to say -- to keep pushing folks to stratify those measures? Or do you want to see something beyond that? Because we -- there is patient and family engagement uptake now around this.

In fact, we just recommended in-patient days for -- like to spark off our kind of part of the conversation around patient and family engagement in CMCS for the -- one of the affinity groups. But do -- would it be valuable to, do you think, in pushing along what we want

to still work in the areas where folks are already working, while moving in these other areas that we know there is not a lot of uptake?

Or would it be your recommendation that we kind of move past that, or not expend as much energy into these areas where we feel like there is more -- I guess more to gain for our population? I mean, I guess it's the -- do we want to know medically, really? Are we still in a space where we, medically, need to know where they are, where duals are, where our population is? Or do we want to be more in a -- you know, pushing the population in a different direction or different -- from a different angle?

VICE CHAIR HANSEN: I think that's a very valuable strategic question, that we think about where the efforts here -- you know, one is, you know, the low-hanging fruit was what we have been doing. But even with the low-hanging fruit, your comment is we don't have stratification, or an opportunity to think about risk-adjusting. So that would be one tactical way to make those

better.

The bigger discussion is the areas that are really important that you are beginning to take up right now in terms of patient engagement would be, I would say, one particular area. But I also like to reflect another part that I heard that is tactical, and perhaps strategic in combination. Tom, you brought up the whole issue of readmissions. Right now, that is kind of almost like the mega measurement.

And if we take what the flow is, and everybody cares about it, all levels of providers, do we take that as a -- our straw person to put in there and pack it with the continuity issues, pack it with the patient- and family-centeredness, but the fact that the wave is moving and everybody cares about it, because there is transparency and there is money attached to it already.

So I don't know you know, these are kind of multi-faceted discussions that I think is worth our time to really use ourselves here,

since we are gathered physically, to have that discussion about how do we focus the portfolio of our focus, knowing that there are different layers of this happening, coupled with the tremendous experience of the SNPs, the tremendous experience going on with the duals right now, to kind of align that way, so that we have a contextual as well as a substantive, informative -- one hat that I'll take off at the moment, some of you who are new may not know, I was involved with the original PACE program for 25 years.

And the PACE program experience was the whole nine yards, you know, but we didn't have -- you know, when you think about this program starting 40 years ago, measurement science was not in there. I had probably 10 measures that I had for my own benchmarking, and our ability to think about it in a much broader way, but it wasn't based on measurement science. It was based about management thinking about what is important, families, engagement. I mean, the net measurement is that 25 years, full

capitation, no lawsuit, the entire population, you know, which is given family involved, people functioning, and all.

So, but we have come to a different place 30 years later. That measurement science is what is recognized, what is reimbursed, and what we should be pushing, but we just know it's new. So going back to those three comments and, Alice and Sarah, if you have some reflection about how we use our efforts here in the most strategic way, that it's not the tweak, it's a new world that we are trying to really address right now, and where the world, frankly, is going. And so I think we have a particular fiduciary responsibility to think through this in a way that is going to be used.

CHAIR LIND: I guess I have written down about 15 most important notes. I started off thinking maybe we'll just be able to crystalize it into, like, five things that we have to tackle in the next 12 hours of meeting. But no, it turns out it's like 15 things. And so

I think we should probably regroup at lunch and see if there is any different way we want to use our time over the course of the meeting, if it's okay with Sarah that -- because I think the context of the next part of the discussion will help frame up where we can tweak the family.

And then, once we've done the tweaking, maybe we can go back and do the big picture again, as far as that goes.

MS. LASH: Sure. So there are a couple paths, or components of the meeting where the staff can take particular action based on the discussion. So we have already talked about our alignment analysis, which we framed as draft, we can sort of go back and pursue additional information on things like, what health plan level measures that we think could be used aren't getting used, and maybe, you know, elevate some of those types of themes with a little bit further digging. And I think we can plan to, you know, put that in the report and give you all the opportunity to review that.

Similarly, we are going to be talking next about more -- a detailed level of conversations with people using measures out in the field to understand their experience. So, again, if there are particular lines of inquiry we should be including or -- such as a measure, which you think it would be a great proxy for person-centered care and asking people all across the board, what would you need to use this, and kind of unpacking more of those root cause challenges. That is another type of thing we can take action on.

And then, there is sort of this third bucket, which -- maybe there's two more. There are quality improvement activities that can move measures but are ultimately a little bit more related to the model of care. And that is sort of Shawn and Clarke's acknowledgment, that we have our family of measures, but we are also recommending a variety of other supporting activities, like engaging with core indicators, pursuing, maybe, particular care transition

models that kind of underpin the measures themselves.

And then the final bucket is a mix of short-term and long-term recommendations for CMS, such as stratification, is it taking oxygen away from the other very important goal of measure development and switching the measures that are used in programs? I think we still have plenty of time to have a lot of robust discussion, and I think we will also come together around more common themes where we all seem to have a lot of agreement, and sort of work from there perhaps.

VICE CHAIR HANSEN: So you can tell we are -- hopefully, this is continuous quality improvement. We are really trying to get to the substance of what we should be doing. From a technical point, I believe we still have -- are asking the operator to see if there are public comments. So, Operator, we would like to open it up, if there are the public wanting to make comments, to have that opportunity. Could you give the instructions, please?

OPERATOR: Yes ma'am. If anybody is wanting to make a public comment, please press star and then the number one. There are no public comments at this time.

VICE CHAIR HANSEN: Thank you, Operator. Okay. So we actually are moving right to Sarah to take the next segment, which is exploring the experience of using the measures that we have talked about. D.E.B.?

MS. POTTER: Are we skipping over our break?

VICE CHAIR HANSEN: Oh.

MS. POTTER: Well, I just want to know, you know?

MS. LASH: We are about to move into some small group work, after I do the setup. If people need to use the restroom, they can do so at that time, or you can excuse yourself now. Sorry, we got a little bit behind. So NQF, as one of our member benefits, hosted what we called a member meet-up event. This was January 29th, and we had 80 participants from the broader NQF

membership who came together to exchange thoughts on the topic of vulnerable populations, dual eligibles, and measures that matter.

So it had a bigger lens than this particular meeting, but it was recognized throughout our organization that this is something that there is a lot of interest in, people want the opportunity to have a dialogue with each other about measure use, for duals or other at-risk groups that don't have the chance to come to MAP.

And so through the course of what was a two-hour event -- and we had a number of people in the room, as well as virtual, there was a presentation by Dr. David Engler from American's Essential Hospitals, talking about, really, the unique characteristics of this group and why delivering them high-quality care can sometimes be challenging.

And then, we broke the participants up into small groups and asked them to reflect on these three core discussion questions. We're

trying to use them as, you know, key informants, really. How is this all working for you? We have these meetings, and then we put these reports out, and there is somewhat a question as to what happens next, at least outside of CMS.

So we asked people to share their experience using measures to improve care, what's working and what's not, what information they thought we should be collecting about measure use and alignment to inform some of the data you just saw. To what extent are they affected by mismatched or redundant measure requirements? And, in particular, what is the role of industry in contributing to the ongoing efforts to coordinate care and ensure access, sort of a customization because we had a large representation of that stakeholder group at the meeting.

We pulled out three main discussion themes that I want to share, the first being about this first question of measure use experience. The data infrastructure challenges

were very pronounced -- interoperability of different data systems, electronic health records across settings came up over and over. I think that challenge has been recognized in this group, too.

There was a desire to think about how entities can more easily share information that they all use to reduce duplication of effort, as opposed to the current state of you have this assessment, and this assessment, and this assessment with many common questions, but no real flow or sharing of information.

A desire to have those assessments include more information about consumer social determinants of health, and be able to tease out if those are adversely affecting their health outcomes, so some something can be done about those risk factors. The notion that measurement is part of a broader culture change around improvement, that we don't want to just be measuring for measure's sake, would also be, you know, self-critical as to when it's not working

and we need to change course.

Many suggestions that methods we use to survey consumers about their experience of care have a long way to go. People thought surveys were too long, there's too much time lag as to when people receive them and when the entity being measured gets their feedback. There was a desire for more flexibility in consumers to have help in responding to these surveys, and some people thought that the way the questions are framed about being very physician-centric, in the case of the clinician CAHPS, doesn't acknowledge the contributions of other people that might be on the consumer's care team that are very central.

The second question and theme is around alignment, with kind of the overarching suggestion made that an aligned measurement framework is one that has a manageable volume, it is focused on the major big dot issues, and it can be consistently understood and used across the system. A desire to build on what is

currently working by mapping the measures across the continuum of care, and finding the most useful information, discarding the rest.

We need to accelerate the slow but very important work of applying measures more consistently across programs. I think this is a micro alignment issue, like Rich was alluding to. The data collection, specific processes, and requirements are sort of under the hood measures that might look aligned on the surface.

And there needs to be the creation of measures that go beyond clinical care to bridge into other sectors, like law enforcement, education, and some creative thinking about how mobile technologies might be used to text consumers or -- if they experience some type of mental health crisis or whatnot, and, you know, we could quickly respond with information about social services and other necessary resources. Also, it was suggested as a way to quickly gauge experience of care information as well.

The third, you know, partnerships to

ensure coordination and access. The idea that process measures are a good starting place, but we really do need measures of long-term outcomes that relate to a consumer's individual longitudinal plan of care. Industry partners might be able to help with the ability to generate research and evidence. They have data.

And they are able to be partners in producing resources, like culturally appropriate health education materials and languages or other specialization. And that community-based partner organizations are vital, but the current payment system doesn't allow resources to flow down to those social supports, like shelters or hotlines or food pantries that are really critical in underpinning good health. So, in general, recognition that more support is needed for the safety net.

So we wanted to take the next 30 minutes before lunch to kind of replicate, if it's okay with you guys, this style of small group discussion, and so we thought we might have

this side of the room kind of gather up in a circle and this side do the same, or we can, since time is a little bit limited, just have a general reaction and discussion.

Is there a sense in the room as to whether you kind of want to get up and stretch your legs and talk in a smaller group, or we should keep this as an open dialogue? Any suggestions? Keep it open? Okay. Great.

So we are interested if the themes that I just communicated resonate with you. Did you pick up on anything that sounds really familiar, that you hear from your colleagues? Do you have any additional points you want to make about your use of measures within your organizations, about what is working or not, and to the extent you experienced good or bad alignment? This is a good open forum for that. It's me, I'm facilitating.

(Laughter.)

Alice, you may go first.

CHAIR LIND: So I thought another

interesting story to tell about Washington, in terms of mapping measures across the continuum, is that we had two separate legislative directives come out over the last two sessions. One directed the Department of Social and Health Services, which has mental health, long-term supports and services, developmental disabilities, over on its side, to convene a group of stakeholders to come up with a common core set of measures that would reflect the continuum of care delivered to people with serious mental illness.

So that group convened over about a year, we did lots and lots of stakeholder input, subgroups that worked on various things. I was on the workgroup about quality of life. It was a really interesting process and came up with a list of 50 measures, which have very little overlap with anything else that anybody had been doing at all in the states.

So there is a lot of groundwork to, like, even develop some of the measures. So like

when you say create measures that go beyond clinical care, there are measures about employment, and housing, and jail time, and all kinds of things that, you know, we have the data for centrally in the state government, but it's not that health plans were measuring, or the managed mental health system was measuring, or individual clinics had been able to measure. A lot of these measures have to be done at the state level, and yet the -- in the law it says that we will require these measures in our contract.

So, you know, there is this really clunky like, you know, how do you apply things like this? You know, so very, you know, good, hard work, but, you know, when it comes to the application, it is still going to be really tricky. That work finished right about the same time a different group was convened also under legislation to come up with statewide core measures across all populations, not just Medicaid, not just public employees, but, you

know, really trying to focus on the health of the population in Washington and how we can use measures to guide that.

And the overlap of the result of that group and the mental health group is like two. I mean, you know, it's just like -- there is like maybe diabetes crosses the two different groups. And so it has been just really interesting -- well, it tied closely to SIM, but it was legislation. The Governor had kind of spearheaded it and the legislature took it on.

So, anyway, just to say that in terms of the whole -- the wrestling to the ground of people's aspirations, and what you can actually apply in the real world, and how the alignment is now, so for us managing the health plan side now we don't only have like the -- you know, what we owe to the duals office and the health home program, but also now the state core and also the mental health core set.

We -- I think we have gone up to like 200 measures that we are trying to figure out, is

there any that we can cross off the list because they're close enough? So, anyway, that's the Washington experience over the last year.

MS. POTTER: So, Alice, you will send us the web link to these reports?

CHAIR LIND: I am happy to do so.

MS. LASH: Susan, go ahead.

MS. REINHARD: So just yesterday we were at the Institute of Medicine on a coalition to -- for advanced -- to transform advanced illness care, I guess it's called. And one of the things that came up was around family caregivers, and that statement about -- it was Kathy Kelly, who would not mind if I said that, who is the Family Caregiver Alliance, and this consistent -- which you captured here, this consistent discussion of getting social support, right?

And so she is one of those organizations, and always tapped to go to different meetings, and all of that, and never ever is it even discussed about what resources

are even out there. She cited the reduction in adult daycare as one example in California, but it is just so strong, and I was glad you captured it there. The other thing was around trying to get more input from consumers, how would they like that innovation, how can we do that, kind of thing. I sit on a hospital board, and even there it is very hard to follow up with patients and families. So, and that's when you have just been there and you're going home. This is a little more diffuse.

And the third thing was around getting only the doctor's opinion. I don't know, really, how that measure works, where it's only the doctor, but it seems that for duals it is -- I don't want to say that's the least important, but there is so much more going on in that person's life that it just seems that has to be addressed.

MS. LASH: Charlie?

MR. LAKIN: I like that recommendation in that first set about methods, improving methods to survey consumers. I think we are

often quite enamored by the progress that has been made in that area. It has been important, and it has really validated people who have the right to a reasonable quality of life. And it is certainly important that we do that, given that 40 percent of the duals are people who need some support to live their life independently. We need to attend much better to that.

But there are huge problems in that -- that whole effort to survey consumers, and we really need to invest. It's incredibly important to do it, and it is incredibly complicated. And the efforts to do it have tended to operate at a state as the unit of analysis. We need to be able to do much more refined analyses if we are going to address the quality of service provision, whether it's nursing homes or community supports.

There is a great deal of variation across states in how they carry out these efforts. Even when they use the same instrumentation, their actual operationalization

of the methodology varies considerably. There is very little psychometric testing at the measure level, at the item level, in these instruments. Some of them have decent psychometric testing for the instrument, but no analysis at the item level, and that is a big challenge in negotiating with groups like this about adoption of those methods.

And then, there are huge variations in the ability of the individuals receiving supports to respond for themselves, to give reliable responses. Response bias is a big problem. Proxies are often used, but the limited amount of research about proxies suggests they don't always answer in ways that the individual would answer. So there is just -- the other problem is that many of these get very high levels of positive response. So you ask, do you like where you live, which is a reasonable thing to ask. But if 90 percent say they do, as is common, then where is the -- where is the ability to discriminate between good and poor service?

And there are ways to ask that to get different responses, like would you rather live somewhere else? The answer there is about 80 percent. So, you know, there is a sophistication here that really needs to be addressed. But there are huge advantages. The communities of practice that are growing across states, around this kind of instrumentation, is powerful and important and it allows states to compare how they are doing with others.

But this is so important to do from my perspective, and yet so complicated and so underfunded that, again, I think -- I think the suggestion that we really work on methods to survey consumers is really, really important.

MS. LASH: Thanks for that. Rich?

MR. BRINGEWATT: I think comments relating to the three specific -- I think if you did this focus group with the SNP Alliance, you would come up with the same answers. This is very representative of the kind of things that we hear, you know. Second issue here is, do you

think the use of measures is improving care for vulnerable populations? I think two concerns I have there. One is, I think the volume of measures is a problem in improving care for vulnerable populations, and adding more measures is not the solution.

You know, I think the most important thing that we should do is try to sort through, what are the most important measures that we -- you know, if we pick five measures, and really say these are high leverage measures, these are the most important measures for the vulnerable populations, you know, what would they be?

I'm not suggesting these are fine, but I asked that question to our medical directors five, six years ago, and they seemed to still resonate for me, you know. One is rehospitalization rates, you know. Now, you have to do risk adjustment, you have to be careful about those measures, because they don't all work for the vulnerable population. But they -- it is something that everybody is collecting. And if

you can do some risk adjustment on those measures, you know, perhaps.

ER visits -- a significant issue. Effect of drug utilization, particularly comorbidity, and use of multiple drug interactions, but the complexity of just medication management, a measure that relates to medication management. Nursing home placement was another one they mentioned. I think we need to find another kind of measure for adults with disabilities where that's more of a frailty measure. But, you know, there is a measure there.

And then, consumer satisfaction. You know, they said if -- if we just focused on those measures and had them risk-adjusted, and did them well, we could move the needle. And I think one of the things that we are constantly faced with is the measures that are defined as most important are in STARs. And the STAR measures are very acute care oriented. And for a vulnerable population, they push the needle the

wrong way.

And so I think it's important for this group to grapple with, what are the most important measures? I'm not -- I'm not going to suggest we should say the five measures I just identified. I just -- I mainly used that as illustrative, but, you know, where do we want to focus? What's -- you know, give me a lever long enough, let me put it in the right place, and I can move the world. You know, that's a very strong theme of the National Quality Forum -- high leverage intervention. Let's use that for this particular group, and what measures are the most important.

And then, you know, is an organization affected by mismatch and redundancy? Yes, capital mark, yes. Yes. It is a problem. I don't think I need to say any more on that.

VICE CHAIR HANSEN: No. Rich, if I can add to yours. One of the -- in previous Committee membership, we had one of -- the Medical Director of Behavioral Health at United

Health, and one of the discussions that we had that I actually have glommed onto that might be a sixth consideration is a measure of days in the community, which is a proxy for stability.

So if we thought about people being able to function -- and I double checked with Sarah because I thought, oh, my gosh, that resonates for me on a common sense level, as well as a quality of living. If you are able to maintain your function in the community for -- and not fall into ER, hospital, nursing home, it's a measure of quality of life for the most part. You know, imperfect perhaps, but it is a gross measure of functionality.

And the fact that there is enough stability in the system that you are living a quality of living that maintains your time in the community. That is a very different area, but it was not -- it is not psychometrically done, but, you know, from a more common sense way, that's the highest function, least expensive, simple measure, you know, that one of the things that I

have used technically almost unconsciously in our work in PACE, that people had fewer hospitalizations despite their comorbidity, against the benchmark of the all 65 and older. I mean, we use a very gross measure of that nature.

