

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

2 (9:05 a.m.)

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

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

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

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

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

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

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

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

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

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

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

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

8 In the room, please let us know when
9 you want to speak by raising your tent card, so
10 that the chairs can recognize and call on you.

11 If you're on the phone, please let us know you
12 would like to say something, and we will make
13 sure that you are in the queue. Just speak up.

14 You can also let us know via the chat box on your
15 web platform, if you'd like to make a comment as
16 a workgroup member.

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

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

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

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

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

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

3 That's all from me.

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

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

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

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

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

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

1 play out in actually improving person-centered
2 care.

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

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

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

22 So we will do the disclosure in

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

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

15 So in light of that, we didn't ask you
16 a lot of questions about your professional
17 activities. We only asked you one question,
18 which is, do you personally have an interest of
19 \$10,000 or more in something that is related to
20 the work of the Committee? So something that
21 will come before the Committee that is directly
22 related to something that you have a financial

1 interest in of \$10,000 or more.

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

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

18 So we will start with Clarke Ross.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12 Thank you.

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

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

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

22 MR. LAKIN: Charlie Lakin. I'm

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

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

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

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

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

1 MS. HAMMERSMITH: Okay. Thank you,
2 Gail.

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

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

16 MS. HAMMERSMITH: Okay. Thank you,
17 Alice.

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

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

1 Day.

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

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

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

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

19 MS. HAMMERSMITH: Okay. Thank you,
20 everyone.

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

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

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

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

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

13 MS. HAMMERSMITH: Okay.

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

22 MS. HAMMERSMITH: Thank you for

1 updating your disclosure. Appreciate it.

2 Go ahead.

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

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

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

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

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

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

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

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

19 MS. DAY: Alice is being modest.

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

1 please give your welcoming remarks.

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

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

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

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

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

7 Improving the quality of health care
8 and long-term services for Medicare and Medicaid
9 enrollees, increasing enrollees' understanding
10 and satisfaction with coverage under Medicare and
11 Medicaid, improving care continuity, and
12 improving the quality of performance and service
13 -- of service and suppliers under Medicare and
14 Medicaid.

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

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

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

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

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

1 provided.

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

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

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

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

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

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

1 10, but I had so many things that I had to scrap
2 that idea.

3 (Laughter.)

4 Top 50, right.

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

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

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

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

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

22 And so we reached, like, a zen point

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

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

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

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

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

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

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

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

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

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

1 issues that we face.

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

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

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

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

18 MS. DAY: So we -- no.

19 (Laughter.)

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

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

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

7 CHAIR LIND: Any other questions?

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

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

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

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

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

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

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

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

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

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

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

1 the impact that it could have on overall costs?

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

12 Did you want to --

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

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

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

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

14 CHAIR LIND: Thank you. Steve?

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

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

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

5 CHAIR LIND: Anne?

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

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

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

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

22 I personally am the lead for the

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

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

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

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

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

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

11 CHAIR LIND: Charlie?

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

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

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

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

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

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

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

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

16 MR. LAKIN: Good. Thanks.

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

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

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

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

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

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

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

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

7 So -- go ahead.

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

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

1 MS. SHAHAB: Thanks, Jennie.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 So on this next slide, this is a

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

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

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

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

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

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

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

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

1 would be helpful.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 Colorado and Washington.

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

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

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

22 And many measures that are in the

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

5 Venesa wanted to add some background.

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

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

1 to get at.

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

8 MS. SHAHAB: Thank you, Venesa.

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

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

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

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

4 So out of the 58 measures in the duals
5 family, approximately 12 percent were in 12 or
6 more of these 43 programs, 19 percent were in
7 nine or more, 41 percent were in four or more
8 programs, and 67 percent were in two or more, and
9 22 percent were not used in any of the national
10 or other state initiatives.

11 So, in this slide, we wanted to once
12 again look at which programs now show the
13 greatest uptake of the family. And the measures
14 were most recently used in the physician quality
15 reporting system, which included 23 of the
16 measures in the family, and the physician value-
17 based payment modifier program, which included
18 22.

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

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

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

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

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

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

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

16 So out of the six priority areas, we
17 have five of them. The only one missing is
18 affordable care. And you can see the
19 distribution; 28 percent is the highest
20 percentage, and that is focused on effective
21 communication and care coordination. Next is
22 24 percent each for health and well-being and

1 prevention and treatment of leading causes of
2 mortality.

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

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

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

1 duals demonstrations or the national or state
2 initiatives.

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

8 VICE CHAIR HANSEN: Joan has a
9 question.

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

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

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

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

11 Are there any other questions?

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

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

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

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

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

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

1 order.

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

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

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

1 particular the current programs, are actively
2 using these measures.

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

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

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

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

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

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

13 So, okay, D.E.B.?

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

22 The second point I wanted to make is

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

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

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

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

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

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

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

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

1 similar.

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

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

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

1 here today are very discouraging, I think.

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

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

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

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

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

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

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

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

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

1 just isn't making sense to me.

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

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

22 Okay. I think I started with Anne.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5 VICE CHAIR HANSEN: Steve?

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

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

22 But, you know, you look at this, the

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

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

12 Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 So I sense that, you know, the

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

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

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

1 is going to be?

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

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

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

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

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

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

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

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

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

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

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

1 does the medical home system meet the standard?

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

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

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

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

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

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

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

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

3 Like, I feel kind of disappointed that
4 you guys are like, oh no, we have all failed, and
5 my -- I mean, I wrote to myself, "Where did you
6 think you would be by now with this work?"

7 Because, I mean, you know, it's really hard --

8 like our -- our team works hard at -- in every
9 meeting. One, we are always raising our hand

10 saying, "What about Medicare or Medicaid?"

11 Because, quite honestly, you know, they don't --

12 they don't -- you know, it's like the other one

13 doesn't exist.

14 And so, and then added to that, this
15 work where we're saying, "Okay. And then what

16 about the duals?" I mean, we literally have

17 programs that are like, "Oh, you mean we have 50

18 percent duals in our population? Oh my. How" --

19 (Laughter.)

20 MS. DAY: You know, and so -- and then
21 when we raise our hand and say, "Oh, but you

22 should be using -- at least aligning with the

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 So when we look at the ones that we

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

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

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

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

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

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

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

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

22 You know, if you look at alignment

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

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

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

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

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

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

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

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

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

1 disconnects are.

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

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

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

1 same measure, but it's a process.

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

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

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

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

22 But unless all components of the

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

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

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

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

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

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

11 I next have Shawn, and then Clarke.

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

22 And I would bet that there is at least

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

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

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

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

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

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

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

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

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

1 Forum approach on distinct measure by measure.

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

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

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

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

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

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

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

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

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

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

17 VICE CHAIR HANSEN: Steve?

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

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

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

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

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

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

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

13 Thanks.

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

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

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

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

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

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

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

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

1 better.

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

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

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

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

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

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

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

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

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

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

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

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

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

1 models that kind of underpin the measures
2 themselves.

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

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

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

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

10 MS. POTTER: Are we skipping over our
11 break?

12 VICE CHAIR HANSEN: Oh.

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

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

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

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

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

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

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

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

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

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

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

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

1 and we need to change course.

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

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

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

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

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

22 The third, you know, partnerships to

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

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

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

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

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

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

20 (Laughter.)

21 Alice, you may go first.

22 CHAIR LIND: So I thought another

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

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

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

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

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

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

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

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

21 We -- I think we have gone up to like
22 200 measures that we are trying to figure out, is

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

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

6 CHAIR LIND: I am happy to do so.

7 MS. LASH: Susan, go ahead.

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

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

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

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

19 MS. LASH: Charlie?

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

1 often quite enamored by the progress that has
2 been made in that area. It has been important,
3 and it has really validated people who have the
4 right to a reasonable quality of life. And it is
5 certainly important that we do that, given that
6 40 percent of the duals are people who need some
7 support to live their life independently. We
8 need to attend much better to that.

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

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

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

9 And then, there are huge variations in
10 the ability of the individuals receiving supports
11 to respond for themselves, to give reliable
12 responses. Response bias is a big problem.
13 Proxies are often used, but the limited amount of
14 research about proxies suggests they don't always
15 answer in ways that the individual would answer.
16 So there is just -- the other problem is that
17 many of these get very high levels of positive
18 response. So you ask, do you like where you
19 live, which is a reasonable thing to ask. But if
20 90 percent say they do, as is common, then where
21 is the -- where is the ability to discriminate
22 between good and poor service?

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

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

16 MS. LASH: Thanks for that. Rich?

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

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

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

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

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

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

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

1 wrong way.

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

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

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

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

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

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

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

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

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

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

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

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

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

1 sensitive to, do we have competing measures?

2 Success on one is failure on the other.

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

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

1 creating care.

2 You know, and here, Jennie, you know,
3 you are going to tell me I'm off point again, but
4 I think communication is as important as food, is
5 as important as pharmaceuticals. And the OCC has
6 this program where they give -- I think it's a
7 \$10 a month credit to the poor for their purchase
8 of a cell phone. Cell phones should be free to
9 this population, and I'm not saying go to
10 Congress and ask for more money. Go to the
11 carriers and tell them if they want to avoid an
12 additional tax, they need to dispense free cell
13 phones and free airtime to the poor, because
14 unless we have communication, we aren't going to
15 get anywhere with this population.

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

22 MS. LASH: Great. Thank you. Joan

1 was next.

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

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

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

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

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

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

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

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

22 So I think that really is an issue.

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

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

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

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

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

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

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

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

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

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

3 MS. LASH: Thank you. Sally?

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

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

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

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

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

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

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

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

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

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

22 I like to think things in a simplistic

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

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

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

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

1 MS. LASH: Thank you. Shawn?

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

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

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

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

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

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

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

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

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

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

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

1 ever think that --

2 (Laughter.)

3 MS. POTTER: Please, please don't.

4 But I want to get at something that I don't think
5 we've really talked about, like what is working
6 and what is not working. I personally -- maybe
7 it's out there and I haven't seen it -- haven't
8 seen the quality measures that are used in the
9 duals program stratified by duals or non-duals.
10 I haven't seen empirical information to answer
11 that question.

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

22 MS. LASH: Anne, last comment before

1 lunch.

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

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

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

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

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

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

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

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

14 (Whereupon, the above-entitled matter
15 went off the record at 12:02 p.m. and resumed at
16 12:45 p.m.)
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18
19
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21
22

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

2 (12:45 p.m.)

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

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

10 MS. LASH: Yes.

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

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

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

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

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

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

22 The new staff led feedback effort that

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

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

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

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

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

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

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

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

1 during the interviews so far.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 We heard about how measures are costly

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

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

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

22 On slide 45 we see some additional

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 potentials on slide 49 for you to pull over.

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

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

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

22 I threw a lot of information really

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

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

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

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

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

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

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

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

1 So, Rich?

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

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

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

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

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

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

16 MR. BRINGEWATT: Yes.

17 CHAIR LIND: Or subset analysis or --

18 MR. BRINGEWATT: Yes.

19 CHAIR LIND: Okay. Thanks, good.

20 MS. POTTER: Can I ask a clarifying
21 question?

22 CHAIR LIND: If you put your

1 microphone on you may.

2 (Laughter)

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

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

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

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

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

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

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

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

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

1 supposed to measure the experience of the
2 consumer.

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

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

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

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

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

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

22 MS. POTTER: Right. Right. There are

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

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

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

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

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

20 (Laughter.)

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

1 it, if that's okay.

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

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

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

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

16 CHAIR LIND: Thank you.

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

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

22 VICE CHAIR HANSEN: I said that that

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

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

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

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

19 CHAIR LIND: Next, Sally?

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

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

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

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

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

1 have done Vietnamese and Russian translations of
2 CAHPS.

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

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

8 CHAIR LIND: Yes, right.

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

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

14 MS. TYLER: Just phone? Okay.

15 CHAIR LIND: Steve?

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

22 And so we take care of a lot of people

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

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

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

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

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

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

3 CHAIR LIND: Sarah?

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

13 Maybe that's a full proxy? Okay.

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

21 MS. LASH: Right.

22 CHAIR LIND: Okay. Clark?

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

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

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

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

19 MR. ROSS: Yes.

20 MR. TERRELL: O'Hara? Yes.

21 MR. ROSS: Yes. The Irishman. Right.

22 MR. TERRELL: I have his -- if you

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

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

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

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

21 CHAIR LIND: Shawn?

22 MR. TERRELL: Charlie just answered my

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

7 CHAIR LIND: Deb, did you have another
8 comment?

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

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

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

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

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

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

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

19 CHAIR LIND: Charlie?

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

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

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

9 MS. ANDERSON: Sure. This is Megan.

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

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

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

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

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

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

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

1 organization or providers that it is making a
2 difference.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 tea Megan.

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

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

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

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

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

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

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

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

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

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

22 VICE CHAIR HANSEN: Okay.

1 MS. ANDERSON: Is that good?

2 VICE CHAIR HANSEN: Sounds good. 45

3 minutes we'll take a break. So --

4 MS. ANDERSON: And you let me know.

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

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

13 MS. ANDERSON: Okay.

14 VICE CHAIR HANSEN: All right.

15 Thanks.

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

1 beneficiaries and high risk groups in the
2 population.

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

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

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

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

17 OPERATOR: One of her lines
18 disconnected. One moment.

19 MS. SHAHAB: Okay.

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

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

3 MS. ANDERSON: Hi, this is Megan.

4 CHAIR LIND: Megan, we can hear you
5 now.

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

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

15 CHAIR LIND: Correct.

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

1 measures.

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

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

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

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

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

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

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

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

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

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

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

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

1 long-term services --

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

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

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

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

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

16 MS. ZLOTNIK: Okay.

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

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

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

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

22 We'll vote by a show of hands and 60

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

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

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

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

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

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

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

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

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

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

1 shared decision-making that are being revised?

