

NATIONAL QUALITY FORUM

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MEASURE APPLICATION PARTNERSHIP  
MEDICAID ADULT TASK FORCE

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TUESDAY  
MAY 23, 2017

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

MEMBERS PRESENT:

HAROLD PINCUS, MD, Chair

DIANE CALMUS, JD, National Rural Health Association

MARY KAY JONES, Centene Corporation

RHYS JONES, MPH, America's Health Insurance Plans

SUE KENDIG, JD, MSN, WHNP-BC, FAANP, National Association of Nurse Practitioners in Women's Health

DEBORAH KILSTEIN, RN, MBA, JD, Association for Community Affiliated Plans

RACHEL LA CROIX, PhD, PMP, Florida Agency for Health Care Administration

ROANNE OSBORNE-GASKIN, MD, MBA, FAAFP, MDWise, Inc.

CLARKE ROSS, DPA, American Association on Health and Disability

MARISSA SCHLAIFER, RPh, MS, Independent Consultant

FEDERAL GOVERNMENT MEMBERS PRESENT (NON-VOTING):

SUMA NAIR, MS, RD, Office of Quality Improvement  
LISA PATTON, PhD, Substance Abuse and Mental  
Health Services Administration  
MARSHA SMITH, MD, MPH, FAAP, Centers for  
Medicare & Medicaid Services

NQF PRESENT:

HELEN BURSTIN, MD, Chief Scientific Officer  
SHACONNA GORHAM, MS, PMP, Senior Project Manager  
MIRANDA KUWAHARA, Policy Analyst  
DEBJANI MUKHERJEE, MPH, Senior Director

ALSO PRESENT:

SEAN CURRIGAN, MPH, American Congress of  
Obstetricians and Gynecologists  
LISA HINES, PharmD, Pharmacy Quality Alliance\*  
JUNQING LIU, PhD, MSW, National Committee for  
Quality Assurance\*  
KAREN MATSUOKA, PhD, Division of Quality and  
Health Outcomes, Centers for Medicaid and  
Medicare Services  
GIGI RANEY, LCSW, Centers for Medicaid and  
Medicare Services

DEIRDRA STOCKMANN, PhD, Division of Quality and  
Health Outcomes, Centers for Medicaid and  
Medicare Services

CATHY YADAMEC, Council on Quality & Leadership

JUDY ZERZAN, MD, MPH, Colorado Department of  
Health Care Policy and Financing

SHEILA CROFT, Quality Measurement Department

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

2 9:06 a.m.

3 MS. MUKHERJEE: Hi everybody.

4 Welcome. My name is Debjani Mukherjee. I am the  
5 senior director for the Medicaid Adult and Child  
6 Core Set Project, and welcome to our three day  
7 meeting. Of course, the Medicaid Adult Task  
8 Force will be here today and tomorrow, and with  
9 that, I will turn it over to Harold, to say a few  
10 welcoming remarks.

11 CHAIR PINCUS: Well, we all really  
12 appreciate your participating in this. It's  
13 really essential that, you know, Medicaid has  
14 certainly been in the news. It's the first thing  
15 on, you know, my sort of news list that showed up  
16 this morning was about Medicaid and the budget.  
17 So and so this is a really important task that we  
18 have in front of us, and we're going to be  
19 speaking today is focusing primarily on the adult  
20 Medicaid issues.

21 Tomorrow, we're going to be talking  
22 about sort of issues across the board that apply

1 to both adult and child, and I think what I want  
2 to emphasize was most important is the kind of  
3 qualitative information that we give CMS, so that  
4 they understand our thinking behind the kind of  
5 things that we support or don't support. In some  
6 ways it's less important what is supported and  
7 what is not supported.

8 It's really the reasons behind it in  
9 terms of the importance of the issues that are  
10 being addressed, in terms of the practicality and  
11 feasibility, and improvability, the extent to  
12 which states can actually make use of this  
13 information.

14 So that's our focus and that's why  
15 each of you, each of the groups have been  
16 identified to participate in this. So we should  
17 be able to get through the agenda. It's a large  
18 agenda, but we should be able to get through it  
19 in time and get everybody sort of done and home  
20 and rested by the end of it.

21 So why don't we move ahead, and  
22 Debjani or Helen, are you going to --

1 MS. MUKHERJEE: Sure. Next slide,  
2 please. So what we're going to do is quickly run  
3 through some of the important things like  
4 restrooms and where to find them. I'm sure you  
5 all know. We have a lot of returning members as  
6 well as new members. For returning, thank you  
7 for coming back for welcome. For new ones,  
8 welcome.

9 So the restrooms are straight down the  
10 hall and then it's to the right, and it's the  
11 second door for the women, and since most of us  
12 are women here today. And then if you need --  
13 please keep your phones on mute. But if you need  
14 to take a call, you can definitely pop out and  
15 right by the reception area there's some seats  
16 for you to take calls.

17 We have the breaks listed here at  
18 11:00, 1:00 and 2:50. We're going to try to keep  
19 them during that time because we have public  
20 comments right before that and we'd like people  
21 who are on the phone to be able to make their  
22 public comments.

1                   And then laptops, cellphones, you all  
2                   probably are logged in by now, but our user name  
3                   is guest, lowercase password NQF capital guest  
4                   lowercase, and with that I'm going to turn it  
5                   over to --

6                   No. We'll quickly do -- do we do  
7                   staff introductions? So as you know I'm Debjani,  
8                   and I'll start with Karen to introduce herself,  
9                   and then we'll introduce staff before turning to  
10                  Helen for our DOIs.