MR. BRINGEWATT: Yeah. I think that's a great addition. Just to make a caution of my own recommendation here, and that is there are subpopulations that we have to be sensitive to. As an example -- AIDS. You know, people who are managing care for people with AIDS will tell you, if you don't control viral loads, you know, they die. And those measures aren't even in the set of measures that are used by plans that specialize in care of that population.

So we have to be sensitive to subpopulations and make sure that there are measures that are identified for those subpopulations. But I think it's more important for us to focus on, what are the right things to do, where can we move the needle the most, and focus on those questions more than, what measures

aren't they using and can't we do something to increase the level of adoption of measures that is on the list. I mean, I don't want to say that's not important. I just think it's not as important as identifying the measure that is most important.

MS. LASH: Great. Thanks. I'm going to come back around, but first I had Tom.

MR. LUTZOW: Yeah. Days in community is an interesting measure. You know, going up from the bottom of this list, is there mismatch or redundancy in the measures, I think the -- another criteria, is there competition between measures? And I want to submit that there is at least one in the D-SET where the elimination of potentially harmful medications from your formulary is one measure. But the second one is a survey measure. Are you getting all of the medications and pharmaceuticals that you need?

And I can't have one, and if I have one, I potentially lose the other. And there is the case where, you know, we do need to be

sensitive to, do we have competing measures? Success on one is failure on the other.

The other thing is, if you look at the duals programs and where they leave the measure set, in terms of what is valuable to those duals demos, there is things like -- that relate to member contact, and completion of an assessment within a certain period of time. And I think there is a lesson there in terms of, what is valuable with this population? This is a mobile population. They are difficult to contact. Even when you contact them, contacting them a second time or a third time is not guaranteed.

And so, you know, this whole idea of building an environment of care for these folks where I know all the touch points. I know the significant others. I don't know -- I know that next of kin, in case of emergency, who do I call, who lives across the hall? All of those things need to be part of my case profile, because it's that environment and the touch points within that environment that are critically important to

creating care.

You know, and here, Jennie, you know, you are going to tell me I'm off point again, but I think communication is as important as food, is as important as pharmaceuticals. And the OCC has this program where they give -- I think it's a $10 a month credit to the poor for their purchase of a cell phone. Cell phones should be free to this population, and I'm not saying go to Congress and ask for more money. Go to the carriers and tell them if they want to avoid an additional tax, they need to dispense free cell phones and free airtime to the poor, because unless we have communication, we aren't going to get anywhere with this population.

And so I don't know who to tell that to. I'm telling it to you. Maybe you can do something about it. Venesa, you know, you're in a power position. You can do something maybe. But we need to improve just the basic core communication structures here.

MS. LASH: Great. Thank you. Joan

was next.

MS. ZLOTNIK: So I have been sort of -- and I missed a little bit of the beginning of the conversation to take my own break. But I have been sort of mulling over these questions and the themes that came out in your discussions of which I could identify at some level with every theme. And I think one of the things we have struggled with in some of our discussions was this whole idea about the measures, do they go beyond clinical, which is not clinical care, it is medical care, and incorporate other factors, you know, in terms of work, or poverty measures, or other things, are critical.

And I think that I sort of work across the lifespan, so last week I was in Portland, Oregon, at -- there is a National Commission whose charge is to come up with a plan to eliminate child abuse and neglect fatalities. And so it was in Portland, Oregon, and so people from Washington State and Oregon were presenting on their coordinated care organizations, which I

see is part of the presentation later here, but sort of talking about, you know, pooling dollars and pooling their perspective, and then all of the other agencies that you have to work with to be more focused on sort of who the client is.

And so it's not so much about dual eligible programs; it is about dual eligible people. You know, it is really critical, and so even in this -- trying to focus on kids that are abused and neglected, the issues of parents who use substances, parents who have mental health problems, people who are living in poverty, people who don't have access to care, so some of the opportunities for the accountable care organizations are critical.

And I was kind of -- and I shared some of this with Sarah in an email, but I was kind of taken with some of the work in Oregon, where they actually are state legislated to develop measures. And I was kind of fascinated with that, because I was trying to figure out if that would -- and it seemed to, at least from what was

being presented -- provide an opportunity to create some measures that were more person-centered and more aligned with these sort of broader outcomes.

And so I know this is a little on the agenda for later, but I think it is really important to think about it, because there is this kind of ongoing mismatch, but I think we sort of know a lot more now, or sort of are more focused on sort of what these population issues are and how we have to sort of approach it much more in that way.

And so the issue that Charlie was mentioning about resources, I think, is really critical, because you are sort of dealing in many instances, particularly if you are going beyond health care delivery system, but obviously even in a health care delivery system. It costs money to do all of this, and I just don't think the resources are there, particularly when you are looking at small community agencies.

So I think that really is an issue.

Cell phones is one. And just the funding to actually do the work, to not only develop and test the measures, but actually to use them, is critical because people work on the fly and not in such a structured environment.

MS. LASH: Thanks, Joan. Maybe one thing we can explore is -- state-level measurement is something this group hasn't actually delved too much into, but it is striking to me that as the entity that can knit together the social system with the health system, and think about it from more of a global budgeting perspective, there could be some traction there. However, if you want to talk about limited resources, that could be a third rail. I will stop editorializing. Clarke was next.

MR. ROSS: Thanks, Sarah. I want to try to tie in Rich, and Jennie, and Charlie's comments. So I put my nametag up when Rich started his list of high priority interests that medical directors of a certain kind of plan have, and so my instant response was, well, if you ask

a different audience the question, if you ask people at Christopher and Dana Reeve Foundation and United Spinal who live with paralysis and use a chair every day, you are going to get a different kind of response than your list, and if you ask people with intellectual disability and the community and people with serious mental illness.

So I think Rich's last point, the importance of unique populations and the challenge of generalization. I wanted to reinforce -- I worked with Rhonda Robinson Beale for 20 years, and she is a medical director -- was a medical director of a managed behavioral health plan that actually hired several thousand people with a history of mental illness as peer providers.

And so, obviously, by directly engaging both advisors and hiring several thousand people with a history of mental illness through a managed care plan, you are going to hear days in a community -- I would say days in

the community at the location of choice, but then we get into the pureness of the method, the methodological pureness.

And so the national core indicators ask these questions, and so 90 percent say they are happy where they are, and 80 percent of the same people want to move, if given a choice. But I'm less interested in the pureness of the metric than building a system that engages the individual user of the service, and that's why I like the national core indicators and the person outcome measures.

They have a series of questions that they ask the individual beneficiary, and they build the entire program out from what the individual -- and get into questions of proxies, and all that stuff. But it's -- the premise is you start with the individual beneficiary and build out. You don't start with some construct up here and eventually get down to the consumer. So it's my effort to try to tie three different people's comments into the theme of the

beneficiary being the center, the person centeredness of all of this.

MS. LASH: Thank you. Sally?

MS. TYLER: Thank you. Yes. Just to echo some of the comments, you know, for us I think a lot of the measures still seem to highlight acute care. And this group, I think originally we -- you know, we always talked about moving toward where duals are, and a lot of this is HCBS, LTSS across the spectrum, but particularly HCBS.

And I feel like we are just still kind of nibbling around the edges there. It is an area we are moving into. I can't be here for tomorrow's discussion on person-centered, which is a disappointment to me. But I am glad that we are getting into it a little bit, and I believe Adam had put forward some thoughts about measures there.

One thing that I saw in his, which I -- the word "training" was in there, to me training should highlight workforce. I think, I

assume that's what he meant; someone can correct me if not. And that's, you know, particularly when we are talking about LTSS across the spectrum, but specifically HCBS, you have to eventually talk about workforce in terms of capacity as well as quality of life and maintaining function, which Jennie was talking about as, you know, should be one of our big measures.

So we have to start getting to it. So that's -- and, again, I think what Charlie had said about the way questions are phrased can be a little bit more sophisticated, and some of the things that Clarke said about the core measures as well I would also agree with. And just one other real specific -- something else earlier that we had said. I know we -- it is hard enough for us to try to get national measures, and then to try to look at different state measures as well as different state departments.

And Clarke had mentioned that all of the states have DD/ID departments as well as

mental health and, you know, looking across that. But then, also, don't forget that at the county level, the behavioral health directors, there is probably data sets there that could be looked at, if we had the time, resource, inclination to do so.

MS. LASH: Thanks, Sally. Next I've got George.

DR. ANDREWS: A lot of the things that I initially started, I was thinking to talk about, have already been touched on, but I will reinforce, you know, some of the comments that Tom made regarding the challenge we have in terms of contacting this particular group, and, if you can't, you cannot support.

In addition to that, you also have the level of education, the level of environmental support within that individual's family unit that may -- that also plays in terms of their compliance, adherence to recommend it, even when provided instructions.

I like to think things in a simplistic

way. I think that we get a lot of times very sophisticated in terms of what we are trying to do, and so I'd like to start with what is simple. And what is simple is I like to look at, you know, depending on the population that you are looking at, there are specific things that you can see that distinguish that population from the other.

And so when you look at the -- our Medicare Advantage, versus when you look at the duals, there are differences in terms of what we are seeing in their utilization of services, and the specific disease conditions that tie to that cost of care. And so getting back to something that Rich mentioned before, which is there are some things that we know they are going to be present in all of these populations, and diabetes, hypertension, other cardiovascular disease, and if you look at the cost of care and the dollar, what percent of that dollar is spent on these three conditions, it is more than 50 percent.

So when I look at the duals, a lot of that is going to be there as well. But at the same time, the duals have specific, unique conditions -- disability, mental, and behavioral health. Is that -- as we look at some of the STAR measures of hospitalization, seven-day followup, or 30, it is pitiful. And there are reasons behind that that tie to the things that I mentioned, in addition to the fact that we don't have enough support care access to do that.

So I think, again, from our perspective, looking at how can we simplify this and begin to move the needle without going at all of it, you know, but just pick the select items, I think we need to be thinking in terms of, again, the uniqueness, the commonality, and just try to keep it in that frame, and also in some ways, through regulatory state, figure out some of the challenges that tie to the communication, that tie to the access of care. Is it reimbursement? What is behind that that is not allowing their access to care?

MS. LASH: Thank you. Shawn?

MR. TERRELL: Thanks. So a couple of quick things from the HCBS perspective. When one of the -- on the bottom it talks -- you know, mismatched, we talked about alignment and mismatched measures, I think that it's really important to understand for a lot of people with disabilities that -- and older adults for that matter -- that there is a foundational concept around it, but it stems from quality of life thinking. That, you know, what might be important to me to do might conflict with what might be important for me in some ways.

So there's a balance that was striking, and this is, really, the skill of good planning and good person centeredness, is how to help strike the right balance between what is important to a person, what is important for them in terms of their health and safety needs, et cetera.

And we all do this in our lives, right? I ride my bicycle in D.C. You know, some

people might think that's a bad idea. But if I wear a helmet and stop at all the stop signs, then perhaps I'll live, you know. But I get exercise at the same time.

And so these are -- we do this in our lives. We eat things, we talk, we -- all the time, and we need to extend this. We have to think about everybody that we are serving the same way, and how do we measure these things, how do we look at measures, and how do we stop thinking about only -- one of the challenges of the social determinants question is that everything needs to map to the important for us stuff, the physical health, or else it's not important.

Well, the fact is is that's all very important, and people are going to do it anyway. I have a colleague who -- a former colleague who had a spinal cord injury, in a wheelchair. You know, the doctor keeps on -- is always on him about the blood pressure, you know. He says, "You know what? If I monitor my blood pressure,

if I keep it underneath where the doctor says I need to be, I'd have to quit my job, stay home all day, and continually monitor my blood pressure." So his quality of life will decline.

So these things are valuable from a medical perspective, and also, you know, how do we -- it makes it more complex, so I totally agree with Charlie's points, and Clarke's as well, that -- but that we really start to think about these questions from a -- if we start to look at it from a quality of life perspective, we might be able to accept that there are conflicts, and actually welcome them in our discussions, rather than thinking that everything has to be perfectly aligned.

MS. LASH: Well said, Shawn. Thanks. Deb?

MS. POTTER: I have really enjoyed listening to everybody talk here today. First of all, Venesa, please do not take this as a criticism of your work at the Duals Office.

MS. DAY: Oh, my gosh. I would never

ever think that --

(Laughter.)

MS. POTTER: Please, please don't. But I want to get at something that I don't think we've really talked about, like what is working and what is not working. I personally -- maybe it's out there and I haven't seen it -- haven't seen the quality measures that are used in the duals program stratified by duals or non-duals. I haven't seen empirical information to answer that question.

We don't publicly report the measures from the Medicare Advantage plans. We report STAR rating, so we don't know where the measures are. We don't get to see the measures for the Medicaid managed care plans, for the Medicare managed care, so I don't think we really know some of this. So I just want to put that on the table, that before we start taking anything away we should have some empirical information to support it.

MS. LASH: Anne, last comment before

lunch.

MS. COHEN: So it is hard not to sort of echo everybody's comments, because I really agree with Rich and Clarke and Shawn. And I was trying to think of an experience of a friend of mine who has been -- because I think when we think of duals we need to remember, in this day and age, it's not just duals that are going to be falling on and off these health plans, various health plans. So Medicaid and Medicare, they are getting tax credits to get private insurance, and they are going to choose to leave duals plans to try to get on private insurance by scraping together whatever money they can.

I have a colleague of mine who probably has MS, who has been trying to diagnose for two years, and has had on and off insurance versus Medicaid, all over the place. And you know what his primary problem was? Access to appointments. His delays in appointments were so unbelievable, and I kept saying, "You need to call the health plan." And he kept saying,

"Well, no, because of such and such, and they said such and such."

But depending on what bucket he was in, whether he was in, you know, a pure Medicaid bucket, a duals bucket, a commercial insurance bucket, his access to care was different. And it wasn't just health plan appointments, it was physical -- you know, physical therapy, it was occupational therapy, it was long-term care services, everything came down to access, and who do you call. He didn't know who to call.

And so when I think about the top five things in the communication issue, I think back to my plan experience where, you know, the mantra was, "Always tell the member to call the plan." So then once they call the plan, and there's a flag in the system, that person is delayed in care. How do we tease out that? Maybe that's where we tease out, did they get access to social services? Did they get access to this? Did they get access to that?

And, again, if it's in a state that is

primarily plan-driven, which many of them will be, maybe that's the bucket is, you know, do you know to call your plan, and did you get the assistance that you needed, and what assistance did you receive? That's a messy measure, but, I mean, there is no excuse. And he's just one example. And I'm a consultant, and my name gets Googled all the time. I kid you not, I probably get 50 calls a month regarding access to delays in care of some form or another.

MS. LASH: Thanks, Anne. All right. I think that is it for this session. We have about 30 minutes for lunch. Thanks, everyone.

(Whereupon, the above-entitled matter went off the record at 12:02 p.m. and resumed at 12:45 p.m.)

A-F-T-E-R-N-O-O-N S-E-S-S-I-O-N

(12:45 p.m.)

MS. LASH: So, let's resume. Still lots of important work ahead today. Megan is going to review with you the preliminary results of our feedback loop discussions with stakeholders. Megan, go ahead and take it away.

MS. ANDERSON: Thanks Sarah. Can everyone hear me okay?

MS. LASH: Yes.

MS. ANDERSON: Okay. I want to apologize in advance for the scratchy throat. I'm going to do my best to get through this presentation as clearly as possible.

We a few short weeks ago met on the web meeting and we had an opportunity to discuss the approach of the staff led feedback loops analysis that really is a paired effort with the alignment analysis that you reviewed this morning. This is a time that we want to deliver on our promise to bring the preliminary results of the analysis for the feedback loops to you.

Before we dig in the results, I'm just going to refresh your memory and make sure that we have a shared foundation and understanding of the concepts and the approach for the feedback loops analysis. I'm on slide 37.

And NQF currently collects some measure use experience about feedback from a few different sources. We get information about measure use during the endorsement submission process about planned and current measure use.

We also track activities through the MAP approval making process about measure use in federal programs. NQF also has an online measure database called QPS, which we have a feedback -- for that feedback button that we invite people to send us their feedback about measure use.

We have an opportunity for people to submit public comments on all NQF reports. And we incorporate that information as well as information that we can get from HHS proposed rules to understand how measures are used.

The new staff led feedback effort that

we're presenting on today is another method that we want to use to get direct targeted outreach from measure users. On slide 38, the staff was collecting direct measure feedback on the measures in the duals Family.

We really want to understand the drivers for measure use. What is helping people select measures whether or not it's required reporting or quality improvement programs. We want to get some general feedback on measures with front features. Do measures with these different data forces work well? Or specific measure types really be -- generally be more effective?

We also really want to get some detailed feedback about specific measures. And we want to understand if there are measures that are meaningful to specific stakeholders but also whether or not some measures are as physically effective at driving improvement.

We have the specific goals for this research effort and we're on track with them.

And we're really excited about the results so far. We aim to conduct interviews with measure users from a mix of stakeholder groups. We're using a fairly structured approach and using questions that are adapted to the conversations that we're having with stakeholders and the context.

The intent of this effort is to have a first shot and make an initial effort to get direct feedback from stakeholders. But it's also potential -- has the potential to be expanded and refined over time.

So like I said, we're really pleased with the results so far. We have successfully recruited eight total participants to date. And we've conducted eight -- four interviews of those eight total recruited participants.

We've talked to two health plans, one leader of a consumer advocacy group and one state financial alignment demonstration quality measurement group. Those -- NQF staff has really appreciated the openness of those stakeholders

during the interviews so far.

We're having really in-depth conversations focused on the stakeholder perspective. And some of our assistants are coming with really well prepared and developed materials that their teams have contributed to and really detailed feedback about specific measures in the Family and other measures they're using as well.

We heard from -- about relevant concepts to address the population needs and gap areas. And some of the stakeholders have also shared their vision for the future of measurement. We have some observations and the following slides about adoption, alignment and implementation challenges generally.

I think we're getting on track on slide 41 with the -- we will have a presentation. First, I'm going to present some things about measure adoption. We definitely heard that measures are collected for specific reasons or targeted. The primary reasons for measure

collection is really to fulfill reporting requirements for federal/state accreditation and organizational programs.

Measures are also collected to inform improvement work, including setting organizational priorities, setting targets and goals and monitoring change. Some measures are also collected to explore important issues and inform research. And for a new measure development but also understanding the populations.

We also have some themes about alignment. For the reasons for measure collection can vary, the specific driver for measure collection really is that reporting requirements.