2 Or is it --

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

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

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

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

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

15 VICE CHAIR HANSEN: Anne?

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

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

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

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

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

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

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

1 adult core set because I was under the impression
2 that the Medicaid adult core set CAHPS measure
3 had a different supplement.

4 MS. DAY: So I'm sorry, I actually
5 misspoke, and I meant to say the National CAHPS
6 survey. But we are using -- there might be a
7 different supplement, but we decided on this with
8 the 4.0(h) with the Medicaid.

9 CHAIR LIND: Okay. I was just trying
10 to clarify. I think that in the Medicaid adult
11 core set, there's also a CAHPS health plan
12 measure that isn't -- doesn't include this
13 supplement.

14 MS. DAY: Oh, okay.

15 CHAIR LIND: Okay? It's the
16 supplement, not the CAHPS health plan. The CAHPS
17 health plan is still endorsed, but there's lots
18 of supplements to CAHPS health plan. So that's
19 all I was trying to clarify.

20 MS. COHEN: That was my clarification.
21 The supplemental questions, if we say no, we
22 don't want to endorse them, and CMS continues to

1 go through -- forward to use them -- I understand
2 that just because something loses an NQF
3 endorsement, doesn't mean they're not going to
4 use them.

5 But then the question is like, we say,
6 okay, let's wait for the new questions to come
7 out and then direct them to include those new
8 questions when they come out. Do you see what
9 I'm saying? I'm trying to?

10 VICE CHAIR HANSEN: You're asking
11 about the sequence of this, and do you basically
12 have something that's vacated, you know? And
13 basically a hole for a while, while CMS continues
14 its use in that way.

15 MS. ANDERSON: Can you use your
16 microphone please?

17 MS. DAY: So, can I just speak to that
18 briefly?

19 CHAIR LIND: Please.

20 MS. DAY: And then tell me if I'm not
21 answering your question, but from the CMS
22 perspective, what we would do is -- so in all of

1 our measures we in the MOU say that we will go
2 back and update as the science changes.

3 So I realize that on this the science
4 might not change. But to answer your question
5 directly, we would not change this particular
6 measure in our demonstrations because we think
7 it's important, and quite frankly, we've invested
8 a lot of resources in developing a survey
9 particular for the duals.

10 VICE CHAIR HANSEN: Can we -- let's
11 back up. Right. So you're going to go on. I
12 guess there's a basic question, is why do we
13 remove it at this particular time?

14 MS. DAY: That's it. Yes.

15 VICE CHAIR HANSEN: So that seems to
16 be kind of a question at least of a few people
17 here, Megan. Do you have a sense of why we would
18 recommend pulling it out?

19 MS. ANDERSON: Yes. I think a
20 recommendation that I'm hearing maybe boiled to
21 the top here is that measures that are in use
22 that need to be updated but there are planned

1 updates might for continuity sake, be recommended
2 for continued use. However, that the workgroup
3 would encourage uptake of the measure once it is
4 updated.

5 This is a similar recommendation that
6 we've seen in the past. However, you know, there
7 are potentially unintended consequences of a
8 measure that is not being maintained
9 scientifically, and especially in pay-for-
10 reporting ---- in pay-for-performance programs
11 and public reporting. You can think about the
12 consequences of reporting measures that are not
13 scientifically maintained and valid anymore.

14 So there's maybe a recommendation but
15 the workgroup would not have people remove it in
16 programs that are currently using it, but update
17 the measure when an update is available and maybe
18 not add it to a program at this time if it's not
19 already in it, or until that measure update is
20 available.

21 VICE CHAIR HANSEN: So that's kind of
22 a friendly amendment is not to pull it out.

1 Leave programs that are currently using it even
2 though it's not scientifically supported, but
3 then when a new measure comes out that is
4 scientifically supported, this would be started
5 up again.

6 So D.E.B., you've been our technical
7 advisor here. Do you have any reaction to that?

8 MS. POTTER: Well, I just worked at
9 AHRQ which developed the CAHPS. And so I -- but
10 I don't really have anything to do with the CAHPS
11 program per se.

12 I do know that there are other CAHPS
13 supplements that measure shared decision-making
14 and coordination of care. There's all these
15 supplements to CAHPS. There's a whole module on
16 patient-centered medical home that has a whole
17 bunch of questions around this. I don't think
18 that particular module has been submitted to NQF
19 for endorsement.

20 I'm not sure what's in the CAHPS
21 clinician survey. I'm pretty sure there's a
22 couple of questions in there ---- I could be

1 wrong, about shared decision-making and care
2 coordination. So maybe -- I like the
3 recommendation that was proposed, but maybe we
4 should also think about are there other endorsed
5 CAHPS measures that might meet our purposes? And
6 I don't know if there are or not.

7 VICE CHAIR HANSEN: Back to the cards
8 -- oh, go ahead, sorry.

9 MS. ANDERSON: We have included
10 currently endorsed measures. We have included
11 all currently CAHPS -- currently endorsed CAHPS
12 measures in the family so far except for those
13 that are specific to children.

14 MS. LASH: I'm sorry, I'm just going
15 to repeat what Megan said in case people had
16 trouble hearing.

17 So there's sort of been a standing
18 recommendation from this group that all CAHPS
19 tools should be used where available and so we
20 have listed in the family all of those that are
21 specifically endorsed, with the exception of the
22 pediatric specific instruments because that

1 population is not represented in duals more than
2 one percent.

3 VICE CHAIR HANSEN: So, Joan?

4 ZLOTNIK: So I have sort of a process
5 question because I'm sort of not sort of working
6 in a healthcare setting sort of using these
7 measures every day. Kind of in terms of like
8 what as the MAP Dual Eligible Beneficiaries
9 Working Group are sort of obligations are?

10 Because well if there's a whole bunch
11 of supplemental measures and some of the other
12 things get there, but from what I gathered what
13 Megan just said, we've actually included all of
14 those in our family of measures. It's just like
15 not clear to me what the obligation is, just in
16 terms of -- it's similar to sort of developing
17 evidence-based practices. It's an ongoing
18 process.

19 So people develop an evidence-based
20 intervention. You want to go to use it. You go
21 back to them and they say oh, well, we're
22 refining it now. You know, so you can -- don't

1 you -- yes, don't you -- stop using it, don't use
2 it, or you're not an authorized user.

3 And I mean, so it sounds kind of
4 similar to that and so it sounds like someone's
5 trying to work, I assume, by improving it for
6 greater use. So it would seem to me that based
7 on that, we would want to kind of say, we want to
8 kind of continue to use it as a placeholder until
9 the new one comes along?

10 Because this issue of, well, you know,
11 it's not being kept up. In a way it is being
12 kept up if someone's trying to develop something
13 bigger and better. So it's a little confusing in
14 terms of the language when I'm not sort of using
15 these things every day and trying to be why?

16 VICE CHAIR HANSEN: We're spending all
17 -- you know, a fair amount of time on it. Just
18 so -- but let me just honor the two tents here.
19 George and then Rich, and then we'll move to
20 clarify what we're voting on and have a vote.

21 DR. ANDREWS: Yes. I was going to say
22 I was confused because I wasn't clear what was

1 being retired, but I think now I'm more clear in
2 terms of what is being retired by the steward,
3 which is a supplement, not the CAHPS core.

4 Well my question still is, you know,
5 if the steward, the developer, is retiring
6 something, why would I want to use something to
7 measure the outcome of when they don't know what
8 they're going to come up with? And I think this
9 party needs to take that into account.

10 We need to rely on good data, on good
11 methodologies, on -- so, I don't feel
12 comfortable, you know, with the retirement from
13 the steward to go in and say yes, let's retain
14 this for now.

15 MR. BRINGEWATT: Yes, I have a
16 question along that line, and that's I heard
17 something -- someone earlier say that there's a
18 question of whether this is valid anymore.

19 And if it's no longer valid, I would
20 raise questions as to whether ---- I mean, we do
21 have some pride in terms of evidence base here as
22 part of a criteria for utilization. And so, it

1 would be helpful to me to know whether -- I mean
2 staff have recommended as I'm understanding it,
3 to not use it. And, is part of the reason to not
4 use it is because it's not seen as valid? And if
5 it's not seen as valid, I would be inclined to
6 say we shouldn't use it.

7 MS. LASH: Let me try to shed some
8 light on that. The steward has withdrawn this
9 measure from endorsement maintenance, which
10 requires resources on their part to participate
11 in, because they know that they're working on a
12 substantial revision.

13 Which is a little bit of a different
14 circumstances than a clinical guideline has
15 changed and it makes an existing measure totally
16 obsolete. So, you know, that it needs to be
17 chucked because we've completely redone blood
18 pressure guidelines or something like that.

19 So, we had been operating under the
20 precedent of removing measures that had lost
21 endorsement I think because primarily we were
22 encountering measures that were losing

1 endorsement for those guideline-related reasons
2 that the validity and the evidence base was
3 evolving.

4 In this case, I think these measures
5 are fundamentally still the best available, even
6 if they don't still have NQF endorsement. I
7 might make an analogy to buying a used car. It
8 might still run quite well and get you from point
9 A to point B, but that doesn't mean you can't get
10 brand new 2015 one off the lot with more bells
11 and whistles pretty soon.

12 So, I think the sense of the group is
13 to keep the measure in the family, but make some
14 specific notations about use expectations going
15 forward.

16 Go ahead. Sure. You're mic's not on
17 Rich.

18 MR. BRINGEWATT: Is there another
19 measure like this in the lot that's ready to be
20 purchased soon?

21 MS. LASH: I can't speak for when NCQA
22 would be ready to release the update. If that is

1 one year away or two years away. But, when it
2 is, it would come to this group for further
3 inspection.

4 VICE CHAIR HANSEN: Steve, do you have
5 one more?

6 DR. COUNSELL: Yes. How many in the
7 family do we have that are not NQF-endorsed?

8 MS. ANDERSON: Two, there are two
9 measures.

10 DR. COUNSELL: And they're serving as
11 placeholders? I think that's what I would
12 subvert this to like a placeholder status I guess
13 because not everyone -- not everything in the
14 family I think we have is fully validated,
15 endorsed, maintained.

16 MS. LASH: Right. So this could stay
17 as a placeholder.

18 VICE CHAIR HANSEN: This could stay?

19 MS. LASH: Yes.

20 VICE CHAIR HANSEN: Okay. So, I think
21 we've had some robust clarifying discussion, and
22 so that this -- how many of you would like to

1 maintain the current measure as a placeholder and
2 using it as that until the -- whenever the new
3 measures come out, whether it's a year or two
4 years from now?

5 So I'd like to have hands up for those
6 who would like to maintain the measure on that
7 basis. Okay.

8 MS. LASH: Federal Partners are non-
9 voting. So keep your hands down. I'm sorry,
10 you're just going to screw up my count.

11 VICE CHAIR HANSEN: Okay. We have
12 ten. So we have sufficient threshold. All
13 right. Thank you. Okay.

14 MS. ANDERSON: Okay. Our second
15 measure that we have as lost endorsement is NQF
16 0111, Bipolar Disorder: Appraisal for risk of
17 suicide. This measure has been retired by the
18 steward and is no longer going to be maintained.

19 We have been told there will not be an
20 update and there will not be a new measure that
21 does the same thing that this measure does.
22 Unfortunately, that's a different scenario than

1 what we've heard about for the e-CAHPS
2 supplement.

3 There are two potential alternative
4 that staff has identified that we want to bring
5 for your consideration. Our thing as a staff is,
6 I want to remind you that when 0111 Bipolar
7 Disorder, this appraisal for risk of suicide was
8 originally included in the family, it was
9 included to really address that risk for suicide
10 component.

11 So we've identified NQF 1880:
12 Adherence to Mood Stabilizers for Individuals
13 with Bipolar I Disorder, which does address
14 bipolar, but does not address suicide risk. And
15 we've also identified 0104, which is Adult Major
16 Depressive Disorder with Suicide Risk Assessment.

17 The question is twofold. Would the
18 workgroup like to remove the measure that's no
19 longer going to be maintained, 0111 Bipolar
20 Disorder: Appraisal for risk of suicide? And the
21 question number two is, would the workgroup like
22 to include either of the available alternatives?

1 I'm going to go briefly through the
2 available alternatives on slide 62 and slide 63.
3 They've also been included in the attachment to
4 your materials, and that is Updating the Family
5 of Measures. So slide 62 please.

6 Potential alternative, the first one
7 to consider is Adherence to Mood Stabilizers for
8 Individuals with Bipolar I Disorder. This
9 measures a percentage of individuals 18 years and
10 older with bipolar disorder who have mood
11 stabilizers or medication prescription and
12 adherence to it. The adherence is defined as a
13 proportion of days covered with -- in 12
14 consecutive months of at least .8.

15 It's a process measure. The measure
16 is specified for settings in outpatient care and
17 behavioral health location care, as well as
18 urgent care, and it's measured at the provider,
19 team, group, and practice. It is not risk
20 adjusted and it can be stratified by Dual
21 Beneficiary, race and ethnicity and other
22 diversity-related issues.

1 Slide number 63 includes Major
2 Depressive Disorder: Suicide Risk Assessment.
3 This measures a percentage of patients 18 and
4 older with a new diagnosis of -- or a recurrent
5 episode of major depressive disorder with a
6 suicide risk assessment completed during a visit.

7 So it's also a process measure. It's
8 also available for application in outpatient
9 settings, inpatient care and behavioral health
10 outpatient. It's a different level of analysis.
11 It's available from providers in group practice,
12 Health Plan, Integrated Delivery System and
13 State. It is not risk adjusted, and it
14 encourages risk stratification by race/ethnicity,
15 primary language and gender.