11                  DR. MATSUOKA: Thanks Debjani. Hi,  
12                  good morning everyone. I'm Karen Matsuoka. I'm  
13                  the chief quality officer for Medicaid and CHIP,  
14                  and I'm also the director of the Division of  
15                  Quality and Health Outcomes at the Centers for  
16                  Medicare and Medicaid Services.

17                  MS. GORHAM: Good morning. My name is  
18                  Shaonna Gorham and I'm the senior project  
19                  manager for the Medicaid Adult and Child Task  
20                  Forces.

21                  MS. KUWAHARA: Hello. My name is  
22                  Miranda Kuwahara, and I'm the project analyst for

1 both Adult and Child Task Forces.

2 MS. CROFT: Good morning. My is  
3 Sheila Croft, and I'm the administrative manager  
4 for the Quality Measurement Department.

5 DR. BURSTIN: Hi everybody. I'm Helen  
6 Burstin. I'm the chief scientific officer here  
7 at NQF. I think I know most of you. Thanks for  
8 those of you returning, and our new -- our new  
9 members today. So I'm going to do a brief  
10 introduction for you as we do disclosures.

11 NQF traditionally does introductions  
12 and disclosures together. So it's an opportunity  
13 for everybody to know sort of where you're coming  
14 from, what your organization is and whether you  
15 have anything you think will be important to  
16 disclose to your fellow task force members as you  
17 deliberate about the measures before you today.  
18 So my understanding is all of you at the table  
19 are organizational members today. There are no  
20 subject matter experts; is that correct?

21 Okay. That's nice to know. So  
22 briefly I'm going to ask you all as we go around

1 the room briefly, to let us know who your  
2 organization is that's your -- that who nominated  
3 you to sit here today. We expect you to come to  
4 this table obviously representing those  
5 interests, different from some of our other  
6 committees that we have since you are  
7 organizational members.

8 The only disclosure we would ask you  
9 to make is whether you have an interest in  
10 \$10,000 or more in any entity that's related to  
11 the work of this Committee. That's really all we  
12 ask as organizational members, and we'll go  
13 around the room and then if we have any questions  
14 at the end we'll start. You're, I think, we'll  
15 come to you at the end. I think you're still a  
16 subject matter expert. All right. We'll get to  
17 Harold at the end. Marissa.

18 MEMBER SCHLAIFER: Hi. I'm Marissa  
19 Schlaifer. I work as an independent consultant  
20 in the health policy space. I'm here  
21 representing the Academy of Managed Care  
22 Pharmacy, and as far as disclosures, as a past

1 employee I have some stock in CVS Health.

2 MEMBER KENDIG: Hi. I'm Sue Kendig,  
3 and I am here representing the American  
4 Association of Nurse Practitioners. I also do  
5 health policy consulting and serve as director of  
6 policy for the National Association for Nurse  
7 Practitioners and Women's Health.

8 MEMBER OSBORNE-GASKIN: Good morning.  
9 Roanne Osborne-Gaskin. I'm here representing the  
10 American Academy of Family Physicians. I am --  
11 I'm the senior medical director at a Medicaid  
12 managed care organization in Indianapolis,  
13 Indiana, and I have nothing to disclose.

14 MEMBER CALMUS: I'm Diane Calmus, and  
15 I represent the National Rural Health  
16 Association, and I have nothing to disclose.

17 MEMBER ROSS: Hi. I'm Clarke Ross.  
18 I work for the American Association on Health and  
19 Disability, but I'm representing here the  
20 Consortium for Citizens With Disabilities, which  
21 is a national policy coalition of 113 national  
22 disability organizations, and I'm also the father

1 of a 26 year-old son with co-occurring  
2 developmental disabilities, and have nothing to  
3 disclose.

4 MS. NAIR: Good morning, Suma Nair.  
5 I'm with the Health Resources and Services  
6 Administration and focus on the Director of  
7 Quality Improvement for the Community Health  
8 Center Program, and I have nothing to disclose.

9 DR. SMITH: Hi. I'm Marsha Smith.  
10 I'm with the Center for Clinical Standards and  
11 Quality at the Center for Medicare/Medicaid  
12 Services. I'm the medical officer, and our  
13 center is responsible for quality measurement  
14 programs and public reporting programs.

15 MEMBER JONES: Hi, good morning. I'm  
16 Mary Kay Jones, and I'm vice president of Quality  
17 Improvement for Centene Corporation, and you may  
18 not know Centene, but you probably know many of  
19 our health plans.

20 We have 23 different health plans  
21 throughout the United States and probably I think  
22 we're now the biggest Medicaid managed care

1 provider in the U.S. So as an officer of the  
2 company, I have stock in the company.

3 MEMBER LA CROIX: My name is Rachel La  
4 Croix and I'm here representing the National  
5 Association of Medicaid Directors. I live in  
6 Tallahassee, Florida, and work for Florida  
7 Medicaid, the Agency for Health Care  
8 Administration there, and I oversee our unit that  
9 does performance measures, CAHPS surveys,  
10 provider surveys, the EQRO contract and  
11 evaluations of our waiver programs, and I have no  
12 interests to disclose.

13 MEMBER KILSTEIN: Hi. My name is  
14 Deborah Kilstein. I'm Vice President for Quality  
15 Management and Operational Support at ACAP, which  
16 is the Association for Community Affiliated  
17 Plans. We're a trade association for 60 non-  
18 profit safety net health plans that operate in 29  
19 states.