The population served has a direct impact on how organizations select measures as well. We have gotten feedback that's consistent with our preliminary alignment analysis about measure -- about alignment in general. And we've heard that there's concerns about conflicting and

redundant reporting requirements. And stakeholders that have a specific population focus might have less to report about misalignment or redundant measures -- measure requirements.

There are some people that really focus on one group or one sub-population. So, they might really find that they're able to report more aligned measures across the different programs that they need to participate in.

There are limited but identifiable program alignment opportunities for the end user. And we see -- we've heard about alignment around HEDIS and CAHPS generally.

And we asked specifically about what programs are affecting the resource requirements. And there are definite regional and state variations and program requirements that do have a big effect on resources that are used for measurement.

We also have some themes about usability. Some measures are really only

collected for required reporting. And they're not really useful for the organizations in any other way for a variety of different reasons.

Sometimes they don't align with the strategic priorities. And the events that the organization maybe doesn't feel like they can really move the needle. So it might be an effort that would be required to make improvements that wouldn't really outweigh the potential benefits.

There's appropriateness and perceived difficulty with moving the needle in the dual's population and other at-risk populations. Unfortunately, we've heard that there is an infrequent data collection and evaluation of measure results for dual beneficiaries and other populations.

We've heard about the importance of stratifications today. And unfortunately, and there's not a lot of stratification being shared with us -- efforts being shared with us during these interviews.

We heard about how measures are costly

and require a significant effort to collect and report across all stakeholder groups. Everyone recognizes that. And they are costly, but there is also limited resources for looking at stratification or identifying disparities within a measure or even addressing those disparities.

There however is a need that has been identified to do just that. So the lack of resources doesn't really match the need that's been identified to address disparities and identify them within measures and across measures.

So that's a lot of unmet needs and concerns about measures. But I did want to share slide 46 with a few paraphrased thoughts and sentiments about the participant. There are definitely challenges but there's a lot of progress being made. And the outlook for the future is positive. People are working very hard and think that we're going to be able to move forward.

On slide 45 we see some additional

implementation challenges. And there's some priorities. But there's also some challenges that can be addressed through priority setting.

So, some of the challenges about screening we've discussed in this workgroup already. The tobacco cessation measures and measures of other prevention, including cancer and colorectal screening are a priority for different stakeholder groups. They also have been able to see changes in these measures. So that's a positive result.

Medication reconciliation has very specific challenges. One of the challenges is defining it and defining what medication reconciliation really needs. And related to that, providers aren't always collecting the measures in the same way or reporting on them in a meaningful way.

Providers are also reporting implementation challenges with advance care planning. There are policies that are being implemented to make sure that people have

advanced care planning in the --- by the providers.

But these policies and procedures aren't really part of measurement programs. So the organization might not be using a measure, but they are targeting to make sure that everyone within their patient population or all the consumers involved do have advanced care plans in the record.

We heard about transition of care measures are really difficult. And providers are not always documenting or completing the required steps. Transitioning between providers can be a confusing process for consumers. Which all of us can really relate to since, you know -- if we've had healthcare recently.

On slide 46 we hear more about some implementation challenges. Care planning and shared care plans are a measure priority for stakeholders. They're helpful for providers. Again, they need to be clearly communicated to consumers and with consumers. Providers are

making specific efforts to establish these types of communication relationships with the different -- with consumers.

On slide 47 we want to share some ideas about issues that we heard about collecting consumer perspectives, which is a priority for all stakeholders. Consumer surveys are really important but have serious limitations.

One example is CAHPS is only delivered in English and Spanish primarily by participants and our interviews collect having -- they report having people across their panel that speak tons of languages. So, how do we really address the diverse population in the United States? The fact that not everyone is English proficient, but also they don't necessarily really understand what the survey is necessarily asking.

Some people report that when someone receives a survey they may not understand or know what they're really asking about or who they're asking about. So if someone has a case manager, they may not know that that person is who's being

asked about on the survey. But they definitely know that their case manager, Debra, visits them every day. They just don't know that Debra is their case manager.

In slide 48 we have heard about the weaknesses of surveys in a variety of ways. But there is some gap filling potentials that are supplemental questions to CAHPS that are being used by different organizations.

There's a short list of them. And they include access to different resources and a lot about consumer service and helpfulness. And then there are clear issues about access to care and ED use. But also shared decision making and beneficiary sense of control and autonomy.

In addition to consumer perspective gaps, we've heard about home community based service gaps and ideas. We've actually heard this morning about some of these concepts, and similar comments, including the total number of days at home or the total number of days in the community. And so there's some gap filling

potentials on slide 49 for you to pull over.

On slide 50, there's just a kind of other implementation challenges about how measures really don't capture everything. For a good reason, we don't videotape provider visits. But the providers are not necessarily documenting and coding everything. So, things are not captured necessarily in the administrative claims.

The providers also may not be keeping medical records that can populate the measures and provide reliable results. There's also lack of common data sets and regular data sets that are reported by providers. Even those that are required to report consistent measures.

There's also an identified need to synthesize measure results across health plans and populations. The measures at the provider level or even at a health plan level aren't often translated into the bigger picture as, in total, what have we seen as overall results?

I threw a lot of information really

quickly. But I want to talk about some next steps and then hear the feedback from the workgroup. The next stop for us at NQF is to incorporate feedback into the upcoming interviews that we have scheduled and are going to schedule.

We're going to continue holding interviews throughout the Spring. And we're going to communicate avenues to -- pursue avenues to communicate the results of the feedback loops to measure developers and measure stewards so that they can potentially take those into consideration in their measure updates and new measure development.

We had other incorporated results into the draft report for public comment and workgroup consideration. And then we're going to submit the final results to all the stakeholder participants, the workgroup and in the final report to HHS.

So that's a brief overview and a glimpse of what we've been hearing from our stakeholder interviews for the feedback loops

analysis. We want to have some workgroup discussion and get your thoughts.

We want to identify if there are any other issues about measure use that you would like us to explore with the participants during these interviews. We want to think about how this preliminary information might point to any specific actions that this workgroup needs to take about measuring.

And we want to hear your feedback about how's the best way to report this information in the upcoming draft and final reports.

CHAIR LIND: Thank you, Megan. So, folks focusing on these questions and considering that many of the themes that you had been bringing up through the morning, the interviews seem to be uncovering as well. So are there other issues regarding measure use that you are hoping that in the last -- you're about halfway through, right? So the last half of interviews that the interviewers could dig into more deeply.

So, Rich?

MR. BRINGEWATT: Yes, without repeating anything I've said, but going back, something I had noted in prior meetings. But particularly as it relates to collecting information, collecting consumer perspective information, two things.

It's my understanding, I would like to hear what my assumption is is wrong, but it's my understanding that dual feedback is still discounted in relation to other non-dual responses where there's an assumption that the dual report has a bias. And therefore they try to remove that bias.

And if a dual is a small percentage of an overall MA plan it doesn't matter much. But if you have all duals compared to non-duals, that question becomes more relevant. And then if you look at a subset of duals, there are in some plans, a majority of the people served have intellectual or cognitive or mental health impairments that impede their reporting, and

where surrogates are allowed to provide response in lieu of that problem.

But to my knowledge there hasn't been subset analysis of the validity and reliability of the reporting for subsets that have certain defined communication problems. And it seems to me like it's important to do that research. Particularly if we have some plans that exclusively serve those subsets and are being compared to other plans who have very few of those subsets and where the scores are somehow assumed to be comparable.

CHAIR LIND: So in terms of this -- of the interview project, to kind of drill down into that topic area of stratification --

MR. BRINGEWATT: Yes.

CHAIR LIND: Or subset analysis or --

MR. BRINGEWATT: Yes.

CHAIR LIND: Okay. Thanks, good.

MS. POTTER: Can I ask a clarifying question?

CHAIR LIND: If you put your

microphone on you may.

(Laughter)

MS. POTTER: I'll ask a clarifying question now. When you were talking about the plans allow proxy reporting, were you talking about CAHPS?

MR. BRINGEWATT: Yes. Not plans required, but in the -- you know, we're told that for purposes of addressing intellectual problems and feedback on consumer survey information, that for populations that have intellectual or cognitive or other kinds of reporting difficulties, that a surrogate report is acceptable.

And, you know, my understanding is in most research that you really want direct feedback from whoever the consumer is. But yet at the same time there is a real problem if the person that is being asked an opinion has certain problems.

And so the question is how to deal with that. And whatever the process is, if we're

not stratifying the information so that there's comparisons against like populations, but in fact looking at different populations, then that --

MS. POTTER: No, I understood your issue. I was just trying to get at the CAHPS protocol actually prohibits the use of proxy reporting. That's why I asked about the question. Because are people implementing CAHPS in a way that doesn't align with the protocol is a different issue, so.

MR. BRINGEWATT: I don't know about -- yes. I don't know the answer to that. But you know, I know we have a problem here.

MS. POTTER: No, I agree that we need to have proxy reporting for these populations. And we need to do it in a valid way. And there are ways to do that and they have been done in other settings.

But to date, the only CAHPS instrument that allows proxy reporting is the nursing home instrument. It's actually not allowed in the protocol. And the reason is because it's

supposed to measure the experience of the consumer.

Now in the HCDS experience survey that's in the field being tested now, there is a way to do proxy reporting. But it's in testing. And they're trying to validate that and figure out if it's allowed and all of that.

So that's why I was just trying to clarify, that's all.

MR. BRINGEWATT: It's a helpful point of clarification. I still have the same kind of question.

MS. POTTER: No, no. It's still an issue.

MR. BRINGEWATT: Yes. Yes. And that is where they can't do it, how does the data get collected? And then, what is a fair comparison if you're looking at sub-populations in relation to the other population?

CHAIR LIND: And asking the question about, are people misusing tools and what --

MS. POTTER: Right. Right. There are

CAHPS surveys. For example the CAHPS Hospital Survey specifically excludes the behavioral health population. The readmission measure that we talk about with respect to hospitals, excludes the behavioral health population.

So, this issue of excluding populations from measures is an issue in and of itself.

CHAIR LIND: So, we have Jennie then Sally then Steve, and Clark, so.

VICE CHAIR HANSEN: To that point Deb, that seems like the issue of exclusions per se may be a part of our work just to raise. Because our populations in general have a greater proportionality of that. So that might be something we would raise.

CHAIR LIND: You don't get to make a comment and then call on people. No cheating. That's totally cheating.

(Laughter.)

MS. COHEN: I just had one thing to add similar to that, so we don't miss track of

it, if that's okay.

MR. ROSS: No, go ahead. It's okay.

MS. COHEN: I just had one thing to add really quickly to the proxy respondent debate. It's something that Clarke and I, we brought up a number of times. And I worked on a basically CAHPS-like survey because it was never certified.

And it was tested -- continually tested by the folks that do CAHPS testing. And we included proxy respondents and we have data -- I took it back and it's a number of years ago, about the differential between proxies and non and all that stuff.

So if that's helpful, I can get that.

CHAIR LIND: Thank you.

VICE CHAIR HANSEN: This may be next, you have my questions.

CHAIR LIND: Oh, that wasn't -- oh boy, you cheated twice. Okay, I will let you go though.

VICE CHAIR HANSEN: I said that that

actually wasn't my question. I was just commenting and reflecting.

I actually have one question here about whether or not it has come up in the interviews thus far or the opportunity for the next set of interviews. Is this visualization of having any measures that frankly do meet?

In other words that hits the straight out all the way through that you're not doing it just because you have to measure it for the reporting process. But that it has true utility of improvement. And the fact that it's useful.

So, flipping it around to say, have there been some measures that they've had to report on? Made good use of for quality improvement? So that there is no worthwhileness so to speak for doing it, because it's truly useful on multiple levels.

CHAIR LIND: Next, Sally?

MS. TYLER: Thank you. I had a point about, I know Megan had mentioned that language access is a problem in terms of getting the

survey out. As now, I believe she said that the CAHPS survey is only in English and Spanish printed. But obviously there's a wide range of languages that come into play when you're talking about duals.

And I wondered if the services of medical interpreters are considered being used in the way -- because some state Medicaid programs have very wide ranging and robust medical interpretation programs. Washington State is one of them. Alice, you may be familiar with.

But you know, have people with skills in Hmong and American, any other language that could be in that population? So, I wondered is that -- that I wouldn't be prohibited. It's not a proxy thing, but there's nothing that would prohibit medical interpreters being used for the CAHPS survey, is there?

CHAIR LIND: We -- I don't know whether it's strictly allowed or not allowed. But we in Washington have done the CAHPS survey using -- it's a long complicated story, but we

have done Vietnamese and Russian translations of CAHPS.

It's very expensive. And we don't use the brokered medical translation service. We have the survey vendor do that, but.

MS. TYLER: I had a question, and not just translation of it, but interpreters?

CHAIR LIND: Yes, right.

MS. TYLER: Interpreter. I mean, somebody's who there but not just the written translation, but someone who's there?

CHAIR LIND: No. Phone, I think they've used phone interpreters.

MS. TYLER: Just phone? Okay.

CHAIR LIND: Steve?

DR. COUNSELL: Yes, with the CAHPS outpatient survey, at least the vendor that we have in Indianapolis, both in two different health systems, the caregiver is able to help you know, as people fill that out. And that's marked on the form.

And so we take care of a lot of people

with duals and those with dementia and other things. And so the caregivers are filling this out. And our scores are going up there and being matched with everybody else's scores where the patients actually fill it out.

And so this is a big issue that you know, we at least will say, well that's why our you know, our scores are maybe -- is low. We can improve them. But don't compare us. So I think it is a real problem. And maybe there's a clarification. Maybe our vendor does that. But then those scores aren't counted at the national level if it's a caregiver? I don't know.

MS. POTTER: There's a whole bunch of surveys that are called CAHPS-like surveys.

DR. COUNSELL: But then that doesn't really go up to Medicare?

MS. POTTER: No, the Medicare, if it's the Medicare one, then it really is a CAHPS survey. And it's an issue probably with the vendor. You know, because just -- you know, and maybe they're not a vendor now.

DR. COUNSELL: No, they're -- you know, I'm misunderstanding but.

CHAIR LIND: Sarah?

MS. LASH: I don't want to muddy the waters, but I believe there is an exception where a person can be assisted in filling out the survey if it is their opinion that is being communicated. So for example, if I had a motor limitation and couldn't physically complete the survey, but I was able to verbally communicate my responses and a family member put in, you know, the marks and mailed it in. That is acceptable.

Maybe that's a full proxy? Okay.

DR. COUNSELL: Yes. That's the problem. Because I know almost half of our patients have a check that they've gotten assistance in that. And that's going to be by caregivers who are not fully informed with that person is. It's not a physical assistance anyway.

MS. LASH: Right.

CHAIR LIND: Okay. Clark?

MR. ROSS: Two items on persons with intellectual disabilities and proxies. Last year ACL and ONC conducted a conference on e-LTSS, using electronic communication and LTSS.

And one of the speakers was a New York University, and I have the information at home if Shawn or Charlie don't remember who this is. But he's a NIDRR funded researcher and he's adapting the CAHPS measure for people with intellectual disability, question by question. And he's in the field -- he's been, in the last year, in the field testing process.

And his goal is to submit it for AHRQ approval. So it's a NIDRR funded project that was presented at the ACL conference. I think he's at Long Island University, but I can't --

MR. TERRELL: I don't -- I'm trying to think of his name. Is it O'Hare? O'Hara?

MR. ROSS: Yes.

MR. TERRELL: O'Hara? Yes.

MR. ROSS: Yes. The Irishman. Right.

MR. TERRELL: I have his -- if you

haven't run into him, I still have his contact information.

MR. ROSS: I communicated with him after the conference. So I have the information. I can send it to you. Westchester. It's starting to bring back some memories.

And then the second thing, Charlie, you can affirm this. But on the National Core Indicators, I'm pretty sure it says is this a proxy response or the direct beneficiary response? And then National Core Indicators then separately analyzes each area of response and looks at the difference or the possible difference in the kind of responses.

MR. LAKIN: And only to add to that, there are quite a number of items on the National Core Indicators and on other similar surveys that no proxy would be allowed to answer. For example, do you like living here. No other -- no proxy could be allowed to respond to that.

CHAIR LIND: Shawn?

MR. TERRELL: Charlie just answered my

question. But I will say that there -- you know, this -- conflicts of interest are huge in the disability world. Particularly intellectual disabilities. People living in group homes, et cetera. How do you get to proxy around that without it being a problem?

CHAIR LIND: Deb, did you have another comment?

MS. POTTER: Yes. My question is more of a process question. You're collecting this feedback and it's the perception of the person. It's their opinion. Which may or may not actually be true. I mean, it could be their perception that X doesn't happen, when in reality X is allowed.

And in your report, will you put that nuance in and attempt to say some people believed, however in these pro -- you know, that kind of thing?

MS. LASH: That's a really important distinction. We do want to emphasize to this group as well. We've only talked to four people

so far. We don't want to overly extrapolate what we've heard and you know, jump to any particular conclusions.

But, what they have raised, I think has come up in many other contexts. So it's just for the accumulated experience that was sort of beginning to take shape. And we -- I think we do need to be very clear that this is a very limited set of key stakeholder opinions that are opinions.

This isn't how services research. You know, there's no P values or anything like that in play.

MS. POTTER: And I would add maybe to the questions. Are there things that you have found that are helping your plan or whatever, to actually move the quality improvement needle? The flip side of it?

CHAIR LIND: Charlie?

MR. LAKIN: I think what Deb said sort of covers what I was wondering about. Megan, you set out to find out a little bit about measures

that are meaningful and drivers of improvement from your interviewees. And it sort of seemed to me that there wasn't a lot of response related to that.

And I think it would be very helpful to see if people could identify ways that going through all this reporting actually led to things that benefitted people. It seems a --

MS. ANDERSON: Sure. This is Megan.

MR. LAKIN: A little bit negative in the list. And I know there are many, many examples about people have used data to improve their practices. If we could capture some of those, it might help the cause.

MS. ANDERSON: Yes. And even some impression on those issues actually, about -- really turns on its head. So, there's different adults, there's the reflecting changes they do. And then there's other specific programs for other specific adults of the measures.

And the answers are yes or are they upgraded. And specific examples that we can get

those really specific examples. And I think there is a couple of things about amending that community that organizations can work on. And there are none of these issues that it really does support the change.

We didn't highlight these stories in this presentation because the end is really too small. But we have heard about people who have been able to feel that they are in the middle, they're waiting for kind of the next year or two years of regardless of people's frustration among measures.