16 This is a staff pick because it
17 addresses suicide -- it has included suicide risk
18 assessment, which was the original intention of
19 including the measure that has -- no longer
20 endorsed.

21 So if the vehicle here would to come
22 to a vote about either removing the measure for

1 Bipolar Disorder: Appraisal for risk of suicide
2 completely, or replacing it with a second
3 measure, and staff recommendation would be the
4 suicide risk assessment for adults with major
5 depressive disorder.

6 Do you have any questions?

7 VICE CHAIR HANSEN: D.E.B. seems to
8 have a technical questions.

9 MS. POTTER: Yes, I have a technical
10 question. In the first measure that you put
11 forth as a potential substitution, you said it
12 could be stratified by duals, and in the second,
13 you said it encouraged stratification, but you
14 didn't mention if it could be stratified for
15 duals.

16 I wonder if you could clarify?

17 MS. ANDERSON: That is information
18 from the measure specifications. I believe that
19 if the steward would have encouraged
20 stratification, then was possible to stratify.

21 VICE CHAIR HANSEN: It would be
22 possible, yes. Okay. Thank you.

1 So I have three other comments. I'll
2 start with Clarke, Vanesa, Anne and Rich.

3 MR. ROSS: So I have a question for
4 the staff. Do we know the opinions of Drs.
5 Pincus, Robinson Beale and Chalk on this? And/or
6 do we know the opinion of the Behavioral Health
7 Measure Committee?

8 MS. LASH: We haven't asked Dr. Harold
9 Pincus as a MAP Coordinating Committee Member,
10 Dr. Robinson Beale is no longer on the MAP, and
11 both of them were endorsed by the Behavioral
12 Health Standing Committee. We haven't put them
13 head-to-head in the context of the endorsement
14 work because they do measure different things.

15 Mady may be on the phone. We didn't
16 hear her introduce herself this morning, but I
17 don't think we've seen her connect.

18 VICE CHAIR HANSEN: Okay. Thank you.
19 Vanesa, you pulled off? Okay. Next I have Anne
20 and then Rich.

21 MS. COHEN: I'm going back to the
22 spreadsheet again, just to see, and it looks like

1 none of the plans -- none of the duals programs
2 have currently adopted this measure. Do you have
3 any insight as to why?

4 MS. ANDERSON: I don't have any
5 insight as to why it hasn't been currently used,
6 but that measure is no longer going to be NQF
7 endorsed.

8 So it wouldn't be recommended for use
9 in any other MAP body, and it's no longer being
10 maintained by the steward, so I don't think the
11 specifications will continue to be available
12 either.

13 MS. COHEN: So actually, I'm looking
14 to CMS and they said, no, we don't ---- you're
15 not sure why.

16 VICE CHAIR HANSEN: Vanesa, may I ask
17 you to use the --

18 MS. DAY: I do not on this particular
19 measure, but I can look into it and get back to
20 the group.

21 MS. COHEN: And then my only other
22 question and it looks like that this has to be

1 done at the provider -- well, it can be done in
2 the provider, plan, integrated system or State.
3 So my only question is, for the -- not that maybe
4 it matters, but these existing duals programs
5 with whether mental health is carved into them,
6 and then if it is, you know, how that impacts
7 this?

8 And if -- because you know what I'm
9 saying? Because if it's carved out, then the
10 question is whether this is an issue of how to
11 collect it, and maybe that's part of why it's not
12 being adopted.

13 MS. DAY: Okay. Well, mental health
14 integration is part of the duals demos. So --
15 yes.

16 MS. COHEN: In some states, like
17 California, it's been completely carved out and
18 they've been struggling with integrating it. So
19 that's why I was like trying to see if it has.

20 MS. POTTER: I have another technical
21 question, and just maybe Vanesa or someone in the
22 room.

1 How do the pharmacy benefits for the
2 dual capitated plans work? Do they -- if they're
3 duals, do they still get a Part D plan, or is the
4 medication included as part of the capitated
5 plan?

6 MS. DAY: So I don't want to misspeak,
7 because that's a little bit out of the -- my area
8 on the capitated plan -- capitated area, but if
9 someone else is from the duals office is on who
10 can speak to that particular area of the
11 capitated model.

12 I can come back to the group on that
13 as well.

14 VICE CHAIR HANSEN: And I'd like to
15 encourage --

16 MS. POTTER: Well the reason I was
17 asking was because the first measure, adherence
18 to mood stabilizers, if the medications are in a
19 Part D plan, there may be issues with the
20 capitated plan having access to that information
21 as opposed to the second measure, which could
22 just be within the plan.

1 MS. DAY: I think --

2 MR. BRINGEWATT: Well, SNFs are
3 required to have Part D as part of their plan. I
4 mean, they're required to have that benefit
5 integral to the overall plan, and the MMPs follow
6 a model of care requirement for special needs
7 plans.

8 MS. POTTER: Oh, okay.

9 MR. BRINGEWATT: So, I assume, but am
10 not a hundred percent certain, that that probably
11 applies to the dual demonstration plans as well.

12 MS. POTTER: Okay.

13 MR. BRINGEWATT: You know, it's
14 important to double check that one, but that's my
15 stream of logic. Whether it holds or not needs
16 to be checked.

17 MS. POTTER: No, that seems very
18 reasonable.

19 MR. BRINGEWATT: Yes. I do have
20 another question that relates to that though, and
21 that's the fourth bullet here recognizes
22 accountability for performance -- for performance

1 of the measure. And that includes health plans
2 and integrated delivery systems and the other
3 measure did not.

4 And so, the question I would have, is
5 what is the assumption as to how plans would be
6 accountable for this, particularly if there's a
7 plan that doesn't provide services directly, but
8 does it through a series of contracted entities?

9 MS. LASH: So when you vote to include
10 this measure in the family, it doesn't come with
11 instructions as to how it finds its way into any
12 of the specific applications.

13 As we were discussing this morning,
14 some measures would be a fit and some measures
15 would not, and those decisions happen
16 sequentially after this.

17 What you're voting on is, would
18 support of 1880 or 104 as measure alternatives
19 further the availability of good measures to
20 improve quality for the dual eligible population?
21 So, that's really the question at hand.

22 Let's you know, try to stay program

1 agnostic in this discussion. Are these measures
2 part of the list that MAP has put out to say, if
3 you want to improve care for duals, start with
4 these options. Which is the best measure to
5 accomplish that goal?

6 MS. DAY: Can I offer a clarification?
7 So thank you Carolyn who just emailed me that the
8 MMPs do incorporate -- require the benefit plan.
9 So thanks.

10 VICE CHAIR HANSEN: I have Shawn and
11 then Steve.

12 MR. TERRELL: So I'm not sure where my
13 boundaries are anymore. I thought I knew, but
14 now -- an I make a comment or some ideas? Like
15 can I throw these out on the table as a Fed?
16 Okay. I just can't vote. Which is fine. I get
17 it. It's good.

18 So just -- I mean, this measure on
19 risk of suicide is really important, right? I
20 mean just the stats, this is like 25 to 50
21 percent of the people with bipolar attempt
22 suicide. There's 15 to 50 percent actually you

1 know, complete a suicide. So okay, so it's a big
2 thing to measure. It's really important.

3 So the first thing would be like the
4 last measure perhaps, holding on to it until
5 there is something really clear. That's one
6 option to think about if we have no other option.

7 The second one, I just have question
8 on this in terms of the alternatives. The first
9 alternative around the mood stabilizer question.
10 Is that -- well, how is that measured? I mean,
11 how do people know whether somebody's you know --
12 -- is it self report? Is it somebody fills a
13 prescription?

14 MS. LASH: It's related to the fill of
15 the prescription.

16 MR. TERRELL: All right. Well, that's
17 you know, I mean 50 percent of people ----
18 there's 50 percent non-adherence on neuroleptic
19 medication. You know, I mean anybody -- family
20 members fill prescriptions, you know, you have a
21 bag of prescriptions sitting there over six
22 months. I mean, it doesn't really tell us a lot

1 I would say. All right, there's that one.

2 And then, on the major depressive
3 disorder, that it would be great. Okay, so
4 there's a risk assessment question there. Would
5 it be -- I don't know how -- again, this is the
6 hold, does it have to go -- do you have to go
7 redo the whole measure just to add in the
8 question of whether somebody had bipolar or not?

9 VICE CHAIR HANSEN: Okay. Well,
10 thanks for your input on that, and the question.

11 Vanesa, were you answering that
12 question specifically? No. Okay. In which case
13 then I'll go over to Steve and come back to you.
14 Steve?

15 DR. COUNSELL: Well, I was just
16 wondering if -- I was surprised that we had a
17 bipolar disorder suicide in, but not depressive
18 disorder suicide risk? And so is this a new
19 measure? Or that we just didn't -- never
20 considered before?

21 MS. LASH: It's not. I don't know
22 what artifact of the old decision process was.

1 Maybe it fell out of the prioritization a little
2 bit. But Anne?

3 MS. COHEN: I think I vaguely remember
4 that conversation that we wanted a suicide risk
5 assessment and that was the one that was best
6 available recognizing that it didn't encompass
7 all mental health disorders. But that was the
8 one that at the time was endorsed available.
9 It's what I recall, but I could be wrong.

10 DR. COUNSELL: Because it seems very
11 important in the population that we're talking
12 about. And it's highly under-recognized and
13 underperformed as an opportunity for improvement.
14 So I encourage that. Thank you.

15 MS. ANDERSON: This is Megan. Can I
16 chime in? Just to highlight one more fact about
17 the adult major depressive order with suicide
18 risk assessment. It's actually currently in
19 meaningful use stage too and the physician
20 quality reporting program. So it's an important
21 thing to think about.

22 Whereas the adherence to mood

1 stabilizers is not currently in any federal
2 programs, and we do not have a measure that is a
3 suicide risk assessment more generally that is
4 not condition-specific unfortunately.

5 VICE CHAIR HANSEN: Okay. All right,
6 thanks Megan.

7 We have two comments and I think we
8 should wrap up for a vote. Vanesa?

9 MS. DAY: You answered my question.
10 I was going to ask, do we care or is this aligned
11 otherwise with a program?

12 VICE CHAIR HANSEN: Okay. Perfect.
13 So it is aligned with meaningful use. And Gail?

14 MS. STUART: So these are three
15 discrete areas. It's not like one can be a proxy
16 for another, and that troubles me. It seems as
17 if we know bipolar disorder is at a high risk.
18 How complicated could that measure be to do --
19 ask whether or not there's been an assessment
20 done?

21 I'm shocked that we didn't have it for
22 major depressive disorder. So again, maybe it

1 was more general or something, but we clearly
2 need it for major depressive disorder. So that's
3 kind of a no brainer.

4 And then the adherence issue is a
5 problem actually across all medications. Not
6 just psychiatric medications. It's about a 50
7 percent compliance rate. So if we don't actually
8 know how we're measuring it, or feel confident in
9 that, then that's just an enormous black hole and
10 I'm not sure we should go into that hole, but I
11 think the other two are pretty essential.

12 VICE CHAIR HANSEN: So do I hear a
13 recommendation of -- at least at this point
14 adopting two? But also, we've identified a major
15 missing one on that is major depressive disorder,
16 which would be a recommendation for something
17 else entirely.

18 But, given this particular item right
19 now, --

20 MS. STUART: No, this is major
21 depressive disorder.

22 VICE CHAIR HANSEN: Okay. All right.

1 MS. STUART: Yes. 0104.

2 VICE CHAIR HANSEN: Okay. Meaning
3 both, right. So this captures the major
4 depressive disorder, but through the suicide
5 assessment. Okay. So that would be for both to
6 be considered. Okay.

7 So, --

8 MS. LASH: We need to take bipolar ---
9 - we need to take one of them at a time.

10 VICE CHAIR HANSEN: Yes. One of them
11 at a time, right. Yes.

12 So the first one then is I heard a
13 more central tendency towards accepting 0111 for
14 a replacement of the original NQF -- measure that
15 is now no longer in place. So, let me ask for a
16 vote -- no, please?

17 MS. LASH: No. So, I'm sorry. I
18 think it might work a little bit better if we
19 sort of took these in order.

20 So first, do we want to keep or remove
21 measure 0111, which has lost endorsement? And
22 then, do we want to add the two -- either, or

1 zero, or some combination of the two alternative
2 measures, which are 1880 and 0104.

3 So first, a show of hands for everyone
4 that would like to retain measure 0111 Bipolar
5 Disorder: Appraisal for risk of suicide, despite
6 lack of endorsement.

7 That's five. That is not consensus.
8 So the measure would be removed from the family.

9 The next vote would be on 1880,
10 Adherence to Mood Stabilizers. A show of hands
11 to who would like to add this measure to the
12 family?

13 Just one? So that's not consensus.
14 We will not add 1880.

15 A show of hands, who would like to add
16 0104 Major Depressive Disorder: Suicide Risk?

17 Fourteen. And that will be added.
18 Great.

19 VICE CHAIR HANSEN: Okay Megan.

20 MS. ANDERSON: So at this point, I
21 might recommend that we take a short break. And
22 I would like to remind the group that we have two

1 groups of measures to add to the family -- to
2 consider for addition to the family and we have
3 21 of those measures.

4 And so we've got two hours upcoming
5 and so we might want to stretch our legs and get
6 some caffeine since we've got through two
7 measures so far and we need 21 additional
8 measures to consider.

9 VICE CHAIR HANSEN: Right. We did two
10 measures in 50 minutes. So let's take a ten
11 minute break and we'll start right on the button
12 at 2:30.

13 (Whereupon, the above-entitled matter
14 went off the record at 2:18 p.m. and resumed at
15 2:35 p.m.)