20 In terms of a disclosure, my husband  
21 is a former employee for a pharmaceutical  
22 manufacturer, so he does have some retiree

1       benefits through them.

2                   DR. BURSTIN:   Perfect, and how about  
3       our federal friends?

4                   DR. PATTON:   Hi there.   Lisa Patton.  
5       I'm the division director for Evaluation Analysis  
6       and Quality within the Center for Behavioral  
7       Health, Statistics and Quality at SAMHSA within  
8       HHS, and nothing to disclose.

9                   DR. BURSTIN:   Perfect, thank you.  
10      Harold, I think, is actually our one, not that  
11      all the rest of us aren't subject matter experts.  
12      But he's an official subject matter expert.   So  
13      we'll ask for a slightly longer disclosure for  
14      you of anything you think related to the subject  
15      matter work of this Committee.

16                  CHAIR PINCUS:   So I am professor and  
17      vice chair of Psychiatry at Columbia University.  
18      I'm also the director of Quality and Outcomes  
19      Research for New York Presbyterian Hospital.   I'm  
20      also senior scientist at the RAND Corporation.

21                  I have been a consultant for  
22      Mathematica and the National Academy of State

1 Health Policy, and have -- my research and  
2 research training funds have come from various  
3 NIH Institutes and multiple non-profit  
4 foundations.

5 DR. BURSTIN: All right. Thank you  
6 all for those disclosures. This would be the  
7 appropriate time, based on anything you've heard,  
8 if there's anything you want to ask each other  
9 that would be fine. As well just to remind you,  
10 if at any point during these proceedings you feel  
11 like you're hearing a tinge of bias, please come  
12 forward, talk to Harold or myself. It's always  
13 easier to kind of deal with those things in real  
14 time.

15 As organizational representatives in  
16 particular, you do bring a point of view to this  
17 table, so we recognize that. Usually not much of  
18 an issue at these tables. But just want to at  
19 least let you know that any point let us know,  
20 and we don't want you to sit silently if you are  
21 concerned about something, and with that, I'll  
22 turn it back over to Harold and Debjani.

1 CHAIR PINCUS: So the first step is  
2 that we want to go over what we're supposed to do  
3 over these next two days, to review the meeting  
4 objectives. So we go to the next slide, please.  
5 So over these next two days, we want to consider  
6 the states' experiences and learn from each of  
7 the states. We have Judy Zerzan here from  
8 Colorado, and we also have, you know, obviously  
9 Rachel here from Florida, who will play a key  
10 role in informing us about the states'  
11 experiences.

12 We want to develop strategic  
13 recommendations for strengthening the Medicaid  
14 adult core sets, and tomorrow we'll be speaking  
15 also about child and adult core sets, especially  
16 where there's overlap between the two. And as I  
17 said earlier, we want to make not just yes-no  
18 recommendations, but we want to give some  
19 qualitative information about what our rationale  
20 is for making our recommendations, because we are  
21 not determining what CMS will do. We're making,  
22 we're giving them advice about it. So it's

1 important to have that kind of background to the  
2 advice.

3 And then also to think about the  
4 future, to think about how we can help CMS think  
5 about the further development of these core  
6 measure sets over time, to meet their program  
7 goals. What kind of work needs to be done, not  
8 so much in terms of adding or removing a  
9 particular measure, but in terms of the longer-  
10 term goals of how the program should be shaped.

11 Next slide. So our specific charge  
12 is, and I guess this is in the official contract  
13 that goes between CMS and NQF, is to review the  
14 states' experiences in reporting measures to  
15 date, to refine the previously identified measure  
16 gap areas, which we did over the past actually  
17 couple of years in terms of accumulating  
18 different measure gap areas, and look at whether  
19 there are additional potential measures that  
20 could be added, and also to identify measures  
21 that might be removed from the set that are  
22 either ineffective or have topped out or have --

1       there's evidence to suggest that they may not be  
2       completely valid.

3               And so the task forces consist of  
4       current measure application partnership members  
5       across the different committees and task forces  
6       across the MAP.

7               So today, we're focusing on primarily  
8       the adult core set. So we're going to hear from  
9       Judy, Judy Zerzan who will shortly introduce  
10      herself, to tell us about both Colorado and also  
11      her broader reviews about the way in which the  
12      states have used and find useful this program,  
13      and then to go over the adult core set measures  
14      themselves for us to make recommendations about  
15      additions or eliminations.

16              Tomorrow, as I said before, we're  
17      going to be going over both child and adult  
18      issues with the Child Task Force. We're going to  
19      hear some additional states make presentations,  
20      and then we're going to go over specific issues  
21      around shared measures that apply to both adults  
22      and children, and also to think about strategic

1 issues in a joint way so we can have some degree  
2 of coordination in terms of how we view these  
3 things.

4 And then on May 25th, it's a Child  
5 Task Force only. I think -- is anybody here  
6 going to be at the Child Task Force also?  
7 Rachel, okay good.

8 (Off microphone comment.)

9 CHAIR PINCUS: Okay, okay. So is  
10 there -- so there's you. Okay. So Miranda.

11 MS. KUWAHARA: Thank you, Harold.  
12 Good morning everyone. So I wanted to take this  
13 time to provide a brief overview of the CMS'  
14 goals for the adult and child core sets. Our  
15 goal is really threefold. We aim to increase the  
16 number of states reporting core set measures;  
17 increase the number of measures reported by each  
18 state; and then increase the number of states  
19 using core set measures to drive quality  
20 improvement.