And we can look back there at the results of measures that are costed and recorded. That takes a while for those changes that are made to get results. But, they feel like they were doing -- that they're getting more done.

They feel like they're getting a better quality. They feel like they're able to make specific changes to their work, to hopefully improve that quality of care. And they're hearing from other individuals within the

organization or providers that it is making a difference.

But the other part of that is that the measure specific results can be helpful. But I think there are people who have used the measures together. There is total besides we can look at what their population measurement can find and also what we can change within the population so that's kind of looking at that broader spectrum.

And then I think the number of measures purely is an issue and that we can get examples of people being able to target one or two specific measures. And make changes to practice and care. But, that's really only going to change one or two specific measures.

So, it's tough and there are people that are sharing as much as they can and we've gotten some really good feedback. And we'll try to be more explicit in the report about those stories and capturing and measuring them.

CHAIR LIND: Thanks Megan. I -- you know, one of the things that I was hoping you

could probe on too, is that if you have 100 measures that you're required to report, how do you choose the ones that you hone in on, focus in on for improvement or, for you know, concentrated work, pay for performance measures, whatever.

So, I mean, just to your point earlier George, there's all those -- you know, do you sort it by how many conditions take up most of the population? Do you sort it by the who -- you know, what drives hospitalization or costs? Or most complications for people or whatever?

And the trouble with that of course is that you know, if you can only keep your attention on five or six or seven measures, then the ones like you say, that affect people -- the smaller numbers of people. People with HIV and AIDS, then you know, do you lose track of some of the really, really important measures like viral loads that you should be keeping your eye on?

So, Jennie and Rich and then we'll transition to the next topic. Oh -- okay, Jennie, Rich, Clarke and then we'll transition.

VICE CHAIR HANSEN: I was thinking about a proactive. Ask you know, a provider. The conference that Susan mentioned on the Coalition to Transform Advanced Care featured a speaker who ran a hospice and palliative care program called Caring -- I forget, I'll find the name.

But she has to of course report on quality measures. But has created a database system of like thousands upon thousands. And they keep track of this data literally on a daily basis. And then they respond.

It would be interesting to see what measures that they have chosen to do this. And they have been doing this for like five, six years. So, I'll get the exact name, but it might be proactive to find one that has used measurement to actually create continuity, confidence and competence.

And that's kind of their endpoint. And the satisfaction level like was incredible. But I'll -- I'll look up my.

MR. BRINGEWATT: Yes, just a quick comment on kind of what drives people to focus on which measures they're in. It may be kind of obvious, but pay for performance, whether you get money or not, makes a huge difference as to whether you're focusing on a measure or not.

And there are measures within the Special Needs Plan pot of measures that the Special Needs Plan C is particularly important. But they get trumped by the measures that will drive their bottom line.

MR. ROSS: Two years ago, in our report to CMS, we mentioned the four states that have consumer/family independent monitoring teams. Massachusetts, eastern Pennsylvania, Maryland and counties in Wisconsin that do this in the area of mental illness.

What Massachusetts and Philadelphia do, Philadelphia for the public mental health system and Massachusetts for the managed behavioral healthcare system, they interview monthly the people who filled out not satisfied.

Because the managed care plans say well, 90 percent of our people are satisfied.

So the precise mission of these consumer monitoring teams are to -- you know, they go through all the confidentiality stuff. But they interview the ten percent who are dissatisfied and document patterns of dissatisfaction.

And John Delman who is the founder of the Massachusetts program is new to the National Quality Forum Home and Community Based Services Committee. So he's sort of one of the guru's in this area.

But we have a lot to learn again from rather than just marketing 90 percent satisfied, what are the commonalities of the ten percent who aren't.

CHAIR LIND: Very helpful discussion. And thank you Megan for presenting remotely.

And now I'm going to turn it to -- oh, Jennie's going to be facilitating Megan again. So I hope you took a little break to get a cup of

tea Megan.

MS. ANDERSON: Well, I am working with that. But I can understand you know, people in the room. I should hope for and make sure that they have enough energy and caffeine.

We do have another big section to go through. Jennie, I don't know if you have any words to kick us off?

VICE CHAIR HANSEN: This next section is Maintaining the MAP Dual Eligible Beneficiaries Family of Measures and the Gap Areas. So this is going to be a big section.

And one of the things that at the end of this, you know, we'll cover the certain measures that are no longer NQF endorsed. And then we'll take a look at some of the more recently endorsed measures to consider adding to the Family. And I think it was mentioned there are over 21 of them.

But as I say that, I want to put the little star there. Because given our whole discussion this morning, the whole question of do

we just add on these 21 measures, or how do we look at it. So, our discussion will go through that. But there will be some individual discussion that Megan will go through the measures themselves.

And so then we'll look at reviewing and updating the prioritized areas that we see are gaps that we want to work on. So, we've kind of traveled into that earlier this morning. But this is what this particular section was. And I have to put a little perimeter on it.

So, the question is, Megan, do you want -- did I hear you say, you suggested a break or not? I'm sorry, I couldn't hear you.

MS. ANDERSON: I know that people will be taking breaks as needed. I think we are intending to take a break partially through the segment. So I'd like to get started.

And then depending on how this goes and how people are feeling, I think we might want to take a break in about 45 minutes.

VICE CHAIR HANSEN: Okay.

MS. ANDERSON: Is that good?

VICE CHAIR HANSEN: Sounds good. 45 minutes we'll take a break. So --

MS. ANDERSON: And you let me know. And I apologize that I am not there to see the rustling in the room and the restlessness. So if you are -- need to take a break, you just let me know and stop me where I am.

VICE CHAIR HANSEN: Sure. You'll probably lose half the group at one little point. No. Seriously, we'll let you know if there needs to be an actual break.

MS. ANDERSON: Okay.

VICE CHAIR HANSEN: All right. Thanks.

MS. ANDERSON: All right. So we are on slide 53 and moving onto slide 54. You've already received an overview of the current Family that I hoped arrived this morning. Just to remind you, the Family of Measures is always the best endurable measures that attract quality issues across the continuum of care for dual

beneficiaries and high risk groups in the population.

It's really intended to be a resource in the field to select measures for specific programs, to promote alignment and to define high-priority measure gaps. It's really important to recognize that the family of measures is not just the measures, but it also includes the gaps.

We need to the workgroup to periodically consider updates to the family.

CHAIR LIND: Are you okay Megan? I wonder if we still have a connection? There's a pause.

MS. SHAHAB: Cathy, is Megan still on the line?

OPERATOR: One of her lines disconnected. One moment.

MS. SHAHAB: Okay.

CHAIR LIND: So she's probably talking and -- unfortunate. She'll probably call back in? All right.

OPERATOR: All right. Megan, your line is unmuted now.

MS. ANDERSON: Hi, this is Megan.

CHAIR LIND: Megan, we can hear you now.

MS. ANDERSON: Great. This is why I have two lines. So I am so sorry about that. We have a backup system in place. So, I'm really glad that worked to prevent me getting cut off for too long. I really apologize for the inconvenience.

So, I'm going to start again with slide 54. And I think you weren't able to hear me talk about the last bullet.

CHAIR LIND: Correct.

MS. ANDERSON: The last bullet is about the workgroup periodically making updates to the family of measures. We want to make sure that we consider measures that have had changes to them, significant changes that would affect their use, but we also want to identify potentially relevant new early NQF-endorsed

measures.

So, the next slide. We want to review the measure selection criteria. There are seven criteria that are used across all of the measure applications. Partnership with NQF to select measures for use and recommendation for use in programs.

The first one is to have measures that are NQF-endorsed that meets the program requirement and such. But as you all know, there is no specific dual beneficiary program. So we look at this as NQF-endorsed measures that really meet the needs of the population as well as the programs that are serving those populations.

We also want to look at the National Quality Strategy three aims and make sure the measures that we are recommending for use adequately meet the needs and address those aims, and that's taken together. So an individual would maybe address one, maybe two of those aims, but taken together the measures in the set would address the National Quality Strategy aims.

We want to make sure the measure set is responsive to the goals and requirements. So that's why -- and one of the reasons why alignment is so important.

We want to look at whether or not there's an appropriate mix of measure types for the program needs, and we want to make sure that the measure set really enables person- and family-centered care and services.

Importantly, we were discussing earlier, addressing healthcare disparities and cultural competency, and number seven is, does the program address this parsimony and alignment?

Now this is an important criterion because there's no specific limit to the number of measures in the family. And just to remind you, this was really a pick list. So we wouldn't expect any single measure user to use every single measure in the program.

So parsimony and alignment are really important, and I think that staff has their eye on some work to get you to look at alignment

differently. But we want to maintain parsimony, but there's no cap on the number of measures that we can have in this family. Next slide.

So there are 58 NQF-endorsed measures in the family, two of which have lost their endorsement. So there are 39 process measures, ten outcome measures, five patient reported outcome or consumer experience measures, three composite measures and one measure of cost/resource use.

There are 14 measures with e-Measures available, this is becoming increasingly important. And there are measures that are applicable across a variety of settings and levels of analysis.

We want to highlight the measure gap areas as a complement to the measures in the family. The prioritize measure gaps, this workgroup has identified and continues to refine over time, are goal-directed, person-centered care planning and implementation, shared decision-making, systems to coordinate care,

long-term services --

VICE CHAIR HANSEN: Megan? Excuse me. This is Jennie. Joan had a clarifying question.

MS. ZLOTNIK: Yes. Can you tell me what e-Measures are? I'm not quite sure what that means.

MS. ANDERSON: That's a very good question. I am not going to be able to give a very good definition, but the measures that have e-specifications so that they can be electronically collected and reported.

I think if Ellen or another SVP in the room that might be able to expound.

MS. LASH: Essentially they can be derived from an electronic health record.

MS. ZLOTNIK: Okay.

MS. ANDERSON: Measures that has e-specifications usually aren't exclusive to e-specifications. They usually can also be collected through some sort of administrative claims or medical record as well. Just to clarify.

So I think I was right about where beneficiary sense of control, autonomy and self-determination is in the list of gap areas. I've also talked about psychosocial needs, community integration/inclusion and participation. And optimal functioning, which means improving when possible, maintaining when that's the goal, and managing decline as well.

So we want to phrase -- frame the upcoming discussion with key questions, and so we don't have to answer these questions right now. They just are something for you think about as we go through this process of updating the family.

So we're going to review measures that have lost endorsement, and after we do that, does the workgroup have any suggestions about measures that need to be retired from the family or replaced? And then after review of the newly endorsed measures, we're going to ask whether or not the workgroup would like to add any measures to the family.

We'll vote by a show of hands and 60

percent agreement is considered consensus. We want more than a simple majority. So we're going to start with the measures that are no longer endorsed. Measures lose endorsement for a variety of reasons, often because the measure developer chooses to retire them.

The first measure we're going to go through is NQF 0007, NCQA Supplemental items for CAHPS. This measure was retired by the steward, and we're making substantial revisions, and you've heard about some of those in previous convenings of this group and other groups from NQF.

There is revision for shared decision-marking and care coordination that are underway. So we'll have staff bring forward the revised CAHPS measures on this topic for the workgroup consideration when they become available, after testing is submitted and they are submitted for NQF endorsement.

Just to remind you, there are several other CAHPS measures that remain in the family.

We do not include pediatric measures in the family because there are very few children in the dual beneficiary population. And so, those other CAHPS measures that are endorsed remain in the dual beneficiary family.

So the question I rose to the group is, would the workgroup like to remove NCQA Supplemental items for CAHPS 4.0 Adult Questionnaire that has been retired from the family until updates are available?

VICE CHAIR HANSEN: Okay. So we discuss them one at a time? All right.

So we currently -- Sarah just has counted how many we have here as voting members. There would be 14 of us, and rounding off the 60 percent would be -- nine people would be a consensus definition here.

So I'll first entertain any comments that people have one way or the other? Okay. I see a comment from Steve?

DR. COUNSELL: Question, what is this measure exactly? Is it, contain questions about

shared decision-making that are being revised? Or is it --

MS. ANDERSON: It's a CAHPS measure that has been NQF-endorsed, but it contains supplemental items from CAHPS as a group for endorsement. The different items don't have to be endorsed for the whole measure to be endorsed, and it does have a focus on shared decision-making and care coordination.

The revisions that are underway -- and I haven't looked at them more recently so I apologize I can't speak to them directly, but they do address shared decision making and care coordination. We wouldn't expect those -- to see those revisions to this workgroup this year for this report. So that would be something to look at in the future.

DR. COUNSELL: So this is maybe part of our decision-making process and just historically at least we've either added a measure or retained a measure as a placeholder or to communicate the value I guess of the group.

MS. ANDERSON: Yes. Unfortunately, I don't have any alternatives to offer to this measures at this time.

And there's -- the workgroup might just say that they want to retire this measure from the family and ensure that it is later considered when it is brought back through NQF endorsement for inclusion into the family, and the Workgroup might also maybe recommend continued use of other CAHPS measures during the time where this measure is being updated and development of other gap-filling measures for shared decision-making and care coordination because it's a high priority gap.

VICE CHAIR HANSEN: Anne?

MS. COHEN: I just had a clarification question. In the spreadsheet it looks like all nine of the duals programs have used this measure in their uptake. So if we remove it from our report, does that mean that CMS tells them to remove?

Like how does that ---- if they're all

-- if it's one of the ones that they're using, it's kind of like, well what do we do here?

MS. DAY: So we probably would not remove it from the set. We are -- we try to update, but at this point I think the Medicaid adult core is also using this exact same measure and so we would probably maintain it until we revisit it.

MS. ANDERSON: So the key component here is just because a measure is retired from NQF endorsement, doesn't mean it's no longer being used. It means that the measure steward is no longer maintaining and submitting testing results, so NCQA is not continuing to test the measure that's currently in use.

And it's really important to think about the changes that we make to the family and how that impacts the measure selection going forward. So it's a really important discussion path.

CHAIR LIND: So I didn't understand the comment that was made about the Medicaid

adult core set because I was under the impression that the Medicaid adult core set CAHPS measure had a different supplement.

MS. DAY: So I'm sorry, I actually misspoke, and I meant to say the National CAHPS survey. But we are using -- there might be a different supplement, but we decided on this with the 4.0(h) with the Medicaid.

CHAIR LIND: Okay. I was just trying to clarify. I think that in the Medicaid adult core set, there's also a CAHPS health plan measure that isn't -- doesn't include this supplement.

MS. DAY: Oh, okay.

CHAIR LIND: Okay? It's the supplement, not the CAHPS health plan. The CAHPS health plan is still endorsed, but there's lots of supplements to CAHPS health plan. So that's all I was trying to clarify.

MS. COHEN: That was my clarification. The supplemental questions, if we say no, we don't want to endorse them, and CMS continues to

go through -- forward to use them -- I understand that just because something loses an NQF endorsement, doesn't mean they're not going to use them.

But then the question is like, we say, okay, let's wait for the new questions to come out and then direct them to include those new questions when they come out. Do you see what I'm saying? I'm trying to?

VICE CHAIR HANSEN: You're asking about the sequence of this, and do you basically have something that's vacated, you know? And basically a hole for a while, while CMS continues its use in that way.

MS. ANDERSON: Can you use your microphone please?

MS. DAY: So, can I just speak to that briefly?

CHAIR LIND: Please.

MS. DAY: And then tell me if I'm not answering your question, but from the CMS perspective, what we would do is -- so in all of

our measures we in the MOU say that we will go back and update as the science changes.

So I realize that on this the science might not change. But to answer your question directly, we would not change this particular measure in our demonstrations because we think it's important, and quite frankly, we've invested a lot of resources in developing a survey particular for the duals.

VICE CHAIR HANSEN: Can we -- let's back up. Right. So you're going to go on. I guess there's a basic question, is why do we remove it at this particular time?

MS. DAY: That's it. Yes.

VICE CHAIR HANSEN: So that seems to be kind of a question at least of a few people here, Megan. Do you have a sense of why we would recommend pulling it out?

MS. ANDERSON: Yes. I think a recommendation that I'm hearing maybe boiled to the top here is that measures that are in use that need to be updated but there are planned

updates might for continuity sake, be recommended for continued use. However, that the workgroup would encourage uptake of the measure once it is updated.

This is a similar recommendation that we've seen in the past. However, you know, there are potentially unintended consequences of a measure that is not being maintained scientifically, and especially in pay-for-reporting ---- in pay-for-performance programs and public reporting. You can think about the consequences of reporting measures that are not scientifically maintained and valid anymore.

So there's maybe a recommendation but the workgroup would not have people remove it in programs that are currently using it, but update the measure when an update is available and maybe not add it to a program at this time if it's not already in it, or until that measure update is available.

VICE CHAIR HANSEN: So that's kind of a friendly amendment is not to pull it out.

Leave programs that are currently using it even though it's not scientifically supported, but then when a new measure comes out that is scientifically supported, this would be started up again.

So D.E.B., you've been our technical advisor here. Do you have any reaction to that?

MS. POTTER: Well, I just worked at AHRQ which developed the CAHPS. And so I -- but I don't really have anything to do with the CAHPS program per se.

I do know that there are other CAHPS supplements that measure shared decision-making and coordination of care. There's all these supplements to CAHPS. There's a whole module on patient-centered medical home that has a whole bunch of questions around this. I don't think that particular module has been submitted to NQF for endorsement.

I'm not sure what's in the CAHPS clinician survey. I'm pretty sure there's a couple of questions in there ---- I could be

wrong, about shared decision-making and care coordination. So maybe -- I like the recommendation that was proposed, but maybe we should also think about are there other endorsed CAHPS measures that might meet our purposes? And I don't know if there are or not.

VICE CHAIR HANSEN: Back to the cards -- oh, go ahead, sorry.

MS. ANDERSON: We have included currently endorsed measures. We have included all currently CAHPS -- currently endorsed CAHPS measures in the family so far except for those that are specific to children.

MS. LASH: I'm sorry, I'm just going to repeat what Megan said in case people had trouble hearing.

So there's sort of been a standing recommendation from this group that all CAHPS tools should be used where available and so we have listed in the family all of those that are specifically endorsed, with the exception of the pediatric specific instruments because that

population is not represented in duals more than one percent.

VICE CHAIR HANSEN: So, Joan?

ZLOTNIK: So I have sort of a process question because I'm sort of not sort of working in a healthcare setting sort of using these measures every day. Kind of in terms of like what as the MAP Dual Eligible Beneficiaries Working Group are sort of obligations are?