16 MS. LASH: All right, Megan, you are on
17 deck. Go ahead.

18 MS. ANDERSON: Great. We are on slide
19 65, and I want to just provide a brief overview
20 of the newly-endorsed measures that have come
21 through the NQF portfolio.

22 Several measures have been endorsed

1 in when the group that last spring, and staff
2 have reviewed those newly-available measures and
3 have identified 21 for your consideration.

4 The measures that we are presenting
5 address priority gaps and population needs,
6 specifically, and the two gaps -- the three gaps
7 that are listed.

8 The question that will be posed to the
9 group at different sessions is, would the work
10 group like to add any new measures to the family?
11 So, we are going to keep moving right along on to
12 Slide 66, and we wanted to let you know that
13 there were some measures that didn't get brought
14 forth to the group for specific reasons.

15 So, seven measures were up in the
16 project that endorsed measures, and six of those
17 seven were for dental care for children, so we
18 did not think they were appropriate for this
19 population and for your consideration for
20 inclusion in the family.

21 Measure No. 2372, Breast Cancer
22 Screening, is a measure that we have retained in

1 the family of measures, but it was retired by the
2 steward because the specifications were out of
3 date and not maintained with NQF endorsement. It
4 has been resubmitted for endorsement, and has
5 been fully endorsed since the work group last
6 met. So, this measure is up to date with United
7 States Preventative Services Task Force
8 guidelines for breast cancer screening.

9 The cardiovascular condition measures
10 were found to be too condition specific, and were
11 -- none of them will be brought for your
12 consideration today.

13 There were also four clinical care
14 measures that were also heavily clinical and did
15 not target the priority gap area. Those was one
16 patient safety measure that was limited to
17 children are not appropriate for the population.

18 But those are the easy things to get
19 through, but now we get to going through the
20 measures that we would like you to consider for
21 inclusion into the family. We are going to take
22 those by topic area, and I'm going to start with

1 the care coordination measure that was NQF
2 endorsed, and it is for your vote to include it
3 in the family.

4 Breast care coordination measure is a
5 medication reconciliation. A number of
6 unintentional medication discrepancies per
7 patient. There's two components of this measure
8 that identify errors in the admission and
9 discharge records, and those are due to the
10 problems with the medication reconciliation
11 process. The idea is to really target the actual
12 quality of the medication reconciliation process
13 itself.

14 There are six other measures in the
15 family that are related to medication
16 reconciliation, documentation, management and
17 review. We would not recommend that this measure
18 replace any of the current measures in the
19 family, but we would ask the workgroup to vote as
20 to whether or not they would like to include this
21 newly and diverse measure of medication
22 reconciliation, the number of unintentional

1 medication discrepancies per patient, into the
2 family of measures.

3 More measure details are available in
4 the specifications that were included as an
5 attachment to your meeting materials. Any
6 workgroup discussion.

7 CHAIR LIND: Okay. So, any specific
8 questions about this one measure before we take a
9 vote on including or not including? What else do
10 you need to know or would you like to say about
11 this measure?

12 Ed, do you have a comment or you are
13 just --

14 Do people feel like you understand
15 this measure enough to vote on it right now? No,
16 there's like a nod, and a shake, and a -- Joan,
17 do you have a specific question?

18 MS. ZLOTNIK: I guess my specific
19 question -- maybe I should be able to figure this
20 out for myself -- if there are six other measures
21 is there something that this measure is adding
22 that would make it something we should support,

1 or is it, actually, just another nuance of these
2 other measures?

3 MS. ANDERSON: This measure targets,
4 uniquely, the medication reconciliation process.
5 There are other measures of review and
6 reconciliation in the family, but it's a
7 different target of the measure, and it would be
8 something that would be unique to the family, but
9 it would be an addition.

10 MS. LASH: Additionally, this is within
11 a hospital stay, so it's quite time limited, but
12 a -- potentially, risky time for a medication-
13 related event, as opposed to the other
14 reconciliation measures which tend to be
15 ambulatory focused, those kind of annual checkup
16 of polypharmacy, or after you are out of the
17 hospital are your medications reconciled once
18 more.

19 So, it's a different flavor of
20 something we have other measures for.

21 CHAIR LIND: Steve?

22 DR. COUNSELL: Yes, I just wanted to

1 say this is a big deal for the population we are
2 talking about, and I think the one we have, 0419,
3 is documentation of current medications, it's one
4 thing to document within another. And so, if we
5 have an NQF endorsed measure that's really
6 looking at the detail of this, and limited to the
7 hospital, which also eases up on the burden of,
8 you know, a measurement, I think is a good one.

9 Thanks.

10 CHAIR LIND: Thanks.

11 George?

12 DR. ANDREWS: Just for clarity again,
13 is this measure just looking at the point of
14 admission and point of discharge, or is it
15 looking at the entire stay, in terms of any
16 medication errors?

17 MS. ANDERSON: There are two points of
18 data collection, and it's really at the point of
19 admission and the point of discharge are the two
20 points. And so, it would not be able to be
21 looking at a daily medication reconciliation or
22 any other interim time frame.

1 CHAIR LIND: Anne, did you have
2 something?

3 MS. COHEN: So, there is existing
4 measure, it says that there are six of them that
5 sort of -- in this family, but there is one
6 specific -- 0097, Medication Reconciliation,
7 presenting patients 18 or older discharged from
8 any in-patient facility, hospital, you know, et
9 cetera, and seen within 30 days of discharge in
10 the office by a physician, prescribing
11 practitioner, registered nurse, pharmacist, to a
12 reconciliation of the discharge medication within
13 the current medication rules.

14 So, how is that different than this
15 one?

16 MS. DAY: One is more for the hospital
17 admission period, and the other one is more in
18 the out-patient setting.

19 MS. COHEN: Okay.

20 CHAIR LIND: Okay, so are we good? No,
21 Gwen, one last question?

22 DR. BUHR: Can we replace this one with

1 another one, or we can only just add this one?
2 Like that one that Steve was referring to,
3 documentation of current medicines in the medical
4 record, would seem redundant if you have this
5 one, where you are going to document it twice and
6 reconcile it.

7 MS. ANDERSON: That is an option.

8 MS. POTTER: I noticed that there are
9 six points of transfer, generally, within a
10 hospital stay, where medications get recorded.
11 There's those in the lab. There's those in the
12 ER. There's those in admission, those at
13 discharge. And when you think about the
14 behavioral health population you are probably
15 titrating medications, so over the
16 hospitalization the medication could actually
17 change.

18 So I agree that it is difficult and
19 it's important to this population, but I would
20 argue it's more important that we get their
21 medications upon discharge to line up with what
22 they are taking after they leave the hospital.

1 MS. ANDERSON: Just a point of
2 clarification. I think that the measure 2456
3 looks at the medication reconciliation upon
4 admission, but then also looks at medication
5 reconciliation upon discharge, including the
6 medications that have been given and have orders
7 for after discharge.

8 So, I --

9 MS. POTTER: But, it doesn't include
10 the medications that the person was taking that
11 have absolutely nothing to do with their
12 hospitalization. The one that she just read. I
13 mean, if all you have is what happened in the
14 hospital, you don't necessarily have the other
15 medications that the person is taking.

16 I mean, people don't always report all
17 of their medications when they come to the
18 hospital. Then they go home and they go, well,
19 it's not on my discharge record, maybe I should
20 or I shouldn't take this.

21 CHAIR LIND: Hence the need for the
22 other complimentary measure.

1 So, okay, I'm going to call the
2 question on this one. So, the question is, should
3 we vote to include this newly-endorsed measure
4 2456? Raise your hand if you would like to
5 include it?

6 One, two, three, four, five, six,
7 seven, eight, nine. Good, all right, that's
8 enough. We are going to include that one.

9 Thanks you very much.

10 Okay, then, Megan, you are going to go
11 on to the next batch, and our goal for this batch
12 is to get through the whole batch and have a vote
13 in 20 minutes. Go.

14 MS. ANDERSON: Going.

15 There are 11 behavioral health
16 measures to consider. We've broken them up by
17 three -- four different topics. We'll consider
18 the first measure that's in emergency departments
19 and follow-up, and then we'll move on to the
20 second, third and fourth topics, which are blood
21 pressure control for people with SMI, screening
22 and follow-up for people with a serious mental

1 illness, and diabetes care. So, slide 70,
2 please.

3 So, these measures have been CSAC
4 approved, they are pending for endorsement for
5 support.

6 The first measure we'd like to
7 consider is 2605, follow-up after discharge from
8 an emergency department for a mental health or
9 alcohol or other drug dependence. This measure
10 has four different components, and it has
11 components for mental health separately from
12 alcohol and drug dependence, but it also has a
13 seven-day and 30-day follow-up after discharge.

14 The measure is newly-endorsed and
15 addresses the areas of care coordination and
16 psychosocial needs.

17 So, the question to the group would be
18 whether or not we'd like to see this measure
19 included in the family for use in the dual
20 beneficiary population.

21 CHAIR LIND: Okay, thanks.

22 Any questions or comments?

1 I would say from our perspective in
2 Washington, this solves some problems of the
3 other follow-up after hospitalization for mental
4 illness, because of having the different time
5 periods, and adding in different conditions. So,
6 I think the mental health folks in Washington
7 refer this one over some of the other ones we've
8 had to work with. Shawn.

9 MR. TERRELL: There are important
10 measures, obviously. I think it's worth being
11 reminded that. This is like a really good
12 example, actually, of the question of what's
13 important to a person, what's important for them.
14 A lot of these conditions are significantly, you
15 know, caused by some of the neuroleptic
16 medications that they have to take.

17 So, there's the sort of balancing
18 question that comes up here right out of the
19 gate, and that might be interesting, you know,
20 this is one of these situations where it might be
21 really important to look at these if we endorse
22 these, accept these measures and use them, to

1 also look at other areas of mental health
2 recovery, and adherence to medication and other
3 factors that, you know, you say to people, okay,
4 we've got to get your blood pressure under
5 control, but I've got high blood pressure because
6 of taking this particular medication that's
7 helping my mental health side.

8 And, it's also important to really --
9 this is a really -- this is the reason why I
10 share decision-making, frankly, in developing
11 mental health, and there's a whole area there to
12 look at.

13 So, just a comment.

14 VICE CHAIR HANSEN: D.E.B.

15 MS. POTTER: This measure is specific
16 to a primary diagnosis of mental health. So, if
17 a person went to the ER because of their blood
18 pressure, but they also had mental health, they
19 wouldn't count in the measure.

20 So, they went to the ER with a primary
21 diagnosis of mental health and/or substance
22 abuse.

1 VICE CHAIR HANSEN: Vanesa?

2 MS. DAY: Just curious about the
3 collection. Is there a consistent tool that
4 would be used to indicate like what the follow-up
5 is, or how we define follow-up?

6 MS. ANDERSON: There's administrative
7 claims, and electronic medical record, and paper
8 medical records. I don't have any further
9 details about follow-up.

10 CHAIR LIND: If it's like HEDIS, almost
11 any kind of provider would count, and that's one
12 thing the mental health folks have a little bit
13 of an issue with in Washington, is that a follow-
14 up visit with any provider is, literally, a
15 follow-up visit with any provider. So, you can
16 be, you know, you could go to your PHP who may or
17 may not know anything about your drug
18 dependence.

19 MS. POTTER: The actual HEDIS measures
20 with a mental provider, I think, I can't remember
21 -- I actually oversaw this project, so I'll be
22 perfectly frank. The document that we submitted

1 to NQF was over 500 pages long, so you can
2 understand how I don't remember all the details.

3 But, we patterned it off of the HEDIS
4 follow-up after hospitalization, in the way that
5 we could, and tested it in the claims data. So,
6 when you actually look at the measure specs, it
7 goes through all of this.

8 MS. DAY: But, it's something that
9 could be selected through claims.

10 MS. POTTER: Well, it's a plan-based
11 measure.

12 CHAIR LIND: Encounter data.

13 MS. POTTER: Right, so it would be
14 encounter data.

15 MS. STUART: So, I think this is
16 important, because it really addresses the short
17 length of stay, the desire to move these patients
18 out before they are ready. And, it gives the
19 provider some defense against, you know, people
20 putting pressure on them to not give the length
21 of care that they need.

22 So, I think it's important.

1 CHAIR LIND: Okay. We are going to
2 take a vote on this one in that case, 2605, raise
3 your hand if you vote to include this one. We
4 have ten. Okay, so that one passes. Thank you.

5 Okay, Megan, you are on for the next
6 one.

7 MS. ANDERSON: Okay, on slide 71 we
8 have 2602, controlling high blood pressure for
9 people with serious mental illness. This is a
10 measure for pressure control, and it's a
11 harmonized specification with NQF 0018, which is
12 controlling high blood pressure in the more
13 general population. That's a provider level
14 measure, this measure is --

15 (Telephonic Interference)

16 MS. ANDERSON: The denominator has
17 been simply adapted for people with serious
18 mental illness. The measure uses specifications
19 with current guidelines, and is reference to
20 mental health disparities.

21 So, my question to the group is, by
22 controlling high blood pressure for people with

1 serious mental illness, and it would be a
2 compliment to the measure currently in the
3 family, but addresses, particularly, high blood
4 pressure for the general population.

5 CHAIR LIND: Thank you. Any questions
6 or comments?

7 Shawn?

8 MR. TERRELL: Yes, a clarification. My
9 earlier comments were referring -- so, that's why
10 I was confused by it. I was looking ahead, so
11 I'm sorry.