21 Core set data are used to obtain a  
22 snapshot of quality across Medicaid and CHIP.

1 They are presented in the annual Child Health  
2 Care Quality Report, the annual Adult Health Care  
3 Quality Report, the chart pack and other  
4 analyses. But ultimately, they aim to inform  
5 policy and program decisions.

6 So to provide a little bit of  
7 background information on the Medicaid adult set,  
8 the ACA requires the Secretary of Health and  
9 Human Services to establish an adult health care  
10 Quality Measurement Program, to standardize  
11 health care quality measurement across state  
12 Medicaid programs, and to drive quality  
13 improvement through the use of measures.

14 The initial core set was published in  
15 2012, and so this year marks MAP's fifth set of  
16 recommendations to HHS. I would also like to  
17 note that states report on the adult core set  
18 measures on a voluntary basis.

19 So here we have listed MAP's measure  
20 selection criteria. These criteria are used for  
21 all MAP task forces and work groups, and they  
22 were developed to assist MAP with identifying

1 characteristics that are associated with the  
2 ideal measure set, for either public reporting  
3 such as the adult core set or payment programs.

4           These should not be looked at as  
5 absolutely rules. They're more like guiding  
6 criteria. The central focus should be on the  
7 selection of high quality measures that address  
8 the National Quality Strategy. Competing  
9 priorities often need to be weighed against one  
10 another, and these measure selection criteria can  
11 be used as a reference when you are evaluating  
12 relative strengths and weaknesses of a program  
13 measure set, and how the addition of a measure  
14 would contribute to that set.

15           In addition to -- in addition to the  
16 measure selection criteria, we should look at  
17 factors that could also influence what a good  
18 measure looks like. You may want to look at the  
19 ability to use administrative data, the ability  
20 to capture a reasonably broad spectrum of the  
21 Medicaid population, also the ability to catalyze  
22 quality improvement in an area with low

1 performance or a recognized disparity.

2 Factors that indicate a measure might  
3 not be a good fit for a particular reporting  
4 program could be something like the measure  
5 requires data from sources that aren't universal,  
6 perhaps a survey or data pulled from a clinical  
7 registry; measures that are closely related to a  
8 measure already in the core set may also not be a  
9 good fit.

10 So I'll briefly walkthrough each of  
11 the measure selection criterion, starting with  
12 the NQF endorsement. That shows that, you know,  
13 the measure has been through the formal  
14 endorsement process. Evaluation criteria such as  
15 scientific acceptability, feasibility, usability,  
16 importance to measure, all of those factors have  
17 been considered.

18 Number two, program measure set  
19 adequately addresses each of the National Quality  
20 Strategy's three aims. Generally, we would like  
21 to see a program measure set that addresses each  
22 of the NQS' aims and corresponding priorities.

1                   Number three, program measure set is  
2 responsive to specific program goals and  
3 requirements. Here, we would like to see a  
4 program measure set that is fit for a purpose for  
5 our particular program.

6                   Number four, program measure set  
7 includes an approximate mix of measure types.  
8 Generally, we would like to see a mix of  
9 structure processed outcome measures, perhaps  
10 composite measures or cost resource use and  
11 experience of care measures. Variety here is  
12 really key.

13                  Number five, program measure set  
14 enables measurement of person- and family-  
15 centered care and services. For this criterion,  
16 we would like to see a program measure set that  
17 addresses access, choice, self-determination and  
18 community integration.

19                  Number six, program measure set  
20 includes considerations for health care  
21 disparities and cultural competency. This can be  
22 demonstrated by a program measure set that

1 promotes equitable access and treatment by  
2 considering sociodemographic factors such as  
3 race, ethnicity, socioeconomic status, gender,  
4 sexual orientation, age, geographical  
5 considerations.

6 We also can address populations that  
7 are at risk for health care disparities such as  
8 people with behavioral or mental illness.

9 Finally number seven, program measure  
10 set. Promotes parsimony and alignment. For this  
11 last criterion, we would like to see a program  
12 measure that supports sufficient use of resources  
13 for data collection and reporting, and supports  
14 alignment across programs. The program measure  
15 set should balance the degree of effort  
16 associated with measurement and its opportunity  
17 to improve quality.

18 CHAIR PINCUS: Just one comment.  
19 These are -- these criteria are not binary.  
20 They're all kind of, you know, kind of a  
21 continuum in terms of the kind of  
22 recommendations, in terms of how to inform our

1 recommendations.

2 MS. KUWAHARA: Thank you. So last  
3 year, the Adult Task Force supported the  
4 continued use of 28 measures in the adult core  
5 set. Additionally, MAP supported or  
6 conditionally supported six new measures from a  
7 total of 14 measures discussed. Recommended  
8 measures were chosen to fill gaps in the measure  
9 set, and measures not yet reviewed for  
10 endorsement by NQF received conditional support  
11 pending NQF endorsement.

12 Here on this slide we have listed the  
13 measures that were recommended by the Adult Task  
14 Force back in 2016, and the measures outlined in  
15 red indicate that they were adopted in the 2017  
16 core set. As an update, NQF No. 2829 was  
17 endorsed October 2016, but at the time of the  
18 recommendation it was not endorsed. Hence, the  
19 conditionally supported distinction.

20 So you'll notice back from our  
21 previous slide you did not see NQF No. 2902,  
22 Contraceptive Care Postpartum. While NQF 2902

1 was considered by the Adult Task Force last year,  
2 it was not recommended. Instead, the Child Task  
3 Force considered that measure and recommended it  
4 for inclusion in the child core set, but CMS  
5 chose to include this measure in both sets.