Because well if there's a whole bunch of supplemental measures and some of the other things get there, but from what I gathered what Megan just said, we've actually included all of those in our family of measures. It's just like not clear to me what the obligation is, just in terms of -- it's similar to sort of developing evidence-based practices. It's an ongoing process.

So people develop an evidence-based intervention. You want to go to use it. You go back to them and they say oh, well, we're refining it now. You know, so you can -- don't

you -- yes, don't you -- stop using it, don't use it, or you're not an authorized user.

And I mean, so it sounds kind of similar to that and so it sounds like someone's trying to work, I assume, by improving it for greater use. So it would seem to me that based on that, we would want to kind of say, we want to kind of continue to use it as a placeholder until the new one comes along?

Because this issue of, well, you know, it's not being kept up. In a way it is being kept up if someone's trying to develop something bigger and better. So it's a little confusing in terms of the language when I'm not sort of using these things every day and trying to be why?

VICE CHAIR HANSEN: We're spending all -- you know, a fair amount of time on it. Just so -- but let me just honor the two tents here. George and then Rich, and then we'll move to clarify what we're voting on and have a vote.

DR. ANDREWS: Yes. I was going to say I was confused because I wasn't clear what was

being retired, but I think now I'm more clear in terms of what is being retired by the steward, which is a supplement, not the CAHPS core.

Well my question still is, you know, if the steward, the developer, is retiring something, why would I want to use something to measure the outcome of when they don't know what they're going to come up with? And I think this party needs to take that into account.

We need to rely on good data, on good methodologies, on -- so, I don't feel comfortable, you know, with the retirement from the steward to go in and say yes, let's retain this for now.

MR. BRINGEWATT: Yes, I have a question along that line, and that's I heard something -- someone earlier say that there's a question of whether this is valid anymore.

And if it's no longer valid, I would raise questions as to whether ---- I mean, we do have some pride in terms of evidence base here as part of a criteria for utilization. And so, it

would be helpful to me to know whether -- I mean staff have recommended as I'm understanding it, to not use it. And, is part of the reason to not use it is because it's not seen as valid? And if it's not seen as valid, I would be inclined to say we shouldn't use it.

MS. LASH: Let me try to shed some light on that. The steward has withdrawn this measure from endorsement maintenance, which requires resources on their part to participate in, because they know that they're working on a substantial revision.

Which is a little bit of a different circumstances than a clinical guideline has changed and it makes an existing measure totally obsolete. So, you know, that it needs to be chucked because we've completely redone blood pressure guidelines or something like that.

So, we had been operating under the precedent of removing measures that had lost endorsement I think because primarily we were encountering measures that were losing

endorsement for those guideline-related reasons that the validity and the evidence base was evolving.

In this case, I think these measures are fundamentally still the best available, even if they don't still have NQF endorsement. I might make an analogy to buying a used car. It might still run quite well and get you from point A to point B, but that doesn't mean you can't get brand new 2015 one off the lot with more bells and whistles pretty soon.

So, I think the sense of the group is to keep the measure in the family, but make some specific notations about use expectations going forward.

Go ahead. Sure. You're mic's not on Rich.

MR. BRINGEWATT: Is there another measure like this in the lot that's ready to be purchased soon?

MS. LASH: I can't speak for when NCQA would be ready to release the update. If that is

one year away or two years away. But, when it is, it would come to this group for further inspection.

VICE CHAIR HANSEN: Steve, do you have one more?

DR. COUNSELL: Yes. How many in the family do we have that are not NQF-endorsed?

MS. ANDERSON: Two, there are two measures.

DR. COUNSELL: And they're serving as placeholders? I think that's what I would subvert this to like a placeholder status I guess because not everyone -- not everything in the family I think we have is fully validated, endorsed, maintained.

MS. LASH: Right. So this could stay as a placeholder.

VICE CHAIR HANSEN: This could stay?

MS. LASH: Yes.

VICE CHAIR HANSEN: Okay. So, I think we've had some robust clarifying discussion, and so that this -- how many of you would like to

maintain the current measure as a placeholder and using it as that until the -- whenever the new measures come out, whether it's a year or two years from now?

So I'd like to have hands up for those who would like to maintain the measure on that basis. Okay.

MS. LASH: Federal Partners are non-voting. So keep your hands down. I'm sorry, you're just going to screw up my count.

VICE CHAIR HANSEN: Okay. We have ten. So we have sufficient threshold. All right. Thank you. Okay.

MS. ANDERSON: Okay. Our second measure that we have as lost endorsement is NQF 0111, Bipolar Disorder: Appraisal for risk of suicide. This measure has been retired by the steward and is no longer going to be maintained.

We have been told there will not be an update and there will not be a new measure that does the same thing that this measure does. Unfortunately, that's a different scenario than

what we've heard about for the e-CAHPS supplement.

There are two potential alternative that staff has identified that we want to bring for your consideration. Our thing as a staff is, I want to remind you that when 0111 Bipolar Disorder, this appraisal for risk of suicide was originally included in the family, it was included to really address that risk for suicide component.

So we've identified NQF 1880: Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder, which does address bipolar, but does not address suicide risk. And we've also identified 0104, which is Adult Major Depressive Disorder with Suicide Risk Assessment.

The question is twofold. Would the workgroup like to remove the measure that's no longer going to be maintained, 0111 Bipolar Disorder: Appraisal for risk of suicide? And the question number two is, would the workgroup like to include either of the available alternatives?

I'm going to go briefly through the available alternatives on slide 62 and slide 63. They've also been included in the attachment to your materials, and that is Updating the Family of Measures. So slide 62 please.

Potential alternative, the first one to consider is Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder. This measures a percentage of individuals 18 years and older with bipolar disorder who have mood stabilizers or medication prescription and adherence to it. The adherence is defined as a proportion of days covered with -- in 12 consecutive months of at least .8.

It's a process measure. The measure is specified for settings in outpatient care and behavioral health location care, as well as urgent care, and it's measured at the provider, team, group, and practice. It is not risk adjusted and it can be stratified by Dual Beneficiary, race and ethnicity and other diversity-related issues.

Slide number 63 includes Major Depressive Disorder: Suicide Risk Assessment. This measures a percentage of patients 18 and older with a new diagnosis of -- or a recurrent episode of major depressive disorder with a suicide risk assessment completed during a visit.

So it's also a process measure. It's also available for application in outpatient settings, inpatient care and behavioral health outpatient. It's a different level of analysis. It's available from providers in group practice, Health Plan, Integrated Delivery System and State. It is not risk adjusted, and it encourages risk stratification by race/ethnicity, primary language and gender.

This is a staff pick because it addresses suicide -- it has included suicide risk assessment, which was the original intention of including the measure that has -- no longer endorsed.

So if the vehicle here would to come to a vote about either removing the measure for

Bipolar Disorder: Appraisal for risk of suicide completely, or replacing it with a second measure, and staff recommendation would be the suicide risk assessment for adults with major depressive disorder.

Do you have any questions?

VICE CHAIR HANSEN: D.E.B. seems to have a technical questions.

MS. POTTER: Yes, I have a technical question. In the first measure that you put forth as a potential substitution, you said it could be stratified by duals, and in the second, you said it encouraged stratification, but you didn't mention if it could be stratified for duals.

I wonder if you could clarify?

MS. ANDERSON: That is information from the measure specifications. I believe that if the steward would have encouraged stratification, then was possible to stratify.

VICE CHAIR HANSEN: It would be possible, yes. Okay. Thank you.

So I have three other comments. I'll start with Clarke, Vanesa, Anne and Rich.

MR. ROSS: So I have a question for the staff. Do we know the opinions of Drs. Pincus, Robinson Beale and Chalk on this? And/or do we know the opinion of the Behavioral Health Measure Committee?

MS. LASH: We haven't asked Dr. Harold Pincus as a MAP Coordinating Committee Member, Dr. Robinson Beale is no longer on the MAP, and both of them were endorsed by the Behavioral Health Standing Committee. We haven't put them head-to-head in the context of the endorsement work because they do measure different things.

Mady may be on the phone. We didn't hear her introduce herself this morning, but I don't think we've seen her connect.

VICE CHAIR HANSEN: Okay. Thank you. Vanesa, you pulled off? Okay. Next I have Anne and then Rich.

MS. COHEN: I'm going back to the spreadsheet again, just to see, and it looks like

none of the plans -- none of the duals programs have currently adopted this measure. Do you have any insight as to why?

MS. ANDERSON: I don't have any insight as to why it hasn't been currently used, but that measure is no longer going to be NQF endorsed.

So it wouldn't be recommended for use in any other MAP body, and it's no longer being maintained by the steward, so I don't think the specifications will continue to be available either.

MS. COHEN: So actually, I'm looking to CMS and they said, no, we don't ---- you're not sure why.

VICE CHAIR HANSEN: Vanesa, may I ask you to use the --

MS. DAY: I do not on this particular measure, but I can look into it and get back to the group.

MS. COHEN: And then my only other question and it looks like that this has to be

done at the provider -- well, it can be done in the provider, plan, integrated system or State. So my only question is, for the -- not that maybe it matters, but these existing duals programs with whether mental health is carved into them, and then if it is, you know, how that impacts this?

And if -- because you know what I'm saying? Because if it's carved out, then the question is whether this is an issue of how to collect it, and maybe that's part of why it's not being adopted.

MS. DAY: Okay. Well, mental health integration is part of the duals demos. So -- yes.

MS. COHEN: In some states, like California, it's been completely carved out and they've been struggling with integrating it. So that's why I was like trying to see if it has.

MS. POTTER: I have another technical question, and just maybe Vanesa or someone in the room.

How do the pharmacy benefits for the dual capitated plans work? Do they -- if they're duals, do they still get a Part D plan, or is the medication included as part of the capitated plan?

MS. DAY: So I don't want to misspeak, because that's a little bit out of the -- my area on the capitated plan -- capitated area, but if someone else is from the duals office is on who can speak to that particular area of the capitated model.

I can come back to the group on that as well.

VICE CHAIR HANSEN: And I'd like to encourage --

MS. POTTER: Well the reason I was asking was because the first measure, adherence to mood stabilizers, if the medications are in a Part D plan, there may be issues with the capitated plan having access to that information as opposed to the second measure, which could just be within the plan.

MS. DAY: I think --

MR. BRINGEWATT: Well, SNFs are required to have Part D as part of their plan. I mean, they're required to have that benefit integral to the overall plan, and the MMPs follow a model of care requirement for special needs plans.

MS. POTTER: Oh, okay.

MR. BRINGEWATT: So, I assume, but am not a hundred percent certain, that that probably applies to the dual demonstration plans as well.

MS. POTTER: Okay.

MR. BRINGEWATT: You know, it's important to double check that one, but that's my stream of logic. Whether it holds of not needs to be checked.

MS. POTTER: No, that seems very reasonable.

MR. BRINGEWATT: Yes. I do have another question that relates to that though, and that's the fourth bullet here recognizes accountability for performance -- for performance

of the measure. And that includes health plans and integrated delivery systems and the other measure did not.

And so, the question I would have, is what is the assumption as to how plans would be accountable for this, particularly if there's a plan that doesn't provide services directly, but does it through a series of contracted entities?

MS. LASH: So when you vote to include this measure in the family, it doesn't come with instructions as to how it finds its way into any of the specific applications.

As we were discussing this morning, some measures would be a fit and some measures would not, and those decisions happen sequentially after this.

What you're voting on is, would support of 1880 or 104 as measure alternatives further the availability of good measures to improve quality for the dual eligible population? So, that's really the question at hand.

Let's you know, try to stay program

agnostic in this discussion. Are these measures part of the list that MAP has put out to say, if you want to improve care for duals, start with these options. Which is the best measure to accomplish that goal?

MS. DAY: Can I offer a clarification? So thank you Carolyn who just emailed me that the MMPs do incorporate -- require the benefit plan. So thanks.

VICE CHAIR HANSEN: I have Shawn and then Steve.

MR. TERRELL: So I'm not sure where my boundaries are anymore. I thought I knew, but now -- an I make a comment or some ideas? Like can I throw these out on the table as a Fed? Okay. I just can't vote. Which is fine. I get it. It's good.

So just -- I mean, this measure on risk of suicide is really important, right? I mean just the stats, this is like 25 to 50 percent of the people with bipolar attempt suicide. There's 15 to 50 percent actually you

know, complete a suicide. So okay, so it's a big thing to measure. It's really important.

So the first thing would be like the last measure perhaps, holding on to it until there is something really clear. That's one option to think about if we have no other option.

The second one, I just have question on this in terms of the alternatives. The first alternative around the mood stabilizer question. Is that -- well, how is that measured? I mean, how do people know whether somebody's you know -- -- is it self report? Is it somebody fills a prescription?

MS. LASH: It's related to the fill of the prescription.

MR. TERRELL: All right. Well, that's you know, I mean 50 percent of people ---- there's 50 percent non-adherence on neuroleptic medication. You know, I mean anybody -- family members fill prescriptions, you know, you have a bag of prescriptions sitting there over six months. I mean, it doesn't really tell us a lot

I would say. All right, there's that one.

And then, on the major depressive disorder, that it would be great. Okay, so there's a risk assessment question there. Would it be -- I don't know how -- again, this is the hold, does it have to go -- do you have to go redo the whole measure just to add in the question of whether somebody had bipolar or not?

VICE CHAIR HANSEN: Okay. Well, thanks for your input on that, and the question.

Vanesa, were you answering that question specifically? No. Okay. In which case then I'll go over to Steve and come back to you. Steve?

DR. COUNSELL: Well, I was just wondering if -- I was surprised that we had a bipolar disorder suicide in, but not depressive disorder suicide risk? And so is this a new measure? Or that we just didn't -- never considered before?

MS. LASH: It's not. I don't know what artifact of the old decision process was.

Maybe it fell out of the prioritization a little bit. But Anne?

MS. COHEN: I think I vaguely remember that conversation that we wanted a suicide risk assessment and that was the one that was best available recognizing that it didn't encompass all mental health disorders. But that was the one that at the time was endorsed available. It's what I recall, but I could be wrong.

DR. COUNSELL: Because it seems very important in the population that we're talking about. And it's highly under-recognized and underperformed as an opportunity for improvement. So I encourage that. Thank you.

MS. ANDERSON: This is Megan. Can I chime in? Just to highlight one more fact about the adult major depressive order with suicide risk assessment. It's actually currently in meaningful use stage too and the physician quality reporting program. So it's an important thing to think about.

Whereas the adherence to mood

stabilizers is not currently in any federal programs, and we do not have a measure that is a suicide risk assessment more generally that is not condition-specific unfortunately.

VICE CHAIR HANSEN: Okay. All right, thanks Megan.

We have two comments and I think we should wrap up for a vote. Vanesa?

MS. DAY: You answered my question. I was going to ask, do we care or is this aligned otherwise with a program?

VICE CHAIR HANSEN: Okay. Perfect. So it is aligned with meaningful use. And Gail?

MS. STUART: So these are three discrete areas. It's not like one can be a proxy for another, and that troubles me. It seems as if we know bipolar disorder is at a high risk. How complicated could that measure be to do -- ask whether or not there's been an assessment done?

I'm shocked that we didn't have it for major depressive disorder. So again, maybe it

was more general or something, but we clearly need it for major depressive disorder. So that's kind of a no brainer.

And then the adherence issue is a problem actually across all medications. Not just psychiatric medications. It's about a 50 percent compliance rate. So if we don't actually know how we're measuring it, or feel confident in that, then that's just an enormous black hole and I'm not sure we should go into that hole, but I think the other two are pretty essential.

VICE CHAIR HANSEN: So do I hear a recommendation of -- at least at this point adopting two? But also, we've identified a major missing one on that is major depressive disorder, which would be a recommendation for something else entirely.

But, given this particular item right now, --

MS. STUART: No, this is major depressive disorder.

VICE CHAIR HANSEN: Okay. All right.

MS. STUART: Yes. 0104.

VICE CHAIR HANSEN: Okay. Meaning both, right. So this captures the major depressive disorder, but through the suicide assessment. Okay. So that would be for both to be considered. Okay.

So, --

MS. LASH: We need to take bipolar ---- we need to take one of them at a time.

VICE CHAIR HANSEN: Yes. One of them at a time, right. Yes.

So the first one then is I heard a more central tendency towards accepting 0111 for a replacement of the original NQF -- measure that is now no longer in place. So, let me ask for a vote -- no, please?

MS. LASH: No. So, I'm sorry. I think it might work a little bit better if we sort of took these in order.

So first, do we want to keep or remove measure 0111, which has lost endorsement? And then, do we want to add the two -- either, or

zero, or some combination of the two alternative measures, which are 1880 and 0104.

So first, a show of hands for everyone that would like to retain measure 0111 Bipolar Disorder: Appraisal for risk of suicide, despite lack of endorsement.

That's five. That is not consensus. So the measure would be removed from the family.

The next vote would be on 1880, Adherence to Mood Stabilizers. A show of hands to who would like to add this measure to the family?

Just one? So that's not consensus. We will not add 1880.

A show of hands, who would like to add 0104 Major Depressive Disorder: Suicide Risk?

Fourteen. And that will be added. Great.

VICE CHAIR HANSEN: Okay Megan.

MS. ANDERSON: So at this point, I might recommend that we take a short break. And I would like to remind the group that we have two

groups of measures to add to the family -- to consider for addition to the family and we have 21 of those measures.

And so we've got two hours upcoming and so we might want to stretch our legs and get some caffeine since we've got through two measures so far and we need 21 additional measures to consider.

VICE CHAIR HANSEN: Right. We did two measures in 50 minutes. So let's take a ten minute break and we'll start right on the button at 2:30.

(Whereupon, the above-entitled matter went off the record at 2:18 p.m. and resumed at 2:35 p.m.)

MS. LASH: All right, Megan, you are on deck. Go ahead.

MS. ANDERSON: Great. We are on slide 65, and I want to just provide a brief overview of the newly-endorsed measures that have come through the NQF portfolio.

Several measures have been endorsed

in when the group that last spring, and staff have reviewed those newly-available measures and have identified 21 for your consideration.

The measures that we are presenting address priority gaps and population needs, specifically, and the two gaps -- the three gaps that are listed.

The question that will be posed to the group at different sessions is, would the work group like to add any new measures to the family? So, we are going to keep moving right along on to Slide 66, and we wanted to let you know that there were some measures that didn't get brought forth to the group for specific reasons.

So, seven measures were up in the project that endorsed measures, and six of those seven were for dental care for children, so we did not think they were appropriate for this population and for your consideration for inclusion in the family.