12 I meant -- on the blood pressure and
13 on the diabetes care, where --

14 CHAIR LIND: I kind of wondered if you
15 were a little ahead.

16 MR. TERRELL: -- yes, so I should look
17 at that and not at my paper. Sorry.

18 CHAIR LIND: So, you were liking this
19 one.

20 MR. TERRELL: Yes, that one is fine.

21 CHAIR LIND: You're good.

22 MR. TERRELL: It's the blood pressure

1 -- it's the question that -- it's implicated in a
2 lot of these, that we are also trying to treat it
3 back at, which creates, you know, a tension
4 around, you know, what should people do. That's
5 all.

6 CHAIR LIND: George?

7 DR. ANDREWS: My question was, again,
8 similar to that. I mean this obviously requires
9 use of a general practitioner, family physician.
10 And yet the follow-up or the previous measure
11 which we all agreed to do, D.E.B., were you
12 saying that that specifically, as the measure was
13 written and we approved it, states that a mental
14 health provider will be seeing the patient in
15 follow-up within seven days or 30 days?

16 Because again, the idea here is that
17 if the patient is discharged, and can't get in to
18 see their behaviorist or whatever, they're still
19 able to see a primary care physician, who not
20 only is going to do that follow-up, but also
21 address whether it be diabetes or other disease.

22 CHAIR LIND: So, he was going forward

1 and you are going backwards. Do you know the
2 very specific answer to that question? And, if
3 not --

4 MS. POTTER: If I was sitting at my
5 desk, I would know the answer, but I can't answer
6 it now.

7 CHAIR LIND: Okay.

8 MS. POTTER: It's, actually, in the
9 measure spec.

10 CHAIR LIND: Sarah, if somebody could
11 research that, we'll keep on going.

12 MS. POTTER: I think it's follow-up
13 with any kind of provider, the idea being that
14 the measure, the first measure, the ER measure,
15 was treat and release. Therefore, they are not
16 as serious as those who were admitted, and
17 therefore they could receive follow-up care from
18 their primary care doctor. Whereas, those who
19 were admitted to the hospital, the thinking being
20 that they are more serious and they need a mental
21 health provider for follow-up.

22 DR. ANDREWS: Well, that makes me feel

1 much better, because that at least ties better
2 with it.

3 CHAIR LIND: Steve, did you have a
4 question on the blood pressure?

5 DR. COUNSELL: Yes. I think we might
6 be able to, at least in my own mind, cut through
7 several of these pretty quickly. There's a
8 general theme with the diabetes and the blood
9 pressure and such, that the reason to pull these
10 out -- because these are already measures in the
11 general population -- but these are now specific,
12 just changing the denominator to people with
13 serious mental illness, which is a common group
14 in the duals.

15 MS. ANDERSON: Right.

16 DR. COUNSELL: And so this will help
17 bring out, I guess, or identify the needs, and
18 the care, and disparity, potentially, of these
19 conditions in that population. Is that right?

20 MS. POTTER: In the measures that were
21 tested, there were disparities between the SMI
22 population and the general Medicaid population

1 for all these measures.

2 DR. COUNSELL: What we need is all
3 these measures then with a denominator of dual
4 eligible.

5 CHAIR LIND: Clarke?

6 MR. ROSS: These do appear as a
7 duplication, but we have a history of mental
8 illness of people being admitted, and only
9 psychiatrists treat the mental illness. But even
10 though they are in a general hospital, they are
11 discharged, and none of this other stuff happens.

12 So, ideally, we shouldn't need this,
13 but experience tells us, because of the attitudes
14 and practice patterns, we need all this.

15 MS. ANDERSON: This is a health plan
16 measure that is for ambulatory care and out-
17 patient behavioral health care, not for in-
18 patient care.

19 CHAIR LIND: I'm sorry, say that again.

20 MS. ANDERSON: 2602, controlling high
21 blood pressure for people with SMI, is an
22 ambulatory care and behavioral health out-patient

1 care measure. It's not for in-patient.

2 CHAIR LIND: Okay, thank you.

3 All right. We are going to take a
4 vote on 2602, vote to include, raise your hand if
5 you'd like to include this measure. Eleven, yes.
6 Okay, sounds good. We are going to include it.

7 And, Megan, you are on for the next
8 one.

9 MS. ANDERSON: Okay. We are going to
10 take the next three together, as Steve was
11 referencing, these measures really do relate to
12 each other and are consistent.

13 So we have 2599, 2600 and 2601. These
14 are three health plan measures that have been
15 adapted similarly for the provider level measure
16 for use in the general population, to address the
17 needs of the serious mental illness population.
18 The measure specifications are harmonized. The
19 numerators are consistent. The denominators are
20 adapted.

21 The family measure includes the
22 provider level measures. These are not as risk

1 adjusted and they are only for out-patient care.

2 So, the question, after I go through
3 each of them, will be to go to ask whether or not
4 these three should be included in the family.

5 So, slide 73, please.

6 Measure 2599, alcohol screening and
7 follow-up for people with serious mental illness,
8 and people who are screened for unhealthy alcohol
9 use and received brief counseling or other
10 follow-up, and are identified as unhealthy
11 alcohol user. It's adopted from 2152, the
12 preventive care and screening measure. And it's
13 been tested in the Medicare and Medicaid
14 population.

15 Slide 74. Measure 2600, tobacco use,
16 screening and follow-up for people with SMI or
17 other alcohol and other drug dependence. This
18 measure has two rates that are reported, and it's
19 a health care measure that has been adapted from
20 the general provider level measure. Similar to
21 the original measure, it is a measure of both the
22 screening and then also the follow-up.

1 Then slide 75. 2601, body mass index,
2 screening and follow-up for people with SMI, and
3 people who have received the PMI, and screening
4 and follow-up for those who are obese, harmonized
5 with a measure that's currently in the family,
6 421, and it addresses their health disparities
7 and is an accepted Medicaid plan for SNPs and D-
8 SNPs.

9 And so, slide 76 brings us back to the
10 question of bringing to a vote to include these
11 three measures in the family, pending their full
12 endorsement and Board ratification.

13 CHAIR LIND: So, I think we would
14 probably love these measures. Should we try
15 taking a vote without discussion and see if we
16 already have consensus? Let's try it.

17 If you support including 2599, 2600
18 and 2601, raise your hand. Okay, sold. So, we
19 have that set of three.

20 And, I'm sorry, Megan, we are not
21 hardly giving you any chance to take your sips of
22 tea in between, and we are ready to move to the

1 next set.

2 MS. ANDERSON: I'm ready to go.

3 So, this set of measures for diabetes
4 care is slightly different. It has commonalities
5 with some of the things that we've heard already,
6 the six health care measures that have been
7 adapted as the others have from the provider
8 level measure 3, use in the general population.
9 They are again harmonized to reduce the overall
10 data collection burden, and the numerators and
11 denominators are consistent, but adapted.

12 These are outcome measures, and they
13 are not risk adjusted or stratified. They are
14 only out-patient or behavioral health out-patient
15 measures.

16 The family, however, does not
17 currently include any of the six original
18 measures that are provider-level specified. So,
19 though all of these new measures have been
20 adapted from those provider-level measures, the
21 work group has previously not selected those six
22 measures to include in the family.

1 Instead, the work group has chosen to
2 include 729, comfortable diabetes care, which is
3 a composite, and it's also included 1932,
4 diabetes screening for people with schizophrenia,
5 bipolar disorder, who are using antipsychotics.
6 So, I'm going to go briefly through the six
7 measures again, but please keep in mind that
8 though these measures have been adapted --
9 currently in NQF endorsed measures, we have not
10 included those six original measures.

11 There's a measure of diabetes care for
12 people with SMI, which is hemoglobin screening
13 A1c for people with Type 1 and Type 2 diabetes,
14 and it is based on the comprehensive diabetes
15 care hemoglobin A1c testing, and has been adopted
16 and uses current guidelines. It does address
17 current known disparities.

18 Next. Then we have a measure 2604,
19 diabetes care with people -- for people with
20 serious mental illness, attention for
21 nephropathy. So, this again is for people with
22 Type 2 -- Type 1 and Type 2 diabetes. It's

1 screening, and then have evidenced that they
2 needed additional attention to their condition.

3 It's been harmonized from the
4 currently endorsed measure of 0062, comprehensive
5 diabetes care for medical attention to
6 nephropathy.

7 So, this has been tested in D-SNPs
8 Medicare plan for people who are disabled --
9 excuse me, Medicaid plans for disabled adults, as
10 well as Medicaid plans for non-disabled adults.

11 Next slide. So we also have 2606,
12 which is blood pressure control, as is another
13 measure, and similar to the one we already saw as
14 blood pressure control, however, it is limited
15 for people with serious mental illness and
16 diabetes. So, this measure is a blood pressure
17 reading that is greater than 140/90 -- excuse me,
18 less than 140/90, which is the target, and then
19 it is similarly based off of the comprehensive
20 diabetes care measure and blood pressure control.

21 Next slide. 2607 is diabetes care for
22 people with serious mental illness and hemoglobin

1 A1c poor controlled. So, this measure applies to
2 people who had a recent reading that is greater
3 than nine percent of hemoglobin A1c. It's
4 similar to NQF endorsed version 0059. It's also
5 adopted in D-SNPs and Medicaid plans for disabled
6 adults and Medicaid plans for non-disabled
7 adults.

8 Next slide. And then, we also have a
9 hemoglobin A1c that is controlled, which is 8.0
10 percent, and this measure is almost exactly the
11 same, but it's not poor controlled, it is
12 controlled. It addresses mental health
13 disparities, and is accepted in the populations
14 of interest, D-SNPs, Medicaid plans for disabled
15 and non-disabled adults.

16 Next. And then we have the eye exam
17 measure that is people again with diabetes and
18 serious mental illness, who have had an eye exam
19 during the measurement year. So, this is
20 complimentary to 0055, and it has been tested in
21 the same populations and addresses health
22 disparities.

1 Next slide. We get to vote on
2 including these measures in the family, and if we
3 would like to include these measures would we
4 like to replace any of the current measures in
5 the family.

6 Just to remind you, we have
7 comprehensive diabetes care in the composite,
8 0729, in the family right now.

9 CHAIR LIND: 0729 is for the general
10 population not for the population of people with
11 serious mental illness.

12 MS. ANDERSON: That's correct. I'll
13 read off the description briefly.

14 The percentage of adults with diabetes
15 who have managed and modifiable risk factors,
16 including hemoglobin A1c, LDL, blood pressure,
17 tobacco non-use, and daily aspirin used for
18 patients who has diagnosis of ischemic vascular
19 disease, with the intent of preventing or
20 reducing future complications associated with
21 poorly managed care. It is limited to adults 18
22 to 75 years old, with a diabetes diagnosis, who

1 meet denominator targets, and A1c is in control
2 at 8.0 percent, LDL is less than 1 percent, blood
3 pressure is less than 140/90, tobacco non-user,
4 and patients with diagnosed ischemic vascular
5 disease, daily aspirin use, and contraindicated.

6 That measure is an ambulatory care
7 measure. It is the clinician level of analysis,
8 whereas, the measures that we have considered and
9 I just described are health plan measures,
10 however, they are also ambulatory care measures
11 only, but they also include behavioral health
12 care.

13 CHAIR LIND: Gail?

14 MS. STUART: So, this is a serious
15 problem for this patient population, and I think
16 it addresses it. It also addresses health
17 disparities that are, again, significant. So, I
18 propose that we endorse them.

19 CHAIR LIND: Anne?

20 MS. COHEN: I guess this is just a
21 harmonization question. Are these currently
22 required to be collected of any mental health

1 programs now?

2 MS. LASH: On the mental health side.

3 MS. COHEN: I mean, there's not a map
4 that focuses on mental health, so I can't really
5 answer that.

6 MS. ANDERSON: This is part of the
7 behavioral project, so they were considered in
8 the NQF endorsement piece, but, no, there is no
9 measure application partnership --

10 MS. POTTER: The measures were also
11 presented last September to the MAP Medicaid Task
12 Force, and they encourage further development.
13 And, they recommended that they come back for the
14 MAP Task Force after endorsement. But, I can't
15 speak for that task force.

16 VICE CHAIR HANSEN: This is very
17 relative to what Gail has said. I know the
18 health disparities is addressed, that was in the
19 previous set that we approved.

20 Could you just talk a little bit about
21 what that background is, when it says that is
22 addressed?

1 MS. STUART: My understanding is that
2 this problem exists largely in an African
3 American and minority population. So by
4 accounting for these assessments, you are really
5 going to impact the health of a minority
6 population. So, that would be the take in there.

7 CHAIR LIND: All right. We are going
8 to try voting on all six together, and if that
9 fails we'll go back and see if there's any that
10 we would want to put forward individually.

11 So, let's start off by voting as a
12 package on 2603, '4, '6, '7, '8 and '9
13 altogether. Let's have a show of hands if you
14 vote to include. One, two, three, four, five,
15 six, seven, eight, nine, ten 11, good. All
16 right. Wonderful. So, we are including those,
17 and, Megan, you are up for the next group.

18 MS. ANDERSON: Okay. We are going to
19 switch gears here a little, and we are going to
20 go to a behavioral health measure that's been
21 approved for trial use. It's been supported by
22 the CSAC, but has yet to be ratified by the

1 Board. It is the last remaining behavioral
2 health measure to discuss.

3 So, it's substance use screening and
4 infringement composite. There are three
5 components of this composite. It's for people 18
6 years old, who have used tobacco within 24
7 months, have unhealthy alcohol use, non-
8 prescription drug use, and illicit drug use, and
9 have received an intervention for a screening
10 result.

11 So, there are two components of this
12 measure that have been NQF endorsed, tobacco use
13 screening, cessation and intervention, and you
14 might recall seeing a similar measure to that
15 recently.

16 And then also 2152, unhealthy alcohol
17 use, screening and brief counseling. There's
18 also a drug component that has a few different
19 elements, and it's a percentage of 18 years --
20 patients who are 18 years or older who have
21 screened within the last 24 months for the
22 tobacco use, alcohol use, non-medical

1 prescription use, and illicit drug use, and have
2 received composite intervention.