6 I would also like to note that the  
7 2017 updates to the core sets will take effect  
8 federal fiscal year 2017, which take effect no  
9 later than fall 2017, and technical  
10 specifications are really spring 2017.

11 So CMCS also added the Electronic  
12 Measure No. 2829, which provides states with an  
13 additional method of reporting for Measure No.  
14 0469, and then finally the last update was that  
15 the measure timely transmission of transition  
16 record was sunsetted.

17 Over the next four slides, we listed  
18 out all of the measures currently on the federal  
19 fiscal year 2017 adult core set, and measures  
20 outlined in red are newly added measures. These  
21 measures are dispersed over five clinical areas  
22 that include primary care access and preventive

1 care, maternal and perinatal health, experience  
2 of care, behavioral health and care of acute and  
3 chronic conditions.

4 I'll just breeze through these. These  
5 are also listed in handouts for those of you in  
6 the room with us today. And then finally on this  
7 slide, we have a breakdown of our measures on the  
8 2017 adult core set. We have measure type and  
9 NQF endorsement status, data collection method  
10 and alignment. But we'd like to note that these  
11 characteristics are not mutually exclusive.

12 Moving on to our core set measure  
13 updates, in 2016 the Adult Task Force  
14 conditionally supported the addition of use of  
15 opioids at high dosage in persons without cancer.  
16 This was recommended prior to NQF's endorsement,  
17 but it did receive endorsement January 2017 and  
18 is now associated with the number 2940.

19 So Measure No. 0418 underwent several  
20 changes in the past year. 0418 is the original  
21 version of No. 3148, which is undergoing  
22 maintenance review through the Behavioral Health

1 2016-2017 Project. No. 3132 is the e-measure  
2 version of 3148, and is currently a new measure  
3 under the same Behavioral Health Project. Both  
4 3148 and 3132 were recommended for endorsement,  
5 and they are currently going through the public  
6 comment phase.

7 Moving on to staff review of federal  
8 fiscal year 2016 state reporting data, the data  
9 we review here summarizes state reporting on the  
10 quality of health care furnished to adults  
11 covered by Medicaid during federal fiscal year  
12 2015. The data is based on state reporting of 26  
13 adult core set measures for federal fiscal year  
14 2015.

15 Just to throw out some highlights, 39  
16 states voluntarily reported at least one adult  
17 core set measure. States reported a median of 16  
18 measures. Comprehensive diabetes care,  
19 hemoglobin A1c testing was reported by the  
20 greatest number of states, coming in at 37  
21 states, and federal fiscal year was the first  
22 year reporting one new measure.

1                   That was comprehensive diabetes care,  
2                   hemoglobin A1c poor control, and during this year  
3                   one measure was retired, comprehensive diabetes  
4                   care, LDL screening. This slide illustrates the  
5                   most frequently reported measures. They were  
6                   largely focused on postpartum care visits,  
7                   diabetes care management and women's preventive  
8                   health care. As I mentioned previously, the  
9                   measure comprehensive diabetes care hemoglobin  
10                  A1c testing was reported by the greatest number  
11                  of states, and timely transmission of transition  
12                  record had the lowest levels of state reporting  
13                  and has since been retired.

14                  This chart compares the number of  
15                  states reporting each measure in 2013, 2014 and  
16                  2015. The measures above the red horizontal  
17                  divide highlight these 16 measures that were  
18                  publicly reported by 25 states. I'm sorry, 25 or  
19                  more states in federal fiscal year 2015.

20                  So for the purposes of illustration,  
21                  we bucketed the measures as high, moderate and  
22                  low levels of reporting. So we characterized

1 measures with high levels of reporting as those  
2 with 25 or more states reporting on a measure.  
3 CMS provided detailed analysis of state  
4 performance on 12 publicly reported measures.

5 For a measure to be publicly reported,  
6 data must be provided to CMS by at least 25  
7 states and meet internal standards of quality.  
8 Measures with medium levels of reporting were  
9 those reported by between 12 and 24 states.  
10 Levels of reporting these measures are generally  
11 gaining ground or holding steady.

12 And then measures with low levels of  
13 reporting were characterized as those reporting  
14 -- I'm sorry, with six or fewer states reporting  
15 on these measures. So I wanted to point your  
16 attention to NQF No. 2082, HIV Viral Load  
17 Suppression. This was collected for the first  
18 time in federal fiscal year 2014, and this  
19 measure decreased from four states collecting in  
20 2014 to three states collecting in 2015.

21 Currently, this is under review in the  
22 infectious disease 2016-2017 project, and it was

1 recommended for endorsement. The antenatal  
2 steroids decreased from five states collecting  
3 this measure in federal fiscal year 2013 to three  
4 in federal fiscal year 2014 and 2015.

5 Screening for clinical depression  
6 increased by one state collecting this measure in  
7 federal fiscal year 2015, and then timely  
8 transmission decreased from four states  
9 collecting this measure in federal fiscal year  
10 2013 and 2014 to two states collecting in federal  
11 fiscal year 2015. Then as a reminder, this  
12 measure, timely transmission of transition record  
13 was retired from the 2017 core set.

14 Finally, this slide and the following  
15 slide provide more granular reporting data at the  
16 state level, and this is also included in your  
17 handout, so you can take a little more detailed  
18 review at your desks.

19 The key takeaway, I think, from all of  
20 this is that while there's certainly room for  
21 improvement, overall the adult core set  
22 participation is strong. With that, if anyone

1 has any questions.