Measure No. 2372, Breast Cancer Screening, is a measure that we have retained in

the family of measures, but it was retired by the steward because the specifications were out of date and not maintained with NQF endorsement. It has been resubmitted for endorsement, and has been fully endorsed since the work group last met. So, this measure is up to date with United States Preventative Services Task Force guidelines for breast cancer screening.

The cardiovascular condition measures were found to be too condition specific, and were -- none of them will be brought for your consideration today.

There were also four clinical care measures that were also heavily clinical and did not target the priority gap area. Those was one patient safety measure that was limited to children are not appropriate for the population.

But those are the easy things to get through, but now we get to going through the measures that we would like you to consider for inclusion into the family. We are going to take those by topic area, and I'm going to start with

the care coordination measure that was NQF endorsed, and it is for your vote to include it in the family.

Breast care coordination measure is a medication reconciliation. A number of unintentional medication discrepancies per patient. There's two components of this measure that identify errors in the admission and discharge records, and those are due to the problems with the medication reconciliation process. The idea is to really target the actual quality of the medication reconciliation process itself.

There are six other measures in the family that are related to medication reconciliation, documentation, management and review. We would not recommend that this measure replace any of the current measures in the family, but we would ask the workgroup to vote as to whether or not they would like to include this newly and diverse measure of medication reconciliation, the number of unintentional

medication discrepancies per patient, into the family of measures.

More measure details are available in the specifications that were included as an attachment to your meeting materials. Any workgroup discussion.

CHAIR LIND: Okay. So, any specific questions about this one measure before we take a vote on including or not including? What else do you need to know or would you like to say about this measure?

Ed, do you have a comment or you are just --

Do people feel like you understand this measure enough to vote on it right now? No, there's like a nod, and a shake, and a -- Joan, do you have a specific question?

MS. ZLOTNIK: I guess my specific question -- maybe I should be able to figure this out for myself -- if there are six other measures is there something that this measure is adding that would make it something we should support,

or is it, actually, just another nuance of these other measures?

MS. ANDERSON: This measure targets, uniquely, the medication reconciliation process. There are other measures of review and reconciliation in the family, but it's a different target of the measure, and it would be something that would be unique to the family, but it would be an addition.

MS. LASH: Additionally, this is within a hospital stay, so it's quite time limited, but a -- potentially, risky time for a medication-related event, as opposed to the other reconciliation measures which tend to be ambulatory focused, those kind of annual checkup of polypharmacy, or after you are out of the hospital are your medications reconciled once more.

So, it's a different flavor of something we have other measures for.

CHAIR LIND: Steve?

DR. COUNSELL: Yes, I just wanted to

say this is a big deal for the population we are talking about, and I think the one we have, 0419, is documentation of current medications, it's one thing to document within another. And so, if we have an NQF endorsed measure that's really looking at the detail of this, and limited to the hospital, which also eases up on the burden of, you know, a measurement, I think is a good one.

Thanks.

CHAIR LIND: Thanks.

George?

DR. ANDREWS: Just for clarity again, is this measure just looking at the point of admission and point of discharge, or is it looking at the entire stay, in terms of any medication errors?

MS. ANDERSON: There are two points of data collection, and it's really at the point of admission and the point of discharge are the two points. And so, it would not be able to be looking at a daily medication reconciliation or any other interim time frame.

CHAIR LIND: Anne, did you have something?

MS. COHEN: So, there is existing measure, it says that there are six of them that sort of -- in this family, but there is one specific -- 0097, Medication Reconciliation, presenting patients 18 or older discharged from any in-patient facility, hospital, you know, et cetera, and seen within 30 days of discharge in the office by a physician, prescribing practitioner, registered nurse, pharmacist, to a reconciliation of the discharge medication within the current medication rules.

So, how is that different than this one?

MS. DAY: One is more for the hospital admission period, and the other one is more in the out-patient setting.

MS. COHEN: Okay.

CHAIR LIND: Okay, so are we good? No, Gwen, one last question?

DR. BUHR: Can we replace this one with

another one, or we can only just add this one? Like that one that Steve was referring to, documentation of current medicines in the medical record, would seem redundant if you have this one, where you are going to document it twice and reconcile it.

MS. ANDERSON: That is an option.

MS. POTTER: I noticed that there are six points of transfer, generally, within a hospital stay, where medications get recorded. There's those in the lab. There's those in the ER. There's those in admission, those at discharge. And when you think about the behavioral health population you are probably titrating medications, so over the hospitalization the medication could actually change.

So I agree that it is difficult and it's important to this population, but I would argue it's more important that we get their medications upon discharge to line up with what they are taking after they leave the hospital.

MS. ANDERSON: Just a point of clarification. I think that the measure 2456 looks at the medication reconciliation upon admission, but then also looks at medication reconciliation upon discharge, including the medications that have been given and have orders for after discharge.

So, I --

MS. POTTER: But, it doesn't include the medications that the person was taking that have absolutely nothing to do with their hospitalization. The one that she just read. I mean, if all you have is what happened in the hospital, you don't necessarily have the other medications that the person is taking.

I mean, people don't always report all of their medications when they come to the hospital. Then they go home and they go, well, it's not on my discharge record, maybe I should or I shouldn't take this.

CHAIR LIND: Hence the need for the other complimentary measure.

So, okay, I'm going to call the question on this one. So, the question is, should we vote to include this newly-endorsed measure 2456? Raise your hand if you would like to include it?

One, two, three, four, five, six, seven, eight, nine. Good, all right, that's enough. We are going to include that one.

Thanks you very much.

Okay, then, Megan, you are going to go on to the next batch, and our goal for this batch is to get through the whole batch and have a vote in 20 minutes. Go.

MS. ANDERSON: Going.

There are 11 behavioral health measures to consider. We've broken them up by three -- four different topics. We'll consider the first measure that's in emergency departments and follow-up, and then we'll move on to the second, third and fourth topics, which are blood pressure control for people with SMI, screening and follow-up for people with a serious mental

illness, and diabetes care. So, slide 70, please.

So, these measures have been CSAC approved, they are pending for endorsement for support.

The first measure we'd like to consider is 2605, follow-up after discharge from an emergency department for a mental health or alcohol or other drug dependence. This measure has four different components, and it has components for mental health separately from alcohol and drug dependence, but it also has a seven-day and 30-day follow-up after discharge.

The measure is newly-endorsed and addresses the areas of care coordination and psychosocial needs.

So, the question to the group would be whether or not we'd like to see this measure included in the family for use in the dual beneficiary population.

CHAIR LIND: Okay, thanks.

Any questions or comments?

I would say from our perspective in Washington, this solves some problems of the other follow-up after hospitalization for mental illness, because of having the different time periods, and adding in different conditions. So, I think the mental health folks in Washington refer this one over some of the other ones we've had to work with. Shawn.

MR. TERRELL: There are important measures, obviously. I think it's worth being reminded that. This is like a really good example, actually, of the question of what's important to a person, what's important for them. A lot of these conditions are significantly, you know, caused by some of the neuroleptic medications that they have to take.

So, there's the sort of balancing question that comes up here right out of the gate, and that might be interesting, you know, this is one of these situations where it might be really important to look at these if we endorse these, accept these measures and use them, to

also look at other areas of mental health recovery, and adherence to medication and other factors that, you know, you say to people, okay, we've got to get your blood pressure under control, but I've got high blood pressure because of taking this particular medication that's helping my mental health side.

And, it's also important to really -- this is a really -- this is the reason why I share decision-making, frankly, in developing mental health, and there's a whole area there to look at.

So, just a comment.

VICE CHAIR HANSEN: D.E.B.

MS. POTTER: This measure is specific to a primary diagnosis of mental health. So, if a person went to the ER because of their blood pressure, but they also had mental health, they wouldn't count in the measure.

So, they went to the ER with a primary diagnosis of mental health and/or substance abuse.

VICE CHAIR HANSEN: Vanesa?

MS. DAY: Just curious about the collection. Is there a consistent tool that would be used to indicate like what the follow-up is, or how we define follow-up?

MS. ANDERSON: There's administrative claims, and electronic medical record, and paper medical records. I don't have any further details about follow-up.

CHAIR LIND: If it's like HEDIS, almost any kind of provider would count, and that's one thing the mental health folks have a little bit of an issue with in Washington, is that a follow-up visit with any provider is, literally, a follow-up visit with any provider. So, you can be, you know, you could go to your PHP who may or may not know anything about your drug dependence.

MS. POTTER: The actual HEDIS measures with a mental provider, I think, I can't remember -- I actually oversaw this project, so I'll be perfectly frank. The document that we submitted

to NQF was over 500 pages long, so you can understand how I don't remember all the details.

But, we patterned it off of the HEDIS follow-up after hospitalization, in the way that we could, and tested it in the claims data. So, when you actually look at the measure specs, it goes through all of this.

MS. DAY: But, it's something that could be selected through claims.

MS. POTTER: Well, it's a plan-based measure.

CHAIR LIND: Encounter data.

MS. POTTER: Right, so it would be encounter data.

MS. STUART: So, I think this is important, because it really addresses the short length of stay, the desire to move these patients out before they are ready. And, it gives the provider some defense against, you know, people putting pressure on them to not give the length of care that they need.

So, I think it's important.

CHAIR LIND: Okay. We are going to take a vote on this one in that case, 2605, raise your hand if you vote to include this one. We have ten. Okay, so that one passes. Thank you.

Okay, Megan, you are on for the next one.

MS. ANDERSON: Okay, on slide 71 we have 2602, controlling high blood pressure for people with serious mental illness. This is a measure for pressure control, and it's a harmonized specification with NQF 0018, which is controlling high blood pressure in the more general population. That's a provider level measure, this measure is --

(Telephonic Interference)

MS. ANDERSON: The denominator has been simply adapted for people with serious mental illness. The measure uses specifications with current guidelines, and is reference to mental health disparities.

So, my question to the group is, by controlling high blood pressure for people with

serious mental illness, and it would be a compliment to the measure currently in the family, but addresses, particularly, high blood pressure for the general population.

CHAIR LIND: Thank you. Any questions or comments?

Shawn?

MR. TERRELL: Yes, a clarification. My earlier comments were referring -- so, that's why I was confused by it. I was looking ahead, so I'm sorry.

I meant -- on the blood pressure and on the diabetes care, where --

CHAIR LIND: I kind of wondered if you were a little ahead.

MR. TERRELL: -- yes, so I should look at that and not at my paper. Sorry.

CHAIR LIND: So, you were liking this one.

MR. TERRELL: Yes, that one is fine.

CHAIR LIND: You're good.

MR. TERRELL: It's the blood pressure

-- it's the question that -- it's implicated in a lot of these, that we are also trying to treat it back at, which creates, you know, a tension around, you know, what should people do. That's all.

CHAIR LIND: George?

DR. ANDREWS: My question was, again, similar to that. I mean this obviously requires use of a general practitioner, family physician. And yet the follow-up or the previous measure which we all agreed to do, D.E.B., were you saying that that specifically, as the measure was written and we approved it, states that a mental health provider will be seeing the patient in follow-up within seven days or 30 days?

Because again, the idea here is that if the patient is discharged, and can't get in to see their behaviorist or whatever, they're still able to see a primary care physician, who not only is going to do that follow-up, but also address whether it be diabetes or other disease.

CHAIR LIND: So, he was going forward

and you are going backwards. Do you know the very specific answer to that question? And, if not --

MS. POTTER: If I was sitting at my desk, I would know the answer, but I can't answer it now.

CHAIR LIND: Okay.

MS. POTTER: It's, actually, in the measure spec.

CHAIR LIND: Sarah, if somebody could research that, we'll keep on going.

MS. POTTER: I think it's follow-up with any kind of provider, the idea being that the measure, the first measure, the ER measure, was treat and release. Therefore, they are not as serious as those who were admitted, and therefore they could receive follow-up care from their primary care doctor. Whereas, those who were admitted to the hospital, the thinking being that they are more serious and they need a mental health provider for follow-up.

DR. ANDREWS: Well, that makes me feel

much better, because that at least ties better with it.

CHAIR LIND: Steve, did you have a question on the blood pressure?

DR. COUNSELL: Yes. I think we might be able to, at least in my own mind, cut through several of these pretty quickly. There's a general theme with the diabetes and the blood pressure and such, that the reason to pull these out -- because these are already measures in the general population -- but these are now specific, just changing the denominator to people with serious mental illness, which is a common group in the duals.

MS. ANDERSON: Right.

DR. COUNSELL: And so this will help bring out, I guess, or identify the needs, and the care, and disparity, potentially, of these conditions in that population. Is that right?

MS. POTTER: In the measures that were tested, there were disparities between the SMI population and the general Medicaid population

for all these measures.

DR. COUNSELL: What we need is all these measures then with a denominator of dual eligible.

CHAIR LIND: Clarke?

MR. ROSS: These do appear as a duplication, but we have a history of mental illness of people being admitted, and only psychiatrists treat the mental illness. But even though they are in a general hospital, they are discharged, and none of this other stuff happens.

So, ideally, we shouldn't need this, but experience tells us, because of the attitudes and practice patterns, we need all this.

MS. ANDERSON: This is a health plan measure that is for ambulatory care and out-patient behavioral health care, not for in-patient care.

CHAIR LIND: I'm sorry, say that again.

MS. ANDERSON: 2602, controlling high blood pressure for people with SMI, is an ambulatory care and behavioral health out-patient

care measure. It's not for in-patient.

CHAIR LIND: Okay, thank you.

All right. We are going to take a vote on 2602, vote to include, raise your hand if you'd like to include this measure. Eleven, yes. Okay, sounds good. We are going to include it.

And, Megan, you are on for the next one.

MS. ANDERSON: Okay. We are going to take the next three together, as Steve was referencing, these measures really do relate to each other and are consistent.

So we have 2599, 2600 and 2601. These are three health plan measures that have been adapted similarly for the provider level measure for use in the general population, to address the needs of the serious mental illness population. The measure specifications are harmonized. The numerators are consistent. The denominators are adapted.

The family measure includes the provider level measures. These are not as risk

adjusted and they are only for out-patient care.

So, the question, after I go through each of them, will be to go to ask whether or not these three should be included in the family.

So, slide 73, please.

Measure 2599, alcohol screening and follow-up for people with serious mental illness, and people who are screened for unhealthy alcohol use and received brief counseling or other follow-up, and are identified as unhealthy alcohol user. It's adopted from 2152, the preventive care and screening measure. And it's been tested in the Medicare and Medicaid population.

Slide 74. Measure 2600, tobacco use, screening and follow-up for people with SMI or other alcohol and other drug dependence. This measure has two rates that are reported, and it's a health care measure that has been adapted from the general provider level measure. Similar to the original measure, it is a measure of both the screening and then also the follow-up.

Then slide 75. 2601, body mass index, screening and follow-up for people with SMI, and people who have received the PMI, and screening and follow-up for those who are obese, harmonized with a measure that's currently in the family, 421, and it addresses their health disparities and is an accepted Medicaid plan for SNPs and D-SNPs.

And so, slide 76 brings us back to the question of bringing to a vote to include these three measures in the family, pending their full endorsement and Board ratification.

CHAIR LIND: So, I think we would probably love these measures. Should we try taking a vote without discussion and see if we already have consensus? Let's try it.

If you support including 2599, 2600 and 2601, raise your hand. Okay, sold. So, we have that set of three.

And, I'm sorry, Megan, we are not hardly giving you any chance to take your sips of tea in between, and we are ready to move to the

next set.

MS. ANDERSON: I'm ready to go.

So, this set of measures for diabetes care is slightly different. It has commonalities with some of the things that we've heard already, the six health care measures that have been adapted as the others have from the provider level measure 3, use in the general population. They are again harmonized to reduce the overall data collection burden, and the numerators and denominators are consistent, but adapted.

These are outcome measures, and they are not risk adjusted or stratified. They are only out-patient or behavioral health out-patient measures.

The family, however, does not currently include any of the six original measures that are provider-level specified. So, though all of these new measures have been adapted from those provider-level measures, the work group has previously not selected those six measures to include in the family.

Instead, the work group has chosen to include 729, comfortable diabetes care, which is a composite, and it's also included 1932, diabetes screening for people with schizophrenia, bipolar disorder, who are using antipsychotics. So, I'm going to go briefly through the six measures again, but please keep in mind that though these measures have been adapted -- currently in NQF endorsed measures, we have not included those six original measures.

There's a measure of diabetes care for people with SMI, which is hemoglobin screening A1c for people with Type 1 and Type 2 diabetes, and it is based on the comprehensive diabetes care hemoglobin A1c testing, and has been adopted and uses current guidelines. It does address current known disparities.

Next. Then we have a measure 2604, diabetes care with people -- for people with serious mental illness, attention for nephropathy. So, this again is for people with Type 2 -- Type 1 and Type 2 diabetes. It's

screening, and then have evidenced that they needed additional attention to their condition.

It's been harmonized from the currently endorsed measure of 0062, comprehensive diabetes care for medical attention to nephropathy.

So, this has been tested in D-SNPs Medicare plan for people who are disabled -- excuse me, Medicaid plans for disabled adults, as well as Medicaid plans for non-disabled adults.

Next slide. So we also have 2606, which is blood pressure control, as is another measure, and similar to the one we already saw as blood pressure control, however, it is limited for people with serious mental illness and diabetes. So, this measure is a blood pressure reading that is greater than 140/90 -- excuse me, less than 140/90, which is the target, and then it is similarly based off of the comprehensive diabetes care measure and blood pressure control.

Next slide. 2607 is diabetes care for people with serious mental illness and hemoglobin

A1c poor controlled. So, this measure applies to people who had a recent reading that is greater than nine percent of hemoglobin A1c. It's similar to NQF endorsed version 0059. It's also adopted in D-SNPs and Medicaid plans for disabled adults and Medicaid plans for non-disabled adults.

Next slide. And then, we also have a hemoglobin A1c that is controlled, which is 8.0 percent, and this measure is almost exactly the same, but it's not poor controlled, it is controlled. It addresses mental health disparities, and is accepted in the populations of interest, D-SNPs, Medicaid plans for disabled and non-disabled adults.

Next. And then we have the eye exam measure that is people again with diabetes and serious mental illness, who have had an eye exam during the measurement year. So, this is complimentary to 0055, and it has been tested in the same populations and addresses health disparities.

Next slide. We get to vote on including these measures in the family, and if we would like to include these measures would we like to replace any of the current measures in the family.

Just to remind you, we have comprehensive diabetes care in the composite, 0729, in the family right now.

CHAIR LIND: 0729 is for the general population not for the population of people with serious mental illness.

MS. ANDERSON: That's correct. I'll read off the description briefly.