3 So, the four components, two of which
4 are NQF endorsed, just to let you know, the NQF
5 does not require all the components to be
6 endorsed for the composite to be endorsed.

7 They have been recommended for further
8 testing and resubmission after three years
9 reliability and validation. And the measure
10 instructor -- the measure steward has instructed
11 not to have this measure be used in
12 accountability applications until that time.

13 So, we'd like you to consider whether
14 or not you'd like to include this measure, and
15 for substance abuse screening and intervention
16 composite.

17 CHAIR LIND: Okay. Any questions or
18 comments on this one?

19 DR. BURSTIN: One quick clarification,
20 Helen Burstin.

21 So, this measure is a new term we have
22 called measures approved for trial use. It's

1 specifically for e-measures, so new electronic
2 health records, base measures, that do not yet
3 have EHRs ready to support their testing. So, it
4 is not actually pending endorsement, it's only
5 pending approval for trial use, just a
6 clarification.

7 I will also point out it was not
8 without controversy, because there was a fair
9 amount of discussion about the evidence base for
10 some of the specific interventions listed under
11 the overall measure, but it has gone through all
12 the process, but it was heavily discussed with
13 the clinical workgroup of the MAP as well.

14 CHAIR LIND: Okay. Other questions or
15 comments of this one?

16 All right. Vote to include if you
17 support including this measure, which is approved
18 for trial use. Show of hands for yes, vote to
19 include. Okay, so that one got nine votes,
20 Megan, so we are going to go ahead and include
21 it.

22 Anne reminded me that there was a

1 second question back on the last package, if
2 there's any that we would want to trim on the
3 list of diabetes care measures. But I said to
4 Sarah here off line that, perhaps, when we get
5 done with all the inclusions, go back to the do
6 we want to trim the measure was the question.
7 When we're all done with adding in work.

8 So, Megan, I think we are ready to go,
9 you still have some left, right?

10 MS. ANDERSON: Yes, we have 13
11 admission and re-admission measures that have
12 been recently endorsed by NQF.

13 There were five that were found to be
14 too narrow or not appropriate for the population,
15 so we have not listed them for your
16 consideration.

17 We have provided six of these
18 measures, and so the question to the group is,
19 really, whether or not we want to include this
20 staff picks. And, if not, then what measures
21 would you want to include, if any at all. So,
22 I'm going to go quickly through the measures.

1 Slide 87. We have two measures
2 currently missing with admission and re-
3 admission. That is all planned -- planned all-
4 cause re-admissions, and hospital-wide all cause
5 unplanned re-admission.

6 Next slide. So, the first measure to
7 consider is measure 2375, and this is an all-
8 cause, risk adjusted re-hospitalization measure.
9 It's for people who entered skill nursing
10 facilities from acute care facilities, and were
11 hospitalized again within 30 days. All payers
12 are included in this measure. It's based on MDS
13 admission assessment data, which is also an
14 electronic clinical data source.

15 However, it does not distinguish
16 between planned and unplanned re-admission. It
17 does compete with 2510, which we'll review later,
18 but the measures are identified that it should
19 not be harmonized because they were distinct.

20 Next slide. 2510 is a skilled nursing
21 facility 30-day all-cause re-admission measure.
22 This is over a standardized rate of all-cause,

1 unplanned hospital re-admissions and which --
2 highlighting the variation from the previous
3 measure. It's limited to Medicare fee-for-
4 service, and it includes re-admissions from
5 hospital discharges, with general acute care
6 hospitals, but also critical access hospitals and
7 psychiatric hospitals.

8 Next slide. The re-hospitalization
9 during the first 30 days, then home health, 2380,
10 is a staff pick. It addresses home health re-
11 admissions from an acute in-patient
12 hospitalization within five days before the start
13 of the home health stay, and where acute -- were
14 admitted to the acute care hospital during the 30
15 days following the start of the home health stay.

16 MS. ANDERSON: It addresses home
17 health readmissions from an acute inpatient
18 hospitalization within five days before the start
19 of the home health stay and who were admitted to
20 the acute care hospital during 30 days following
21 the start of the home health stay.

22 It does have some relevant exclusions.

1 I think we -- I'd like to go back one slide.

2 Thank you.

3 It addresses, I guess, in home health
4 care -- home health care, it has planned public
5 reporting for Home Health Compare, and then it
6 has a complement measure that's intended to be
7 used with 2505. Next slide?

8 2505, also a staff pick. The
9 Emergency Department Use Without Hospitalization
10 Readmission During the First 30 Days of Home
11 Health. It's the general releasing principle of
12 home health stays for patients who have had an
13 acute hospitalization in five days before the
14 start of the home health stay, and then used the
15 emergency department but were not admitted to an
16 acute care hospital within 30 days following the
17 home health stay.

18 It similarly addresses home health --
19 is going to be planned to be used for Home Health
20 Compare public reporting. Next slide.

21 2502 is All Cause Unplanned
22 Readmission. The measure is for 30 days post

1 discharge at the inpatient rehab facilities.
2 This includes a hospital or a long-term care
3 hospital and has a population -- a general focus
4 on the inpatient rehab facilities. It's Medicare
5 fee-for-service beneficiaries only, and it's
6 based on 24 months' worth of inpatient rehab
7 facility discharges, to both acute levels or to
8 the community.

9 Its planned use is inpatient
10 rehabilitation facility public reporting, which
11 I'll draw the distinction from Compare, it's a
12 public -- it's a reporting program, not a Compare
13 program. Next slide.

14 The next two slides are relatively
15 similar. There is a 2503, Hospitalization for
16 1000 Medicare Fee-For-Service Beneficiaries.
17 This is the number of discharges from an acute
18 care hospital including an IPPS or a Critical
19 Access Hospital per 1000 fee-for-service
20 beneficiaries at the state and community level,
21 and it's also reported by quarter and by year, so
22 this is a measure that addresses a gap in

1 community-level measurement, and it can be
2 reported at the state and the community in
3 general.

4 There are no risk adjustments.
5 There's no risk adjustment for SES or SDS, but
6 there is seasonal risk adjustment.

7 It's intended for communities to
8 compare themselves to like communities, and
9 there's a question against comparing against
10 communities that are not like the others.

11 20 -- the next slide is 2504, which is
12 a similar measure, which is Rehospitalization
13 Per 1000 Medicare Fee-For-Service Beneficiaries,
14 and it similarly addresses a gap in community
15 measurement, with the same seasonal risk
16 adjustment and comparison for communities against
17 other like communities. Next slide.

18 There is 2496, which is Standardized
19 Readmission Ratio for Dialysis Facilities. It
20 measures unplanned readmissions to acute care
21 hospitals within 30 days of discharge for
22 Medicare-covered dialysis patients treated at a

1 particular dialysis facility, and it only -- it
2 has a rate compared to the expected given
3 discharge from hospitals, and it includes the
4 patient characteristics.

5 It also is important to draw attention
6 to the fact that a lot of people who are on
7 dialysis are in -- are dual beneficiaries.
8 However, only a small number of dual
9 beneficiaries are on dialysis or have end stage
10 renal disease, so there are other ESRD programs
11 as well that this measure might be included in at
12 some point. Next slide.

13 So staff have culled out three
14 measures that we'd like you to consider as
15 staff's picks to be added to the family. We
16 would like to take a vote on whether the group
17 would like to add those staff picks, and then if
18 not, then we would consider other measures for
19 inclusion in the family, and just to remind you,
20 the staff picks are 2380, Rehospitalization
21 During the First 30 Days of Home Health; 2505,
22 Emergency Department Use Without Hospital

1 Readmission During the First 30 Days of Home
2 Health; and also a staff pick for inpatient rehab
3 facilities, All Cause Unplanned Readmission
4 Measure for 30 Days Post Discharge from Inpatient
5 Rehab Facilities.

6 CHAIR LIND: All right, thanks very
7 much, and we're going to let you save your voice
8 and make Sarah and Helen answer questions for you
9 for a minute while we gather up people's input,
10 so Kata, do you want to go first?

11 MS. KERTESZ: Thanks. I just have two
12 clarification questions. The first one, on the
13 first slide, you mentioned that there was risk
14 adjustment. Was that seasonal risk adjustment or
15 was that for some other factors like SES or
16 something else?

17 And then my second question --

18 MS. POTTER: Could you speak louder?

19 MS. KERTESZ: Yes, did you hear my
20 first question? My first question was whether
21 the risk adjustment in the first slide was for
22 seasonal factors, or was it for something else

1 like SES?

2 And then my second question is all of
3 the readmissions are based on inpatient stays, is
4 that right? So if the patient is outpatient or
5 in observation status, that wouldn't be factored
6 into their readmission rate? Thanks.

7 CHAIR LIND: I would assume more than
8 likely Sarah or Helen, do you have a comment on
9 that?

10 MS. LASH: I am just not totally clear
11 which specific measure you're asking -- so --

12 MS. KERTESZ: The first measure in
13 this group --

14 MS. LASH: 2375 --

15 MS. KERTESZ: Yes --

16 MS. LASH: -- when it writes that --

17 MS. KERTESZ: -- it said that -- it
18 said that it was a risk adjustment, but it didn't
19 say what -- for what factors.

20 DR. BURSTIN: It is primarily adjusted
21 for clinical risk factors. I don't know that
22 there's any seasonality.

1 MS. KERTESZ: But it's not for
2 socioeconomic status or other --

3 MS. LASH: No --

4 DR. BURSTIN: No.

5 MS. LASH: -- not at this time.

6 DR. BURSTIN: Although it is one of
7 the measures that is endorsed with conditions, so
8 it will be entering the trial period for SES
9 adjustment in this coming year.

10 CHAIR LIND: And then the second
11 question was all of these readmission measures,
12 you have to have actually been admitted to the
13 hospital, you can't have just been held in a 24-
14 hour observation state --

15 DR. BURSTIN: Correct.

16 CHAIR LIND: -- or whatever.

17 DR. BURSTIN: Admission, true
18 admission.

19 CHAIR LIND: All right.

20 DR. BURSTIN: Yes.

21 CHAIR LIND: All right.

22 Okay, D.E.B.?

1 MS. POTTER: I just have a
2 clarification. So do we have any readmission
3 measures in the portfolio currently? That is the
4 part I didn't understand. That is why we're not
5 talking about nursing home readmission?

6 CHAIR LIND: Way back to slide 85, the
7 two that we have now are Planned All Cause
8 Readmission, 1768, and 1789, Hospital-Wide All
9 Cause Unplanned Readmission. So we do have two.

10 Shawn.

11 MR. TERRELL: Just -- so I have just
12 a scope question. Within home health, does that
13 include, I mean, or do you address scope at all
14 around, you know, personal assistants for ADLs?
15 Is that -- that is not part of the -- or you
16 don't address it?

17 CHAIR LIND: Would it be like home and
18 community based services kind of --

19 MR. TERRELL: Well, a lot of home
20 health agencies, you know, would go into the home
21 and help with ADLs as part of their service --

22 CHAIR LIND: Right.

1 MR. TERRELL: -- but that's not part
2 of this?

3 CHAIR LIND: This wouldn't be like
4 long-term supports and services --

5 MR. TERRELL: Okay.

6 CHAIR LIND: -- no.

7 MR. TERRELL: And then on the --

8 DR. COUNSELL: This would just be
9 skilled home healthcare under Medicare.

10 CHAIR LIND: Yes.

11 MR. TERRELL: Okay, thanks.

12 And then I don't understand quite --
13 just maybe a quick clarification on 2380, where
14 the exclusions of cancer and rehab care
15 particularly -- what, you know, why would they
16 exclude that if --

17 PARTICIPANT: Which slide is that?

18 MR. TERRELL: It's slide 88.

19 CHAIR LIND: Do you have any comments
20 about the exclusions and --

21 MR. TERRELL: I guess I understand --
22 maybe I can understand psychiatric, but I don't

1 know the other two, just curious. Is it facility
2 based?

3 DR. BURSTIN: My guess is they
4 probably just tried to exclude things they
5 thought would be more likely to have planned
6 readmissions, and cancer tends to be a planned
7 readmission for chemo or things along those
8 lines.

9 MR. TERRELL: Oh.

10 DR. BURSTIN: But I can kind of --

11 MR. TERRELL: Okay.

12 DR. BURSTIN: -- from that.

13 MS. POTTER: I think it's to align
14 with 1789.

15 CHAIR LIND: Jennie?

16 VICE CHAIR HANSEN: I am on page 93.
17 Thanks. I am on page 93, with these broader
18 admission, readmission measures, and I just
19 wondered, I know we have other readmission
20 measures that are kind of site-specific, and this
21 is more population-based comparison, so I
22 wondered if this is something we would be

1 interested to start that shift to looking at
2 population-based comparisons, so it's more of a
3 question for us in terms of our beginning shift.

4 MS. POTTER: Can I ask a clarifying
5 question?

6 We have IRFs in here for readmission,
7 but we don't have long-term care hospitals in
8 here. Was the thinking that those populations
9 didn't apply to the duals, or --

10 MS. LASH: We could consider that, if
11 you all think it's relevant, for -- as an
12 additional option.

13 MS. POTTER: You mean just scour for
14 measures in that area, or --

15 MS. LASH: Well, we know that there is
16 one within --

17 MS. POTTER: Okay.

18 MS. LASH: -- the same project that
19 endorsed the others. I am not sure how it fell
20 out of our list, but we can -- I think it would
21 be sort of along the same lines.

22 I think maybe to the group, there's

1 sort of a strategic question of you could select
2 all of these measures, you know, that are sort of
3 one setting to the other, some subset of them.
4 If you wanted to take the really inclusive route,
5 then we would probably want to put the long-term
6 care hospitals on the table with that additional
7 measure.