2 CHAIR PINCUS: Do people have  
3 questions for Miranda, in terms of the current  
4 state of states reporting and the kinds of -- and  
5 the measures that are part of this set? We'll  
6 have a chance to hear more from both state  
7 representatives and also from CMS about sort of  
8 their views about their current state of state  
9 reporting. But anything specific, any sort of  
10 technical issues about the measures themselves?

11 (No response.)

12 CHAIR PINCUS: Okay, Karen.

13 DR. MATSUOKA: So if we can go to the  
14 next slide, and then the next slide. So this is  
15 meant to be just a really short recap of that  
16 orientation webinar we had, was it a couple of  
17 months ago? I can't believe that time is flying  
18 so fast.

19 So most of us should be familiar for  
20 you, but we want to just reinforce a few key  
21 things that we have found helpful to reinforce in  
22 the experience that we've had in these MAP

1 meetings.

2 So as Harold mentioned, the reason why  
3 you're here is because you're here to recommend  
4 ways that we can strengthen these two core sets  
5 of measures for today in particular with the  
6 adult core set. At a really high level and in a  
7 nutshell, what are the core sets meant to be?

8 They're really meant to be sort of  
9 high level key indicators that experts like you  
10 have told us, along with our internal CMS  
11 colleagues, as well as our state partners have  
12 told us other things that we really need to be  
13 measuring, to ensure that we're monitoring how  
14 well our beneficiaries are faring and our served,  
15 in terms of the access to the care that they have  
16 as well as the quality of the care that they  
17 receive.

18 So that's the intent, and the core  
19 measures themselves really form the foundation to  
20 what we have here as sort of a quality  
21 measurement and improvement program in Medicaid  
22 and CHIP. It's a little startling to think that,

1       you know, prior to the CHIPRA for the child core  
2       set and the ACA for the adult core set, in  
3       Medicaid we never really had a consistent set of  
4       measures that states agreed to use and also  
5       measure consistently.

6               And so in many ways, the adult core  
7       set is the building block, the backbone of the  
8       measurement portion of the Medicaid and CHIP  
9       Measurement Improvement Program.

10              Next slide. So I'm really going to  
11       focus just on the measurement aspects really at a  
12       very high level, because our next two speakers,  
13       Deirdra Stockmann and Judy Zerzan, are going to  
14       get into a lot more depth in terms of how we  
15       actually use the measures, in terms of how we  
16       analyze them, how we use them for quality  
17       improvement, and we want you to keep this in mind  
18       because at the end of the day, the people who are  
19       reporting these measures are states.

20              So we really want you to think about  
21       picking measures that are going to really help  
22       them in terms of measuring the things that

1 matter, as well as facilitate their quality  
2 improvement efforts.

3 Next slide. So as Miranda mentioned,  
4 the core sets are voluntary quality reporting  
5 programs by states. We break the measures out  
6 into five broad domains that you see there,  
7 primary care access and preventive care,  
8 behavioral health, perinatal health, care of  
9 acute and chronic conditions and dental and oral  
10 health services for kids.

11 We have two sets of measures. The  
12 adult core set is less developed in terms of  
13 evolution in years and practice, just because of  
14 the ACA and when it started. But you'll see that  
15 as Miranda mentioned, we have 30 measures in the  
16 2017 core set. We just completed our fourth year  
17 of voluntary reporting, and as Miranda mentioned,  
18 we have 39 states reporting at least one adult  
19 core set measure.

20 Similarly, on the child core set it's  
21 been around a little bit longer, so we have a  
22 little bit more states reporting those measures.

1 But that's been -- we just finished the eighth  
2 year of voluntary reporting for that set, and we  
3 have all 50 states and D.C. reporting on at least  
4 one child core set measure.

5 Next slide. So in terms of how we in  
6 CMCS think about this Quality Measurement  
7 Program, we have a few key goals. The first is  
8 to increase the number of states reporting our  
9 core set measures. So you know, here we would  
10 encourage you to really think about, you know,  
11 desirability and relevance for the measure to  
12 what states are trying to do, as well as the  
13 feasibility for them to report.

14 We're trying to maintain or increase  
15 the number of measures reported by each state.  
16 We're trying to improve the quality of the data  
17 that's reported to us in terms of completeness  
18 and accuracy. So for example in the case of  
19 child core set, the extent to which states are  
20 reporting both Medicaid and CHIP.

21 We're looking to streamline data  
22 collection and reporting processes as much as

1 possible. So if states are already reporting  
2 data somewhere, it's an opportunity to leverage  
3 that and not have states report the same thing  
4 twice, and most importantly we really want to  
5 support states to drive improvements in health  
6 care quality and health outcomes using this core  
7 set data.

8 Next slide. So again, in concrete  
9 terms what is it that we're asking of you? We're  
10 asking you to give us recommendations on how we  
11 might strengthen and today the adult core set.  
12 In particular, you can assist us by identifying  
13 ways to identify gaps and help us identify  
14 measures that could help fill those gaps, give us  
15 input into what measures we might think about  
16 retiring, and ways to better align our measure  
17 set with other kinds of measure sets and quality  
18 reporting programs happening across HHS and also  
19 at the state level and in commercial plans.

20 We really urge you to focus on  
21 incremental changes. This is a fairly young  
22 program and as you know, and as the states will

1 attest, you know, reporting these measures is not  
2 an easy task. So big overhauls of measure sets  
3 will be very disruptive and not in a good way.