The percentage of adults with diabetes who have managed and modifiable risk factors, including hemoglobin A1c, LDL, blood pressure, tobacco non-use, and daily aspirin used for patients who has diagnosis of ischemic vascular disease, with the intent of preventing or reducing future complications associated with poorly managed care. It is limited to adults 18 to 75 years old, with a diabetes diagnosis, who

meet denominator targets, and A1c is in control at 8.0 percent, LDL is less than 1 percent, blood pressure is less than 140/90, tobacco non-user, and patients with diagnosed ischemic vascular disease, daily aspirin use, and contraindicated.

That measure is an ambulatory care measure. It is the clinician level of analysis, whereas, the measures that we have considered and I just described are health plan measures, however, they are also ambulatory care measures only, but they also include behavioral health care.

CHAIR LIND: Gail?

MS. STUART: So, this is a serious problem for this patient population, and I think it addresses it. It also addresses health disparities that are, again, significant. So, I propose that we endorse them.

CHAIR LIND: Anne?

MS. COHEN: I guess this is just a harmonization question. Are these currently required to be collected of any mental health

programs now?

MS. LASH: On the mental health side.

MS. COHEN: I mean, there's not a map that focuses on mental health, so I can't really answer that.

MS. ANDERSON: This is part of the behavioral project, so they were considered in the NQF endorsement piece, but, no, there is no measure application partnership --

MS. POTTER: The measures were also presented last September to the MAP Medicaid Task Force, and they encourage further development. And, they recommended that they come back for the MAP Task Force after endorsement. But, I can't speak for that task force.

VICE CHAIR HANSEN: This is very relative to what Gail has said. I know the health disparities is addressed, that was in the previous set that we approved.

Could you just talk a little bit about what that background is, when it says that is addressed?

MS. STUART: My understanding is that this problem exists largely in an African American and minority population. So by accounting for these assessments, you are really going to impact the health of a minority population. So, that would be the take in there.

CHAIR LIND: All right. We are going to try voting on all six together, and if that fails we'll go back and see if there's any that we would want to put forward individually.

So, let's start off by voting as a package on 2603, '4, '6, '7, '8 and '9 altogether. Let's have a show of hands if you vote to include. One, two, three, four, five, six, seven, eight, nine, ten 11, good. All right. Wonderful. So, we are including those, and, Megan, you are up for the next group.

MS. ANDERSON: Okay. We are going to switch gears here a little, and we are going to go to a behavioral health measure that's been approved for trial use. It's been supported by the CSAC, but has yet to be ratified by the

Board. It is the last remaining behavioral health measure to discuss.

So, it's substance use screening and infringement composite. There are three components of this composite. It's for people 18 years old, who have used tobacco within 24 months, have unhealthy alcohol use, non-prescription drug use, and illicit drug use, and have received an intervention for a screening result.

So, there are two components of this measure that have been NQF endorsed, tobacco use screening, cessation and intervention, and you might recall seeing a similar measure to that recently.

And then also 2152, unhealthy alcohol use, screening and brief counseling. There's also a drug component that has a few different elements, and it's a percentage of 18 years -- patients who are 18 years or older who have screened within the last 24 months for the tobacco use, alcohol use, non-medical

prescription use, and illicit drug use, and have received composite intervention.

So, the four components, two of which are NQF endorsed, just to let you know, the NQF does not require all the components to be endorsed for the composite to be endorsed.

They have been recommended for further testing and resubmission after three years reliability and validation. And the measure instructor -- the measure steward has instructed not to have this measure be used in accountability applications until that time.

So, we'd like you to consider whether or not you'd like to include this measure, and for substance abuse screening and intervention composite.

CHAIR LIND: Okay. Any questions or comments on this one?

DR. BURSTIN: One quick clarification, Helen Burstin.

So, this measure is a new term we have called measures approved for trial use. It's

specifically for e-measures, so new electronic health records, base measures, that do not yet have EHRs ready to support their testing. So, it is not actually pending endorsement, it's only pending approval for trial use, just a clarification.

I will also point out it was not without controversy, because there was a fair amount of discussion about the evidence base for some of the specific interventions listed under the overall measure, but it has gone through all the process, but it was heavily discussed with the clinical workgroup of the MAP as well.

CHAIR LIND: Okay. Other questions or comments of this one?

All right. Vote to include if you support including this measure, which is approved for trial use. Show of hands for yes, vote to include. Okay, so that one got nine votes, Megan, so we are going to go ahead and include it.

Anne reminded me that there was a

second question back on the last package, if there's any that we would want to trim on the list of diabetes care measures. But I said to Sarah here off line that, perhaps, when we get done with all the inclusions, go back to the do we want to trim the measure was the question. When we're all done with adding in work.

So, Megan, I think we are ready to go, you still have some left, right?

MS. ANDERSON: Yes, we have 13 admission and re-admission measures that have been recently endorsed by NQF.

There were five that were found to be too narrow or not appropriate for the population, so we have not listed them for your consideration.

We have provided six of these measures, and so the question to the group is, really, whether or not we want to include this staff picks. And, if not, then what measures would you want to include, if any at all. So, I'm going to go quickly through the measures.

Slide 87. We have two measures currently missing with admission and re-admission. That is all planned -- planned all-cause re-admissions, and hospital-wide all cause unplanned re-admission.

Next slide. So, the first measure to consider is measure 2375, and this is an all-cause, risk adjusted re-hospitalization measure. It's for people who entered skill nursing facilities from acute care facilities, and were hospitalized again within 30 days. All payers are included in this measure. It's based on MDS admission assessment data, which is also an electronic clinical data source.

However, it does not distinguish between planned and unplanned re-admission. It does compete with 2510, which we'll review later, but the measures are identified that it should not be harmonized because they were distinct.

Next slide. 2510 is a skilled nursing facility 30-day all-cause re-admission measure. This is over a standardized rate of all-cause,

unplanned hospital re-admissions and which -- highlighting the variation from the previous measure. It's limited to Medicare fee-for-service, and it includes re-admissions from hospital discharges, with general acute care hospitals, but also critical access hospitals and psychiatric hospitals.

Next slide. The re-hospitalization during the first 30 days, then home health, 2380, is a staff pick. It addresses home health re-admissions from an acute in-patient hospitalization within five days before the start of the home health stay, and where acute -- were admitted to the acute care hospital during the 30 days following the start of the home health stay.

MS. ANDERSON: It addresses home health readmissions from an acute inpatient hospitalization within five days before the start of the home health stay and who were admitted to the acute care hospital during 30 days following the start of the home health stay.

It does have some relevant exclusions.

I think we -- I'd like to go back one slide. Thank you.

It addresses, I guess, in home health care -- home health care, it has planned public reporting for Home Health Compare, and then it has a complement measure that's intended to be used with 2505. Next slide?

2505, also a staff pick. The Emergency Department Use Without Hospitalization Readmission During the First 30 Days of Home Health. It's the general releasing principle of home health stays for patients who have had an acute hospitalization in five days before the start of the home health stay, and then used the emergency department but were not admitted to an acute care hospital within 30 days following the home health stay.

It similarly addresses home health -- is going to be planned to be used for Home Health Compare public reporting. Next slide.

2502 is All Cause Unplanned Readmission. The measure is for 30 days post

discharge at the inpatient rehab facilities. This includes a hospital or a long-term care hospital and has a population -- a general focus on the inpatient rehab facilities. It's Medicare fee-for-service beneficiaries only, and it's based on 24 months' worth of inpatient rehab facility discharges, to both acute levels or to the community.

Its planned use is inpatient rehabilitation facility public reporting, which I'll draw the distinction from Compare, it's a public -- it's a reporting program, not a Compare program. Next slide.

The next two slides are relatively similar. There is a 2503, Hospitalization for 1000 Medicare Fee-For-Service Beneficiaries. This is the number of discharges from an acute care hospital including an IPPS or a Critical Access Hospital per 1000 fee-for-service beneficiaries at the state and community level, and it's also reported by quarter and by year, so this is a measure that addresses a gap in

community-level measurement, and it can be reported at the state and the community in general.

There are no risk adjustments. There's no risk adjustment for SES or SDS, but there is seasonal risk adjustment.

It's intended for communities to compare themselves to like communities, and there's a question against comparing against communities that are not like the others.

20 -- the next slide is 2504, which is a similar measure, which is Rehospitalization Per 1000 Medicare Fee-For-Service Beneficiaries, and it similarly addresses a gap in community measurement, with the same seasonal risk adjustment and comparison for communities against other like communities. Next slide.

There is 2496, which is Standardized Readmission Ratio for Dialysis Facilities. It measures unplanned readmissions to acute care hospitals within 30 days of discharge for Medicare-covered dialysis patients treated at a

particular dialysis facility, and it only -- it has a rate compared to the expected given discharge from hospitals, and it includes the patient characteristics.

It also is important to draw attention to the fact that a lot of people who are on dialysis are in -- are dual beneficiaries. However, only a small number of dual beneficiaries are on dialysis or have end stage renal disease, so there are other ESRD programs as well that this measure might be included in at some point. Next slide.

So staff have culled out three measures that we'd like you to consider as staff's picks to be added to the family. We would like to take a vote on whether the group would like to add those staff picks, and then if not, then we would consider other measures for inclusion in the family, and just to remind you, the staff picks are 2380, Rehospitalization During the First 30 Days of Home Health; 2505, Emergency Department Use Without Hospital

Readmission During the First 30 Days of Home Health; and also a staff pick for inpatient rehab facilities, All Cause Unplanned Readmission Measure for 30 Days Post Discharge from Inpatient Rehab Facilities.

CHAIR LIND: All right, thanks very much, and we're going to let you save your voice and make Sarah and Helen answer questions for you for a minute while we gather up people's input, so Kata, do you want to go first?

MS. KERTESZ: Thanks. I just have two clarification questions. The first one, on the first slide, you mentioned that there was risk adjustment. Was that seasonal risk adjustment or was that for some other factors like SES or something else?

And then my second question --

MS. POTTER: Could you speak louder?

MS. KERTESZ: Yes, did you hear my first question? My first question was whether the risk adjustment in the first slide was for seasonal factors, or was it for something else

like SES?

And then my second question is all of the readmissions are based on inpatient stays, is that right? So if the patient is outpatient or in observation status, that wouldn't be factored into their readmission rate? Thanks.

CHAIR LIND: I would assume more than likely Sarah or Helen, do you have a comment on that?

MS. LASH: I am just not totally clear which specific measure you're asking -- so --

MS. KERTESZ: The first measure in this group --

MS. LASH: 2375 --

MS. KERTESZ: Yes --

MS. LASH: -- when it writes that --

MS. KERTESZ: -- it said that -- it said that it was a risk adjustment, but it didn't say what -- for what factors.

DR. BURSTIN: It is primarily adjusted for clinical risk factors. I don't know that there's any seasonality.

MS. KERTESZ: But it's not for socioeconomic status or other --

MS. LASH: No --

DR. BURSTIN: No.

MS. LASH: -- not at this time.

DR. BURSTIN: Although it is one of the measures that is endorsed with conditions, so it will be entering the trial period for SES adjustment in this coming year.

CHAIR LIND: And then the second question was all of these readmission measures, you have to have actually been admitted to the hospital, you can't have just been held in a 24-hour observation state --

DR. BURSTIN: Correct.

CHAIR LIND: -- or whatever.

DR. BURSTIN: Admission, true admission.

CHAIR LIND: All right.

DR. BURSTIN: Yes.

CHAIR LIND: All right.

Okay, D.E.B.?

MS. POTTER: I just have a clarification. So do we have any readmission measures in the portfolio currently? That is the part I didn't understand. That is why we're not talking about nursing home readmission?

CHAIR LIND: Way back to slide 85, the two that we have now are Planned All Cause Readmission, 1768, and 1789, Hospital-Wide All Cause Unplanned Readmission. So we do have two.

Shawn.

MR. TERRELL: Just -- so I have just a scope question. Within home health, does that include, I mean, or do you address scope at all around, you know, personal assistants for ADLs? Is that -- that is not part of the -- or you don't address it?

CHAIR LIND: Would it be like home and community based services kind of --

MR. TERRELL: Well, a lot of home health agencies, you know, would go into the home and help with ADLs as part of their service --

CHAIR LIND: Right.

MR. TERRELL: -- but that's not part of this?

CHAIR LIND: This wouldn't be like long-term supports and services --

MR. TERRELL: Okay.

CHAIR LIND: -- no.

MR. TERRELL: And then on the --

DR. COUNSELL: This would just be skilled home healthcare under Medicare.

CHAIR LIND: Yes.

MR. TERRELL: Okay, thanks.

And then I don't understand quite -- just maybe a quick clarification on 2380, where the exclusions of cancer and rehab care particularly -- what, you know, why would they exclude that if --

PARTICIPANT: Which slide is that?

MR. TERRELL: It's slide 88.

CHAIR LIND: Do you have any comments about the exclusions and --

MR. TERRELL: I guess I understand -- maybe I can understand psychiatric, but I don't

know the other two, just curious. Is it facility based?

DR. BURSTIN: My guess is they probably just tried to exclude things they thought would be more likely to have planned readmissions, and cancer tends to be a planned readmission for chemo or things along those lines.

MR. TERRELL: Oh.

DR. BURSTIN: But I can kind of --

MR. TERRELL: Okay.

DR. BURSTIN: -- from that.

MS. POTTER: I think it's to align with 1789.

CHAIR LIND: Jennie?

VICE CHAIR HANSEN: I am on page 93. Thanks. I am on page 93, with these broader admission, readmission measures, and I just wondered, I know we have other readmission measures that are kind of site-specific, and this is more population-based comparison, so I wondered if this is something we would be

interested to start that shift to looking at population-based comparisons, so it's more of a question for us in terms of our beginning shift.

MS. POTTER: Can I ask a clarifying question?

We have IRFs in here for readmission, but we don't have long-term care hospitals in here. Was the thinking that those populations didn't apply to the duals, or --

MS. LASH: We could consider that, if you all think it's relevant, for -- as an additional option.

MS. POTTER: You mean just scour for measures in that area, or --

MS. LASH: Well, we know that there is one within --

MS. POTTER: Okay.

MS. LASH: -- the same project that endorsed the others. I am not sure how it fell out of our list, but we can -- I think it would be sort of along the same lines.

I think maybe to the group, there's

sort of a strategic question of you could select all of these measures, you know, that are sort of one setting to the other, some subset of them. If you wanted to take the really inclusive route, then we would probably want to put the long-term care hospitals on the table with that additional measure.

CHAIR LIND: Steve?

DR. COUNSELL: Yes, that was going to be part of my question. It is hard for me to sort of follow and group these. I would request that we take them one at a time, just walk through them, and it's hard for me to understand why the staff have selected some and not the others, and --

MS. LASH: I can give maybe a little bit more insight on that.

The three we had pulled out, two relate to home health, which is a very frequently used service in this population, and we decided against some of the others that are population-based, the admissions per 1000, because they --

there was some provisions against using them for comparisons, sort of meant for community to compare oneself over time as opposed to more of accountability measures.

The dialysis measure is an appeal, so that one has been somewhat controversial. So we came to a pretty grey area in choosing among these, so I don't want to direct your thinking too much with my commentary.

But we did try to prioritize among them to some extent.

CHAIR LIND: Rich.

MR. BRINGEWATT: Yes, actually, I don't mind you directing kind of what your thinking is, in fact it's helpful to me.

My problem right now is, one is I stepped out, and I apologize, I had not been part of this last discussion, I just had to do what I needed to do.

But in trying to be helpful here, it is helpful to me if you share -- we picked these three because, and we rejected these because, and

the fact is you guys have looked at these more carefully than we possibly can look at them right now, and so I -- I value your opinion in that regard. It does weigh in terms of how I am going to think about this.

MS. LASH: Megan, were there other decision factors that you want to highlight that I have forgotten to mention?

MS. ANDERSON: Yes. So I would say that the staff didn't have a pick between the two skilled nursing facility measures. There is a measure, the Pro 30, it's quite different in the method for data collection and whether or not it's planned and unplanned from the 30 Days All Cause Readmission measure for skilled nursing facilities.

I don't have a staff pick on those because I think that they are very different and that I would recommend the Workgroup to weigh them against each other. The skilled nursing facility is an important preventative care for this population.

Then, the -- if we want to look at those two specifically, and then we could talk more about the others separately? I heard Steve say that he wanted to go through them more one by one.

CHAIR LIND: Let's hear from Gwen and George, and then we'll go back. Gwen?

DR. BUHR: Well, I was just going to ask, and I think what she was just talking about, the skilled nursing facility measures, why they weren't included in the staff picks.

And I think she just said that because they couldn't decide between the two, and that they wanted us to decide between the two. It wasn't that they were not including skilled nursing facility, but you guys couldn't decide which was the best one, is that what I am understanding? Okay.

MS. ANDERSON: Yes, I don't have a staff pick on that.

DR. ANDREWS: Looking at this, to me, it looks like we're peeling the onion, and we're

peeling the onion, we already have all cause -- you know, the two measures that we are currently following for readmissions, but it doesn't give us enough insight into well what is driving those readmissions? Where are those patients coming from?

And this allows for differentiation as to the place of care that is driving a lot or not driving a lot of those admissions, so I like the fact that the staff picked the home health, that's one.

I am questioning also why we didn't choose at least one that ties to the nursing home. The rehabilitation has been picked. I like that. So we have rehabilitation, home health. I would like to see why we can't pick the skilled nursing facility because that would be again important to incorporate.

And other than that, you know, the question, as somebody asked, is -- it might be, I think, Jennie -- is whether we want to pick something that begins to identify the specific

populations like fee-for-service versus what we already are now measuring that is global.

CHAIR LIND: Rich, did you have another comment, or are you -- was that left over?

(No audible response.)

CHAIR LIND: Okay. Sarah?

MS. LASH: I just want to highlight maybe two salient differences among the nursing facility measures, if we're ready to go there.

The first one, 2375, was developed by the American Health Care Association, so the nursing home industry, and it is based on MDS data.

The second measure was developed by CMS, so the payer side, and it was designed to harmonize with the hospital-level measure of readmission.

That might weigh in the decision process.

Planned procedures are excluded.

CHAIR LIND: So 2510 distinguishes

that this is just for unplanned, it is from administrative claims data, whereas the other one is MDS data, which not everybody has access to. I mean, the nursing homes do, and then in some states the states sometimes have MDS data, but not the health plans, necessarily.

Rich.

MR. BRINGEWATT: I do have a question on these rehospitalization measures.