8 CHAIR LIND: Steve?

9 DR. COUNSELL: Yes, that was going to
10 be part of my question. It is hard for me to
11 sort of follow and group these. I would request
12 that we take them one at a time, just walk
13 through them, and it's hard for me to understand
14 why the staff have selected some and not the
15 others, and --

16 MS. LASH: I can give maybe a little
17 bit more insight on that.

18 The three we had pulled out, two
19 relate to home health, which is a very frequently
20 used service in this population, and we decided
21 against some of the others that are population-
22 based, the admissions per 1000, because they --

1 there was some provisions against using them for
2 comparisons, sort of meant for community to
3 compare oneself over time as opposed to more of
4 accountability measures.

5 The dialysis measure is an appeal, so
6 that one has been somewhat controversial. So we
7 came to a pretty grey area in choosing among
8 these, so I don't want to direct your thinking
9 too much with my commentary.

10 But we did try to prioritize among
11 them to some extent.

12 CHAIR LIND: Rich.

13 MR. BRINGEWATT: Yes, actually, I
14 don't mind you directing kind of what your
15 thinking is, in fact it's helpful to me.

16 My problem right now is, one is I
17 stepped out, and I apologize, I had not been part
18 of this last discussion, I just had to do what I
19 needed to do.

20 But in trying to be helpful here, it
21 is helpful to me if you share -- we picked these
22 three because, and we rejected these because, and

1 the fact is you guys have looked at these more
2 carefully than we possibly can look at them right
3 now, and so I -- I value your opinion in that
4 regard. It does weigh in terms of how I am going
5 to think about this.

6 MS. LASH: Megan, were there other
7 decision factors that you want to highlight that
8 I have forgotten to mention?

9 MS. ANDERSON: Yes. So I would say
10 that the staff didn't have a pick between the two
11 skilled nursing facility measures. There is a
12 measure, the Pro 30, it's quite different in the
13 method for data collection and whether or not
14 it's planned and unplanned from the 30 Days All
15 Cause Readmission measure for skilled nursing
16 facilities.

17 I don't have a staff pick on those
18 because I think that they are very different and
19 that I would recommend the Workgroup to weigh
20 them against each other. The skilled nursing
21 facility is an important preventative care for
22 this population.

1 Then, the -- if we want to look at
2 those two specifically, and then we could talk
3 more about the others separately? I heard Steve
4 say that he wanted to go through them more one by
5 one.

6 CHAIR LIND: Let's hear from Gwen and
7 George, and then we'll go back. Gwen?

8 DR. BUHR: Well, I was just going to
9 ask, and I think what she was just talking about,
10 the skilled nursing facility measures, why they
11 weren't included in the staff picks.

12 And I think she just said that because
13 they couldn't decide between the two, and that
14 they wanted us to decide between the two. It
15 wasn't that they were not including skilled
16 nursing facility, but you guys couldn't decide
17 which was the best one, is that what I am
18 understanding? Okay.

19 MS. ANDERSON: Yes, I don't have a
20 staff pick on that.

21 DR. ANDREWS: Looking at this, to me,
22 it looks like we're peeling the onion, and we're

1 peeling the onion, we already have all cause --
2 you know, the two measures that we are currently
3 following for readmissions, but it doesn't give
4 us enough insight into well what is driving those
5 readmissions? Where are those patients coming
6 from?

7 And this allows for differentiation as
8 to the place of care that is driving a lot or not
9 driving a lot of those admissions, so I like the
10 fact that the staff picked the home health,
11 that's one.

12 I am questioning also why we didn't
13 choose at least one that ties to the nursing
14 home. The rehabilitation has been picked. I
15 like that. So we have rehabilitation, home
16 health. I would like to see why we can't pick
17 the skilled nursing facility because that would
18 be again important to incorporate.

19 And other than that, you know, the
20 question, as somebody asked, is -- it might be, I
21 think, Jennie -- is whether we want to pick
22 something that begins to identify the specific

1 populations like fee-for-service versus what we
2 already are now measuring that is global.

3 CHAIR LIND: Rich, did you have
4 another comment, or are you -- was that left
5 over?

6 (No audible response.)

7 CHAIR LIND: Okay. Sarah?

8 MS. LASH: I just want to highlight
9 maybe two salient differences among the nursing
10 facility measures, if we're ready to go there.

11 The first one, 2375, was developed by
12 the American Health Care Association, so the
13 nursing home industry, and it is based on MDS
14 data.

15 The second measure was developed by
16 CMS, so the payer side, and it was designed to
17 harmonize with the hospital-level measure of
18 readmission.

19 That might weigh in the decision
20 process.

21 Planned procedures are excluded.

22 CHAIR LIND: So 2510 distinguishes

1 that this is just for unplanned, it is from
2 administrative claims data, whereas the other one
3 is MDS data, which not everybody has access to.
4 I mean, the nursing homes do, and then in some
5 states the states sometimes have MDS data, but
6 not the health plans, necessarily.

7 Rich.

8 MR. BRINGEWATT: I do have a question
9 on these rehospitalization measures.

10 The current all cause readmission
11 measures for plans and in fee-for-service
12 incorporate -- they adjust for the presence of
13 age, gender, and condition. These don't have any
14 adjustment factors associated with them, right?

15 DR. BURSTIN: No, the -- I am sorry,
16 the two SNF readmission measures do. The only
17 ones that are not risk adjusted are the
18 community-level admission measures, per 1000
19 population we were talking about earlier.

20 These have -- at least the CMS one has
21 an almost identical readmission risk adjustment
22 approach to the hospital measure already --

1 MR. BRINGEWATT: So --

2 DR. BURSTIN: -- in use.

3 MR. BRINGEWATT: -- 2505, 2380, and
4 2502 are risk adjusted?

5 DR. BURSTIN: Yes.

6 MR. BRINGEWATT: Okay. Using the same
7 factors as age, gender, and condition?

8 DR. BURSTIN: That sounds right.

9 MR. BRINGEWATT: Is that right?

10 CHAIR LIND: Steve?

11 DR. COUNSELL: Yes, I think in the --
12 just speaking from the skilled nursing facility
13 perspective, if you have a planned admission for
14 something that's in follow-up, that's a good
15 thing, and you don't want to be -- so I am a
16 little surprised that the nursing home industry,
17 maybe, suggested this measure.

18 So -- and then for alignment purposes
19 with other, you know, readmission measures, it
20 seems like the one developed, you know, that
21 excludes planned and by CMS that uses the same
22 kind of methodology as the other readmission

1 measures would be the preferred things.

2 CHAIR LIND: So I am going to try to
3 call in the question on 2510 of the two nursing
4 home measures. It sounds like we're leaning a
5 little bit more strongly to that one, so let's
6 try voting on 2510, if you would like to include
7 NQF No. 2510, Skilled Nursing Facility 30 Day All
8 Cause Readmission, vote of support for that one.

9 9, 10, you have 10. Okay.

10 So good. We're all -- we will include
11 2510, and then we will go back to 2375 and just
12 check in, does anybody support also including
13 that one or no? Any support for that one? No,
14 okay.

15 So we have dealt with two. Now let's
16 move on to the three home health measures, so the
17 three -- two home health measures. So there's
18 two home health measures. Let's take them
19 together. 2380 is Rehospitalization During the
20 First 30 Days of Home Health, and the other home
21 health measure is the Emergency Department Use
22 During the First 30 Days, so that would be a good

1 one too to say, you know, if something serious
2 enough happened at home that you had to go back
3 to the ED even if you weren't admitted.

4 So 2580 and 2505, let's try first
5 taking them together. If you vote to include, a
6 show of hands?

7 Three, four, five, six, seven, eight,
8 nine, 10, yes, we're good, okay. So we're going
9 to include those two.

10 Then let's go on next to the staff
11 pick, the other -- the third staff pick, which is
12 the IRF 2502 All Cause Unplanned Readmission
13 Measure for 30 Days Post Discharge from Inpatient
14 Rehab Facilities. Are we good? Any questions on
15 that one before we vote? Steve.

16 DR. COUNSELL: Is that aligned with
17 the SNF one and the CMS -- is that -- yes,
18 perfect, great.

19 CHAIR LIND: Okay, all right. Then
20 everybody -- is everybody good to vote on that
21 one?

22 So 2502, All Cause Unplanned

1 Readmission for 30 Days Post Discharge from IRF.

2 Okay, good.

3 All right, then, let me just ask the
4 question, are -- would anyone like to vote on any
5 of these other ones? Would anyone like to like
6 put up your card to say I surely hope that we're
7 not just ignoring such-and-such, let's go ahead
8 and vote on it? D.E.B.

9 MS. POTTER: I would like to suggest
10 long-term care hospital readmission measure.
11 Like a couple weeks ago, we had the webinar
12 meeting where we heard about the impact measures
13 and how they were to align, and so maybe since
14 we've already talked about alignment today, that
15 would be a logical thing to talk about.

16 CHAIR LIND: So did you guys pull that
17 one up?

18 So if you all want to look on your own
19 devices, on the QPS -- maybe, would we crash the
20 QPS if we all looked at the --

21 MS. LASH: It is number 2512. My
22 computer was asleep.

1 So this sounds really similar to the
2 measures we have reviewed. It estimates the
3 risk-standardized rate of unplanned all cause
4 readmissions for patients who are Medicare fee-
5 for-service beneficiaries discharged from a long-
6 term care hospital who are readmitted to a short-
7 stay acute-care hospital or to a long-term care
8 hospital within 30 days of the long-term care
9 hospital discharge.

10 The measure requires data for 24
11 months of long-term care hospital discharges to
12 non-hospital post-acute levels of care or to the
13 community. It is risk-adjusted. It's a CMS
14 measure as well. And I can answer any other
15 questions.

16 MS. SHAHAB: I think this falls in the
17 same family, and I think if there's consistency,
18 it's -- it would -- I would suggest that it be
19 included.

20 MS. COHEN: Is that one listed under
21 gap measures in the spreadsheet?

22 MS. LASH: Readmission measures in

1 general were, although I don't think we ever
2 laundry listed every setting.

3 MS. COHEN: Okay, and I just meant to
4 look it up in general, too. Is it in the
5 spreadsheet that you sent us?

6 MS. LASH: It was not. We missed it
7 --

8 MS. COHEN: Okay.

9 MS. LASH: -- somehow.

10 MS. COHEN: Okay.

11 CHAIR LIND: Rich.

12 MR. BRINGEWATT: Why didn't staff
13 include this?

14 MS. LASH: We missed it. We were in
15 a hurry.

16 MR. BRINGEWATT: I am sorry?

17 MS. LASH: D.E.B. saved us.

18 MR. BRINGEWATT: Okay, but you didn't
19 change your mind --

20 MS. LASH: No, it was not --

21 MR. BRINGEWATT: -- you know, I mean,
22 it --

1 MS. LASH: -- no, it was not, yes, it
2 was not a purposeful exclusion.

3 MR. BRINGEWATT: Okay, okay.

4 MS. LASH: Somehow we had a data
5 error.

6 CHAIR LIND: This would be a
7 complementary filling in the gap between all
8 those other settings we've identified --

9 MS. LASH: Right.

10 CHAIR LIND: -- for readmission, so
11 the number is 2512, so a show of hands to include
12 2512 in our family of readmission measures.

13 Okay, wonderful. So then Steve, did
14 you have something you wanted to go back to on
15 the other measures?

16 DR. COUNSELL: I was just looking
17 through, we don't have any population-based
18 admissions per 1000, readmissions per 1000, at
19 this point, and I like the, you know, in our
20 conversations in the past around, you know,
21 looking at comparisons even within the same
22 population in a community or a region and then

1 being able to compare similar regions or
2 communities that have high rates of low income
3 and dual-eligible populations, I think that could
4 be valuable.

5 You know, and as we look at risk
6 adjustment using socioeconomic, you know, kind of
7 things, this might be another way to look at
8 similar-type communities, you know, and speaking
9 from the American Essential Hospitals, you know,
10 group, I think this might be valuable.

11 CHAIR LIND: And Jennie is here --

12 VICE CHAIR HANSEN: I would support
13 that --

14 CHAIR LIND: -- saying amen over here.

15 VICE CHAIR HANSEN: Yes, because I
16 think that it -- it isn't just within, it's
17 across communities, and so it just starts that
18 focus of giving back directionality of looking
19 apples and apples.

20 CHAIR LIND: So you would be in favor
21 of 2304 and 2503 both, that pair, yes? Steve is
22 nodding his head. D.E.B. is shaking -- no?

1 You're not really shaking, you're just --

2 VICE CHAIR HANSEN: I guess a
3 question, is the population-based MAP doing
4 something similar, do you know?

5 MS. LASH: The Population Health Task
6 Force probably didn't have the opportunity to
7 review these measures because they're newly
8 endorsed, they're too new.

9 MS. SHAHAB: They were just endorsed
10 in December, so the MAP Population Health Family
11 met around May or June, so -- .

12 DR. BURSTIN: Not that these
13 community-based are --

14 MS. ANDERSON: And --

15 DR. BURSTIN: -- considered at the
16 community level, so comparisons would need to be
17 really constructed to make sure you're getting
18 the like-to-like.

19 CHAIR LIND: Megan, were you starting
20 to say something?

21 MS. ANDERSON: I was concurring with
22 Helen that it would seem like it would be a

1 limited utility for the dual beneficiary
2 population in general.

3 I know that a lot of communities do
4 have more than 1000 Medicare fee-for-service
5 beneficiaries. However, that seems like it would
6 be more difficult to use at the community level
7 for this population, specifically, and it might
8 be okay to use at the state level, but -- but it
9 would be hard to compare like communities with
10 this number of dual beneficiaries, potentially.