4 So focusing on incremental changes and  
5 considering state and staff time resources that  
6 it will take to learn and incorporate whatever  
7 new measures it is that you're thinking about  
8 recommending.

9 Next slide. And a couple of key  
10 important considerations, and we want to put this  
11 forward because in many ways, this MAP task force  
12 and the core sets serve a very different purpose  
13 than what other MAP task forces that you might  
14 have been sitting on do.

15 So a couple of reminders, that the  
16 Medicaid core sets are tools that states can use  
17 voluntarily to monitor and improve the quality of  
18 health care provided to Medicaid and CHIP  
19 enrollees. They're really intended for quality  
20 improvement purposes. They're not intended for  
21 things like payment and accountability purposes.

22 The Medicaid core sets are for state

1 level reporting, not provider level reporting.  
2 That means the denominator is the beneficiaries  
3 across a state, not necessarily benies in a  
4 particular practice or a plan. Under statute,  
5 state reporting on these measures is voluntary,  
6 and we do encourage you to think about alignment  
7 with other Quality Measurement Programs, but  
8 always keeping in mind that the Medicaid and CHIP  
9 populations are unique, and that there are trade-  
10 offs to think about in terms of adopting measures  
11 that may be used -- may be in use across other  
12 programs.

13 Next slide. So I'll leave you here  
14 with resources that anyone can click on to learn  
15 a little bit more. So as I mentioned, the  
16 Medicaid, CHIP child core and adult core set  
17 measures, they are state level Medicaid and CHIP  
18 measures. We're working very hard with many of  
19 you in the room actually to develop some plan  
20 level Medicaid and CHIP measures as part of the  
21 quality rating system for Medicaid managed care.

22 We've also been at work developing

1 some provider-level measures that align well with  
2 the state level measures, and here are just a  
3 couple of them, and I think that's it.

4 CHAIR PINCUS: Questions for Karen?  
5 Clarke.

6 MEMBER ROSS: I'd like your thoughts  
7 on -- you have five domains on one of those  
8 slides, and patient experience is not one of the  
9 domains, and the January National Quality Forum  
10 MAP report to CMS said, identified six high-value  
11 needed measures. One was patient reported  
12 outcomes and two was patient experience.

13 So your thoughts on integrating  
14 patient experience as an equal important  
15 recognizable domain in this endeavor.

16 DR. MATSUOKA: Yes. So I will say  
17 that, you know, I think divisionally as well as  
18 the agency overall, we very much believe in the  
19 importance of patient-reported outcome measures,  
20 and I think the reason why you don't necessarily  
21 see that called out as its own domain is because  
22 we tend to think of it more as a data source, as

1       opposed to a domain.

2               So in any one of those five domains  
3       you could have patient-reported outcome measures,  
4       just like you could have measures that are  
5       sourced from claims or measures that sourced from  
6       medical records. We think of it more as a source  
7       and, you know, in many ways maybe the most  
8       important source.

9               But I think some of the trade-offs in  
10       terms of feasibility come with sort of the burden  
11       that's often associated with collecting patient-  
12       reported outcome measures, especially at the  
13       state level. So on the child core set side, for  
14       example, we've had a lot of discussion about  
15       hospital HCAHPS, just as an example.

16               I will say that CAHPS, CAHPS 5.0 is on  
17       both the child and adult core sets. We do have  
18       at least one patient-reported outcome measure.  
19       But even when we think about a variant of that  
20       like HCAHPS, Hospital CAHPS on the child side,  
21       helping states think through how do you collect  
22       that information voluntarily from hospitals in

1 your state, and then aggregate that up to a state  
2 level measure, there are different, different  
3 -- it becomes exponentially challenging when we  
4 start to get into those kinds of data sources.

5 So it's not to say that we don't think  
6 that they're important. We absolutely believe  
7 that they're important. But we want you to help  
8 us think through, you know, what measures we  
9 should be including beyond the CAHPS, but then  
10 also thinking about some of the measurement  
11 strategies to ensure that that's something that  
12 states can do without additional resources,  
13 because this is not a funded program either.  
14 That's important to know, that states do not get  
15 funding from us to do this reporting.

16 MEMBER ROSS: If I could follow up,  
17 the National Health Council has a grant from  
18 PCORI. The National Health Council is an  
19 organization that's been around since 1920. It  
20 represents all the key sectors in health care but  
21 most important is they represent 52 voluntary  
22 health agencies, heart, cancer, diabetes, all the

1 big ones, and smaller family-based organizations.

2 And I think what unifies diabetes,  
3 heart, mental illness, intellectual disability  
4 patients and consumers and beneficiaries is that  
5 the patient experience is an equally important  
6 domain and not just a piece of data within the  
7 domains you have. So and it's a uniform -- it's  
8 a high priority of the National Health Council  
9 and of course Consortium for Citizens With  
10 Disabilities and all the consumer family-based  
11 organizations that are organized nationally.

12 DR. MATSUOKA: Great. So I'll just  
13 underscore that. We think patient-reported  
14 outcomes are incredibly important, and we would  
15 love to talk with you further about how we might  
16 help states to measure that at state levels.