The current all cause readmission measures for plans and in fee-for-service incorporate -- they adjust for the presence of age, gender, and condition. These don't have any adjustment factors associated with them, right?

DR. BURSTIN: No, the -- I am sorry, the two SNF readmission measures do. The only ones that are not risk adjusted are the community-level admission measures, per 1000 population we were talking about earlier.

These have -- at least the CMS one has an almost identical readmission risk adjustment approach to the hospital measure already --

MR. BRINGEWATT: So --

DR. BURSTIN: -- in use.

MR. BRINGEWATT: -- 2505, 2380, and 2502 are risk adjusted?

DR. BURSTIN: Yes.

MR. BRINGEWATT: Okay. Using the same factors as age, gender, and condition?

DR. BURSTIN: That sounds right.

MR. BRINGEWATT: Is that right?

CHAIR LIND: Steve?

DR. COUNSELL: Yes, I think in the -- just speaking from the skilled nursing facility perspective, if you have a planned admission for something that's in follow-up, that's a good thing, and you don't want to be -- so I am a little surprised that the nursing home industry, maybe, suggested this measure.

So -- and then for alignment purposes with other, you know, readmission measures, it seems like the one developed, you know, that excludes planned and by CMS that uses the same kind of methodology as the other readmission

measures would be the preferred things.

CHAIR LIND: So I am going to try to call in the question on 2510 of the two nursing home measures. It sounds like we're leaning a little bit more strongly to that one, so let's try voting on 2510, if you would like to include NQF No. 2510, Skilled Nursing Facility 30 Day All Cause Readmission, vote of support for that one.

9, 10, you have 10. Okay.

So good. We're all -- we will include 2510, and then we will go back to 2375 and just check in, does anybody support also including that one or no? Any support for that one? No, okay.

So we have dealt with two. Now let's move on to the three home health measures, so the three -- two home health measures. So there's two home health measures. Let's take them together. 2380 is Rehospitalization During the First 30 Days of Home Health, and the other home health measure is the Emergency Department Use During the First 30 Days, so that would be a good

one too to say, you know, if something serious enough happened at home that you had to go back to the ED even if you weren't admitted.

So 2580 and 2505, let's try first taking them together. If you vote to include, a show of hands?

Three, four, five, six, seven, eight, nine, 10, yes, we're good, okay. So we're going to include those two.

Then let's go on next to the staff pick, the other -- the third staff pick, which is the IRF 2502 All Cause Unplanned Readmission Measure for 30 Days Post Discharge from Inpatient Rehab Facilities. Are we good? Any questions on that one before we vote? Steve.

DR. COUNSELL: Is that aligned with the SNF one and the CMS -- is that -- yes, perfect, great.

CHAIR LIND: Okay, all right. Then everybody -- is everybody good to vote on that one?

So 2502, All Cause Unplanned

Readmission for 30 Days Post Discharge from IRF.

Okay, good.

All right, then, let me just ask the question, are -- would anyone like to vote on any of these other ones? Would anyone like to like put up your card to say I surely hope that we're not just ignoring such-and-such, let's go ahead and vote on it? D.E.B.

MS. POTTER: I would like to suggest long-term care hospital readmission measure. Like a couple weeks ago, we had the webinar meeting where we heard about the impact measures and how they were to align, and so maybe since we've already talked about alignment today, that would be a logical thing to talk about.

CHAIR LIND: So did you guys pull that one up?

So if you all want to look on your own devices, on the QPS -- maybe, would we crash the QPS if we all looked at the --

MS. LASH: It is number 2512. My computer was asleep.

So this sounds really similar to the measures we have reviewed. It estimates the risk-standardized rate of unplanned all cause readmissions for patients who are Medicare fee-for-service beneficiaries discharged from a long-term care hospital who are readmitted to a short-stay acute-care hospital or to a long-term care hospital within 30 days of the long-term care hospital discharge.

The measure requires data for 24 months of long-term care hospital discharges to non-hospital post-acute levels of care or to the community. It is risk-adjusted. It's a CMS measure as well. And I can answer any other questions.

MS. SHAHAB: I think this falls in the same family, and I think if there's consistency, it's -- it would -- I would suggest that it be included.

MS. COHEN: Is that one listed under gap measures in the spreadsheet?

MS. LASH: Readmission measures in

general were, although I don't think we ever laundry listed every setting.

MS. COHEN: Okay, and I just meant to look it up in general, too. Is it in the spreadsheet that you sent us?

MS. LASH: It was not. We missed it --

MS. COHEN: Okay.

MS. LASH: -- somehow.

MS. COHEN: Okay.

CHAIR LIND: Rich.

MR. BRINGEWATT: Why didn't staff include this?

MS. LASH: We missed it. We were in a hurry.

MR. BRINGEWATT: I am sorry?

MS. LASH: D.E.B. saved us.

MR. BRINGEWATT: Okay, but you didn't change your mind --

MS. LASH: No, it was not --

MR. BRINGEWATT: -- you know, I mean, it --

MS. LASH: -- no, it was not, yes, it was not a purposeful exclusion.

MR. BRINGEWATT: Okay, okay.

MS. LASH: Somehow we had a data error.

CHAIR LIND: This would be a complementary filling in the gap between all those other settings we've identified --

MS. LASH: Right.

CHAIR LIND: -- for readmission, so the number is 2512, so a show of hands to include 2512 in our family of readmission measures.

Okay, wonderful. So then Steve, did you have something you wanted to go back to on the other measures?

DR. COUNSELL: I was just looking through, we don't have any population-based admissions per 1000, readmissions per 1000, at this point, and I like the, you know, in our conversations in the past around, you know, looking at comparisons even within the same population in a community or a region and then

being able to compare similar regions or communities that have high rates of low income and dual-eligible populations, I think that could be valuable.

You know, and as we look at risk adjustment using socioeconomic, you know, kind of things, this might be another way to look at similar-type communities, you know, and speaking from the American Essential Hospitals, you know, group, I think this might be valuable.

CHAIR LIND: And Jennie is here --

VICE CHAIR HANSEN: I would support that --

CHAIR LIND: -- saying amen over here.

VICE CHAIR HANSEN: Yes, because I think that it -- it isn't just within, it's across communities, and so it just starts that focus of giving back directionality of looking apples and apples.

CHAIR LIND: So you would be in favor of 2304 and 2503 both, that pair, yes? Steve is nodding his head. D.E.B. is shaking -- no?

You're not really shaking, you're just --

VICE CHAIR HANSEN: I guess a question, is the population-based MAP doing something similar, do you know?

MS. LASH: The Population Health Task Force probably didn't have the opportunity to review these measures because they're newly endorsed, they're too new.

MS. SHAHAB: They were just endorsed in December, so the MAP Population Health Family met around May or June, so -- .

DR. BURSTIN: Not that these community-based are --

MS. ANDERSON: And --

DR. BURSTIN: -- considered at the community level, so comparisons would need to be really constructed to make sure you're getting the like-to-like.

CHAIR LIND: Megan, were you starting to say something?

MS. ANDERSON: I was concurring with Helen that it would seem like it would be a

limited utility for the dual beneficiary population in general.

I know that a lot of communities do have more than 1000 Medicare fee-for-service beneficiaries. However, that seems like it would be more difficult to use at the community level for this population, specifically, and it might be okay to use at the state level, but -- but it would be hard to compare like communities with this number of dual beneficiaries, potentially.

CHAIR LIND: Okay. Rich, did you still have a comment, or you just have a leftover card?

(No audible response.)

CHAIR LIND: Okay, so we're going to vote on 2304 and -- I mean 2503 and 2504 together. Show of hands if you would support adding these two population-based measures to the family of measures.

Five, five? One, two, three, four, yes, five, I think, so okay, that group doesn't pass.

I think, Megan, that was it for the include list, right?

MS. ANDERSON: Yes ma'am.

CHAIR LIND: So now we want to go back a little bit to the -- do we -- do any of these newly added, or in light of the earlier conversation this morning on the lack of alignment in a couple areas, are there any measures you would like to take off the list at this time?

And so one area specifically that Megan had brought up was if we add in a whole new family of diabetes measures, are there any diabetes-related measures that we would like to remove from the family?

Nobody is rushing to remove any diabetes-related measures. Are there any other --

MS. ANDERSON: Can I ask a clarifying question --

CHAIR LIND: Yes, go ahead, Megan.

MS. ANDERSON: -- about the inclusion

of the diabetes care measures for people with serious mental illness.

The Workgroup included -- it voted to include those six measures for the health plan level of analysis for people with serious mental illness. They did not vote to include, to my understanding, the original provider-level measures for the general population. Is that true?

CHAIR LIND: Which number would that have been? Sarah is going back to the --

MS. ANDERSON: And --

CHAIR LIND: -- chart, which number?

MS. ANDERSON: Sarah -- sorry, I have to get there as well.

We have 2603, Diabetes Care for People with Serious Mental Illness. There is a Diabetes Care for the General Population at the Health Plan Level, that's the complement to that measure. I have to get to the slide, to the -- but I think we've only chosen to include a modified harmonized measure for people with

serious mental illness, not those from the general population.

CHAIR LIND: So are you talking about the 0057, Harmonized Specifications with --

MS. ANDERSON: Yes.

CHAIR LIND: -- 0057 Comprehensive Diabetes Care, Hemoglobin Testing?

So you are saying that we have the 2603, a specific one for serious mental illness, but we don't have the general population one that is the companion measure to that one.

MS. ANDERSON: That is correct, and that would be a consistent conclusion for the remaining five diabetes care first use for people with serious mental illness measures.

CHAIR LIND: So rather than sticking with the topic of trimming, you're suggesting adding a whole slew? I am just --

MS. ANDERSON: I want to clarify what the --

CHAIR LIND: Is there any big sensation, rushing to the microphone to include a

bunch? Steve.

DR. COUNSELL: I am just trying to harken back to some of our prior conversations, and I think we do have the composite measure, the family currently includes Optimal Diabetes Care, and I think that we, just with a little parsimony there, that's what we chose to use as a composite measure rather than detail out every diabetes measure.

And the rationale then for adding this next grouping is because it's specifically focused on the serious mental illness, which we think is under-recognized. Thanks.

CHAIR LIND: Okay, thanks.

So I think we're happy with what we decided or didn't decide, accidentally decided.

Anne?

MS. COHEN: So two things. I think I want to claim all these serious mental illness ones that we added, because there's a lot of them now, gets to what Rich was saying about focusing on a specific population, so I am wondering if a

big part of the next report should be like our goal is to eventually come up with measures for specific sub-populations, here is a whole group for this population, and then like encourage CMS to include all of those measures -- like if you can't include a bunch of other new ones we added, at least include this whole group for this group and get them tested and make that a priority, like, for the next, you know, how many number of years, as a way to move the needle.

And then the other one was the hospital readmissions stuff. We added a whole bunch of those, so that would be like another priority area.

And in terms of deleting, it sounds like there's a whole bunch of ones that haven't been adopted, so the question is do we delete those? Do we -- you know, how do you, in terms of the duals plans --

CHAIR LIND: Right. So the list of the ones that were not in any state duals demonstration, we could go back to that slide

just to refresh your memory. That was number 24 I think, at least on my printed version of the slides.

So -- so we have already dealt with a couple that had been -- have been retired or are no longer endorsed, but some of the other ones, I think, are fairly obvious about why they hadn't been picked up. The transition record was specified, elements received by discharged patients is just a notoriously hard set of data to collect, and so it's, you know, again, it signals good intention on our part, but it is not particularly easy, and so people tend to kind of give up on that one when they learn more about it.

I don't know about 0709. D.E.B., you might have an opinion about why that chronic condition avoidable complication wasn't picked up.

The ICU care preference is documented. It is probably a setting issue more than anything. It's like once you narrow down to the

numbers of people who are admitted to the ICU, then it becomes a pretty narrow measure.

I think the question that we raised earlier about health literacy, it's like if you're not using this to measure health literacy, what on Earth are you using? We don't have any idea, and that could be another one of those questions to ask in the interviews, like what are you doing about health literacy, and the -- on the client side, what are you doing about cultural competency on the clinician side? You know, those are other good things to drill down in.

Medical home system survey, what we have heard is just it's really intensive and expensive, so those are some reasons that we know of.

Steve?

DR. COUNSELL: Yes, I was just noticing that it was not only were these not used in the duals demos, but in any other national or state initiative, so not in the Special Needs

Plans or anything else.

But I think, in general, I think that all you've gone through and even the rest are great placeholders representative of some of the kind of difficult --

CHAIR LIND: Right.

DR. COUNSELL: -- and challenging issues that --

CHAIR LIND: Right.

DR. COUNSELL: -- that this population faces.

CHAIR LIND: Things we wish we had better measures for.

MS. LASH: Some of the higher numbers that start with 2 are relatively newly endorsed, so I -- it would be premature in my opinion to remove these from the family when they really haven't had the time to be considered for those programs, to be parts of annual updates, et cetera, et cetera. The wheels of change are a little slow.

CHAIR LIND: Jennie and then Vanesa.

VICE CHAIR HANSEN: Going -- going back to 1626, Patients Admitted to ICU Who Have Care Preferences Documented, there was some conversation at some point that this was very specific to setting, but it was a place where patient goals was acknowledged when we had talked about how few items there are about patient goals.

So one is, you know, the idea of keeping it in, but is there a way to kind of elevate that as we have our discussions about how we want to frame clusters with this?

CHAIR LIND: Vanesa?

MS. DAY: First, I think that for this list and in general, my impression of what we are supposed to do in this group is to lay out what we think is the best possible measure set for duals, or family for duals.

The fact that these are not included in whatever is going on in CMS or elsewhere really doesn't mean that we should be considering them not there. Like, if you put them there,

they're there for a reason.

There are so many things that happen once you give us -- I know I said this before, but there are so many things that happen once we get these reports that, I mean, just -- it doesn't mean that it's not valid and we shouldn't be aiming for it, so I would -- I think that in looking at this and in judging the overlaps, we should look at overlaps to the extent that yes, we don't want to have -- we don't want to be so burdensome in our measure family that we aren't able to get to what we really need to get to, or we limit access. But I think that should be the extent to which we look at the overlaps.

So as we look at new measures and we say, okay, does something exist like this otherwise, or is there another measure that is otherwise in use that maybe makes sense for us to stratify? Then I think that is an appropriate place for us to look at the overlaps, but I think if we just kind of say oh, well it's not being used, or harp on that too much, then we kind of

get into a place, a dangerous place where we're kind of playing to the policy and politics of it all as opposed to really thinking -- like, thinking of the broader mission, which is what makes sense for this population?

Because again, even with all the overlaps that we see, there is more analysis that needs to be done and more work on our part that needs to be done in actually using those measures in those different programs for our population, so -- .

CHAIR LIND: You are our new hero.

(Laughter.)

CHAIR LIND: So no -- no big vocal leaning towards deleting measures, so I think we'll leave the set at that for today.

MS. DAY: I did have a question.

CHAIR LIND: Okay.

MS. DAY: Not a delete, but a question.

So there is an HIV measure that you contemplated the last time, and we had a broader STD measure, but -- and I think in the last

grouping, we changed to just the HIV measure.

And I was curious as to why we selected a measure that wasn't -- didn't address STDs more broadly.

MS. ANDERSON: Because there wasn't one. This is Megan.

MS. DAY: Okay.

MS. ANDERSON: There wasn't one available.

MS. LASH: I think there was a suggestion that the CDC was working on a composite of some kind, which we haven't had -- we haven't seen that come through yet.

MS. DAY: Okay.

MS. LASH: Still a gap, an important one.

CHAIR LIND: Okey-dokey. D.E.B.?

MS. POTTER: The question that was put on the table was should we take anything off, and I am going to flip it the other way because I did hear us have a pretty firm conclusion that we still thought that we were light in terms of

person-centered care, and that even though we've got all these measures, this concept that we know is central to these populations we still haven't captured, and I don't want us to lose that.

CHAIR LIND: So I think that's tomorrow morning, Charting A Path Forward on Measuring Person- and Family-Centered Care, so we're just going to forge through the snow in whatever way we can.

I might have to go buy snowshoes tonight, but first, we're going to pause for public comment before we adjourn for the evening. So Operator, could you just make sure if we have any folks who would like to make public comment at this point?

THE OPERATOR: Okay. At this time, if you would like to make a comment, please press star, then the number 1.

(No audible response.)

THE OPERATOR: And there are no public comments at this time.

CHAIR LIND: All right.

So Sarah -- it says Alice and Sarah will help provide themes. I think that that last point that D.E.B. just brought up has certainly been a consistent theme today, and not losing sight on these really important gap areas of person-centered care, family caregivers, we've mentioned other themes in that -- in the family of gaps in terms of the problems with collecting good, quality survey measures that we know actually reflect people's needs and perceptions.

And my new favorite phrase is, though, what's important for you versus what's important to you, that is my new favorite thing in that family of themes that we talked about.

And the one that I'm going to bring home is about insisting that health plans issue free cell phones and airtime to clients. That is my new favorite, and that's going to be my new mission in life.

So those are some of the themes that I heard today. I really liked how we started off by looking at the alignment half-full and then

really flipped it around to -- or look at it half-empty at first and then flipped it around to half-full, but there is still all this, you know, need of all of us to fill the glass even that much more as you hear, so care coordination, transitions, still very important and still needing a lot more emphasis.

And the whole point of we just don't know a lot yet about if we had stratified measures on all the measures that we hope to be collecting, we don't know if we're starting to narrow the gaps or not.

So all really helpful conversation today. It will make Sarah's report-writing very rich and challenging --

MS. LASH: Yes, among other things. I just want to thank you all for the concentration and the hard work, especially this afternoon.

I know that updating the family of measures, Jennie described it as a very linear activity, and it is sort of hard to see where all

of that is going and what the choices mean, but maybe to sum up, that list of measures that gains the support of the MAP has slow ripple effects on uptake of measures that are important for this population, and it is sort of a necessary first step to do this work, but we had some great conversation about how it's not enough, that there is a lot more quality improvement work and policy that sort of wraps around that measure list and sort of needs to all function together.

So we might share some other themes in the morning once we have a chance to synthesize a little bit more, but don't want to take up any more of your day right now, so thanks everyone. I will see you in the morning, safe travels, or we'll -- well, I will see you on the webcast.

And don't hesitate to email myself or Zehra if you have any technical difficulties in the morning. We'll be as helpful as we can be.

All right.

(Whereupon, the above-entitled matter went off the record at 4:01 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: Measure Applications Partnership

Before: NQF

Date: 03-04-15

Place: Washington, DC

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Neal R Gross

Court Reporter