11 CHAIR LIND: Okay. Rich, did you
12 still have a comment, or you just have a leftover
13 card?

14 (No audible response.)

15 CHAIR LIND: Okay, so we're going to
16 vote on 2304 and -- I mean 2503 and 2504
17 together. Show of hands if you would support
18 adding these two population-based measures to the
19 family of measures.

20 Five, five? One, two, three, four,
21 yes, five, I think, so okay, that group doesn't
22 pass.

1 I think, Megan, that was it for the
2 include list, right?

3 MS. ANDERSON: Yes ma'am.

4 CHAIR LIND: So now we want to go back
5 a little bit to the -- do we -- do any of these
6 newly added, or in light of the earlier
7 conversation this morning on the lack of
8 alignment in a couple areas, are there any
9 measures you would like to take off the list at
10 this time?

11 And so one area specifically that
12 Megan had brought up was if we add in a whole new
13 family of diabetes measures, are there any
14 diabetes-related measures that we would like to
15 remove from the family?

16 Nobody is rushing to remove any
17 diabetes-related measures. Are there any other
18 --

19 MS. ANDERSON: Can I ask a clarifying
20 question --

21 CHAIR LIND: Yes, go ahead, Megan.

22 MS. ANDERSON: -- about the inclusion

1 of the diabetes care measures for people with
2 serious mental illness.

3 The Workgroup included -- it voted to
4 include those six measures for the health plan
5 level of analysis for people with serious mental
6 illness. They did not vote to include, to my
7 understanding, the original provider-level
8 measures for the general population. Is that
9 true?

10 CHAIR LIND: Which number would that
11 have been? Sarah is going back to the --

12 MS. ANDERSON: And --

13 CHAIR LIND: -- chart, which number?

14 MS. ANDERSON: Sarah -- sorry, I have
15 to get there as well.

16 We have 2603, Diabetes Care for People
17 with Serious Mental Illness. There is a Diabetes
18 Care for the General Population at the Health
19 Plan Level, that's the complement to that
20 measure. I have to get to the slide, to the --
21 but I think we've only chosen to include a
22 modified harmonized measure for people with

1 serious mental illness, not those from the
2 general population.

3 CHAIR LIND: So are you talking about
4 the 0057, Harmonized Specifications with --

5 MS. ANDERSON: Yes.

6 CHAIR LIND: -- 0057 Comprehensive
7 Diabetes Care, Hemoglobin Testing?

8 So you are saying that we have the
9 2603, a specific one for serious mental illness,
10 but we don't have the general population one that
11 is the companion measure to that one.

12 MS. ANDERSON: That is correct, and
13 that would be a consistent conclusion for the
14 remaining five diabetes care first use for people
15 with serious mental illness measures.

16 CHAIR LIND: So rather than sticking
17 with the topic of trimming, you're suggesting
18 adding a whole slew? I am just --

19 MS. ANDERSON: I want to clarify what
20 the --

21 CHAIR LIND: Is there any big
22 sensation, rushing to the microphone to include a

1 bunch? Steve.

2 DR. COUNSELL: I am just trying to
3 harken back to some of our prior conversations,
4 and I think we do have the composite measure, the
5 family currently includes Optimal Diabetes Care,
6 and I think that we, just with a little parsimony
7 there, that's what we chose to use as a composite
8 measure rather than detail out every diabetes
9 measure.

10 And the rationale then for adding this
11 next grouping is because it's specifically
12 focused on the serious mental illness, which we
13 think is under-recognized. Thanks.

14 CHAIR LIND: Okay, thanks.

15 So I think we're happy with what we
16 decided or didn't decide, accidentally decided.

17 Anne?

18 MS. COHEN: So two things. I think I
19 want to claim all these serious mental illness
20 ones that we added, because there's a lot of them
21 now, gets to what Rich was saying about focusing
22 on a specific population, so I am wondering if a

1 big part of the next report should be like our
2 goal is to eventually come up with measures for
3 specific sub-populations, here is a whole group
4 for this population, and then like encourage CMS
5 to include all of those measures -- like if you
6 can't include a bunch of other new ones we added,
7 at least include this whole group for this group
8 and get them tested and make that a priority,
9 like, for the next, you know, how many number of
10 years, as a way to move the needle.

11 And then the other one was the
12 hospital readmissions stuff. We added a whole
13 bunch of those, so that would be like another
14 priority area.

15 And in terms of deleting, it sounds
16 like there's a whole bunch of ones that haven't
17 been adopted, so the question is do we delete
18 those? Do we -- you know, how do you, in terms
19 of the duals plans --

20 CHAIR LIND: Right. So the list of
21 the ones that were not in any state duals
22 demonstration, we could go back to that slide

1 just to refresh your memory. That was number 24
2 I think, at least on my printed version of the
3 slides.

4 So -- so we have already dealt with a
5 couple that had been -- have been retired or are
6 no longer endorsed, but some of the other ones, I
7 think, are fairly obvious about why they hadn't
8 been picked up. The transition record was
9 specified, elements received by discharged
10 patients is just a notoriously hard set of data
11 to collect, and so it's, you know, again, it
12 signals good intention on our part, but it is not
13 particularly easy, and so people tend to kind of
14 give up on that one when they learn more about
15 it.

16 I don't know about 0709. D.E.B., you
17 might have an opinion about why that chronic
18 condition avoidable complication wasn't picked
19 up.

20 The ICU care preference is documented.
21 It is probably a setting issue more than
22 anything. It's like once you narrow down to the

1 numbers of people who are admitted to the ICU,
2 then it becomes a pretty narrow measure.

3 I think the question that we raised
4 earlier about health literacy, it's like if
5 you're not using this to measure health literacy,
6 what on Earth are you using? We don't have any
7 idea, and that could be another one of those
8 questions to ask in the interviews, like what are
9 you doing about health literacy, and the -- on
10 the client side, what are you doing about
11 cultural competency on the clinician side? You
12 know, those are other good things to drill down
13 in.

14 Medical home system survey, what we
15 have heard is just it's really intensive and
16 expensive, so those are some reasons that we know
17 of.

18 Steve?

19 DR. COUNSELL: Yes, I was just
20 noticing that it was not only were these not used
21 in the duals demos, but in any other national or
22 state initiative, so not in the Special Needs

1 Plans or anything else.

2 But I think, in general, I think that
3 all you've gone through and even the rest are
4 great placeholders representative of some of the
5 kind of difficult --

6 CHAIR LIND: Right.

7 DR. COUNSELL: -- and challenging
8 issues that --

9 CHAIR LIND: Right.

10 DR. COUNSELL: -- that this population
11 faces.

12 CHAIR LIND: Things we wish we had
13 better measures for.

14 MS. LASH: Some of the higher numbers
15 that start with 2 are relatively newly endorsed,
16 so I -- it would be premature in my opinion to
17 remove these from the family when they really
18 haven't had the time to be considered for those
19 programs, to be parts of annual updates, et
20 cetera, et cetera. The wheels of change are a
21 little slow.

22 CHAIR LIND: Jennie and then Vanesa.

1 VICE CHAIR HANSEN: Going -- going
2 back to 1626, Patients Admitted to ICU Who Have
3 Care Preferences Documented, there was some
4 conversation at some point that this was very
5 specific to setting, but it was a place where
6 patient goals was acknowledged when we had talked
7 about how few items there are about patient
8 goals.

9 So one is, you know, the idea of
10 keeping it in, but is there a way to kind of
11 elevate that as we have our discussions about how
12 we want to frame clusters with this?

13 CHAIR LIND: Vanesa?

14 MS. DAY: First, I think that for this
15 list and in general, my impression of what we are
16 supposed to do in this group is to lay out what
17 we think is the best possible measure set for
18 duals, or family for duals.

19 The fact that these are not included
20 in whatever is going on in CMS or elsewhere
21 really doesn't mean that we should be considering
22 them not there. Like, if you put them there,

1 they're there for a reason.

2 There are so many things that happen
3 once you give us -- I know I said this before,
4 but there are so many things that happen once we
5 get these reports that, I mean, just -- it
6 doesn't mean that it's not valid and we shouldn't
7 be aiming for it, so I would -- I think that in
8 looking at this and in judging the overlaps, we
9 should look at overlaps to the extent that yes,
10 we don't want to have -- we don't want to be so
11 burdensome in our measure family that we aren't
12 able to get to what we really need to get to, or
13 we limit access. But I think that should be the
14 extent to which we look at the overlaps.

15 So as we look at new measures and we
16 say, okay, does something exist like this
17 otherwise, or is there another measure that is
18 otherwise in use that maybe makes sense for us to
19 stratify? Then I think that is an appropriate
20 place for us to look at the overlaps, but I think
21 if we just kind of say oh, well it's not being
22 used, or harp on that too much, then we kind of

1 get into a place, a dangerous place where we're
2 kind of playing to the policy and politics of it
3 all as opposed to really thinking -- like,
4 thinking of the broader mission, which is what
5 makes sense for this population?

6 Because again, even with all the
7 overlaps that we see, there is more analysis that
8 needs to be done and more work on our part that
9 needs to be done in actually using those measures
10 in those different programs for our population,
11 so -- .

12 CHAIR LIND: You are our new hero.

13 (Laughter.)

14 CHAIR LIND: So no -- no big vocal
15 leaning towards deleting measures, so I think
16 we'll leave the set at that for today.

17 MS. DAY: I did have a question.

18 CHAIR LIND: Okay.

19 MS. DAY: Not a delete, but a question.

20 So there is an HIV measure that you
21 contemplated the last time, and we had a broader
22 STD measure, but -- and I think in the last

1 grouping, we changed to just the HIV measure.

2 And I was curious as to why we
3 selected a measure that wasn't -- didn't address
4 STDs more broadly.

5 MS. ANDERSON: Because there wasn't
6 one. This is Megan.

7 MS. DAY: Okay.

8 MS. ANDERSON: There wasn't one
9 available.

10 MS. LASH: I think there was a
11 suggestion that the CDC was working on a
12 composite of some kind, which we haven't had --
13 we haven't seen that come through yet.

14 MS. DAY: Okay.

15 MS. LASH: Still a gap, an important
16 one.

17 CHAIR LIND: Okey-dokey. D.E.B.?

18 MS. POTTER: The question that was put
19 on the table was should we take anything off, and
20 I am going to flip it the other way because I did
21 hear us have a pretty firm conclusion that we
22 still thought that we were light in terms of

1 person-centered care, and that even though we've
2 got all these measures, this concept that we know
3 is central to these populations we still haven't
4 captured, and I don't want us to lose that.

5 CHAIR LIND: So I think that's
6 tomorrow morning, Charting A Path Forward on
7 Measuring Person- and Family-Centered Care, so
8 we're just going to forge through the snow in
9 whatever way we can.

10 I might have to go buy snowshoes
11 tonight, but first, we're going to pause for
12 public comment before we adjourn for the evening.
13 So Operator, could you just make sure if we have
14 any folks who would like to make public comment
15 at this point?

16 THE OPERATOR: Okay. At this time, if
17 you would like to make a comment, please press
18 star, then the number 1.

19 (No audible response.)

20 THE OPERATOR: And there are no public
21 comments at this time.

22 CHAIR LIND: All right.

1 So Sarah -- it says Alice and Sarah
2 will help provide themes. I think that that last
3 point that D.E.B. just brought up has certainly
4 been a consistent theme today, and not losing
5 sight on these really important gap areas of
6 person-centered care, family caregivers, we've
7 mentioned other themes in that -- in the family
8 of gaps in terms of the problems with collecting
9 good, quality survey measures that we know
10 actually reflect people's needs and perceptions.

11 And my new favorite phrase is, though,
12 what's important for you versus what's important
13 to you, that is my new favorite thing in that
14 family of themes that we talked about.

15 And the one that I'm going to bring
16 home is about insisting that health plans issue
17 free cell phones and airtime to clients. That is
18 my new favorite, and that's going to be my new
19 mission in life.

20 So those are some of the themes that
21 I heard today. I really liked how we started off
22 by looking at the alignment half-full and then

1 really flipped it around to -- or look at it
2 half-empty at first and then flipped it around to
3 half-full, but there is still all this, you know,
4 need of all of us to fill the glass even that
5 much more as you hear, so care coordination,
6 transitions, still very important and still
7 needing a lot more emphasis.

8 And the whole point of we just don't
9 know a lot yet about if we had stratified
10 measures on all the measures that we hope to be
11 collecting, we don't know if we're starting to
12 narrow the gaps or not.

13 So all really helpful conversation
14 today. It will make Sarah's report-writing very
15 rich and challenging --

16 MS. LASH: Yes, among other things.
17 I just want to thank you all for the
18 concentration and the hard work, especially this
19 afternoon.

20 I know that updating the family of
21 measures, Jennie described it as a very linear
22 activity, and it is sort of hard to see where all

1 of that is going and what the choices mean, but
2 maybe to sum up, that list of measures that gains
3 the support of the MAP has slow ripple effects on
4 uptake of measures that are important for this
5 population, and it is sort of a necessary first
6 step to do this work, but we had some great
7 conversation about how it's not enough, that
8 there is a lot more quality improvement work and
9 policy that sort of wraps around that measure
10 list and sort of needs to all function together.

11 So we might share some other themes in
12 the morning once we have a chance to synthesize a
13 little bit more, but don't want to take up any
14 more of your day right now, so thanks everyone.
15 I will see you in the morning, safe travels, or
16 we'll -- well, I will see you on the webcast.

17 And don't hesitate to email myself or
18 Zehra if you have any technical difficulties in
19 the morning. We'll be as helpful as we can be.

20 All right.

21 (Whereupon, the above-entitled matter
22 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.



Court Reporter

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