17 CHAIR PINCUS: Marissa.

18 MEMBER SCHLAIFER: I just wondered if  
19 you could provide any more information. I know  
20 it's forthcoming, but on the Medicaid managed  
21 care quality rating system. How, and I know when  
22 I asked this second question that was way too

1 early to be asking, but how these measures may or  
2 may not feed into the Medicaid managed care QRS  
3 and I think one thing that I know last year was  
4 still outstanding is whether those measures will  
5 go out for public comment, how you see --

6 I mean are we -- your thoughts, yeah,  
7 on a little more than just forthcoming.

8 DR. MATSUOKA: Well, so you're only a  
9 little less earlier than you were last year.  
10 We've literally just started, you know, the work  
11 around this and we have expert panels kind of  
12 weighing in and giving us feedback, not unlike  
13 these MAP task forces before the QRS. We're also  
14 doing specific stakeholder listening sessions of  
15 key groups of individuals like state programs and  
16 health plans.

17 So we're really still very much in the  
18 early days of our thinking, but certainly, you  
19 know, to the extent that these core sets are  
20 meant to be the key indicators of quality for the  
21 beneficiaries that we serve, that for sure means  
22 that, you know, the extent to which QRS measures

1 that aligns with and helps to facilitate the kind  
2 of information states need to drive improvement  
3 ultimately for all their beneficiaries at the  
4 state level, that is a key principle that guides  
5 the work of the QRS.

6 In terms of whether the measures will  
7 get released for public comment, the managed care  
8 final rule did say that the federal QRS,  
9 including the measures, the methodology, the  
10 framework, all of that will be published for --  
11 in proposed and final form in the Federal  
12 Register. So there will at least be a formal  
13 public comment process, but we're also trying to  
14 take a very rigorous and transparent stakeholder  
15 listing approach.

16 And so our hope is that even before  
17 those formal comment opportunities come, that  
18 there will be lots of informal opportunities as  
19 well.

20 CHAIR PINCUS: I had a question  
21 myself. So and actually your initial discussion  
22 in terms of presenting how long this has been

1 around, maybe think about in the first meeting  
2 that we had several blocks from here in the  
3 basement of a big hotel, where we went, where we  
4 first went through this.

5 I guess at some point you had, CMS had  
6 a contract with I think it was Mathematica or  
7 RTI, I can't remember which one it was, to  
8 actually work with states around the  
9 implementation of this. I think that's expired,  
10 that contract or is it something still going on,  
11 where you're actually engaging with states to  
12 help them to implement that, and if so, what are  
13 you learning?

14 DR. MATSUOKA: Yes. So we do have an  
15 MPR contract. I'm looking to -- I want say it's  
16 the same contract for the duration of the entire  
17 Quality Measurement Program. So that contract is  
18 still very much in place. The data quality  
19 standards that Miranda alluded to is in large  
20 part what our contractors help us with, which is  
21 you know states, we put out the technical  
22 specifications, you know.

1                   There's -- it's not an easy task to  
2                   take what might have originated as a health plan  
3                   level measure or a provider level measure and  
4                   translate that into a state level measure. So  
5                   the first step that the contractor does is to do  
6                   that translation, and then the rest of the year  
7                   is really helping and fielding questions that  
8                   come in from states with regard to how do  
9                   you -- how do you actually report that measure  
10                  according to the specifications.

11                 Then of course once the data's in,  
12                 there's an additional level of review. You know,  
13                 a lot of times despite, you know, our contractors  
14                 and states' best efforts, it's not until we  
15                 actually see the data that we start to see oh,  
16                 you know, improvement jumps 300 percent in one  
17                 year. Is that really right, you know?

18                 And it's those kinds of things and  
19                 data anomalies that then spark an additional  
20                 round of data claiming, data review, data  
21                 technical assistance with states, to then finally  
22                 come up with the bar charts and the maps that

1 Miranda presented. There's a lot of work that  
2 actually goes into the production of those.

3 So yes, our contractors is very  
4 engaged. We're tied at the hip with each other  
5 in terms of the work that we do with the states.

6 CHAIR PINCUS: Is there a link that we  
7 could get, so some information or feedback to us  
8 about sort of, you know, the more specific nature  
9 of the states', sort of, issues and problems in  
10 gathering the data and sort of interpreting it  
11 and using it?

12 DR. MATSUOKA: Sure.

13 CHAIR PINCUS: Obviously, we get  
14 testimony from some states and there are people  
15 here that are involved in it, but you know, the  
16 consolidated information across all, the whole  
17 program, would be useful for us to get that  
18 information, you know, in some kind of summative  
19 way obviously.

20 DR. MATSUOKA: I think we did send  
21 you, the task force members, in summary not  
22 deidentified, aggregated form some of these high

1 level reporting issues that have cropped up for  
2 the states. But if there is anything more  
3 specific than that, certainly you all should let  
4 us know. It would be helpful.

5 CHAIR PINCUS: Deborah.

6 MEMBER KILSTEIN: Just a question. Is  
7 there any ongoing auditing of -- or has there  
8 been any auditing of the state data collection  
9 and submission, to see that they are in fact  
10 submitting the data in accordance with the  
11 specifications that you issued?

12 DR. MATSUOKA: No formal audit in the  
13 sense of like OIG or anything like that. But  
14 certainly that's the role that we ask our  
15 contractor to play. But more in a quality  
16 improvement/quality assurance kind of way as  
17 opposed to an auditing kind of function.

18 CHAIR PINCUS: Okay.

19 (Off mic comments.)

20 CHAIR PINCUS: Okay. Deirdra.

21 DR. STOCKMANN: Good morning and thank  
22 you for the opportunity to join you today and

1 share for a few minutes a little bit more about  
2 how we at the Center for Medicaid and CHIP  
3 Services at CMS use the adult core set measures  
4 for learning and improvement, and I think we'll  
5 build nicely off the conversation we've just been  
6 having.

7 Next slide, please. So how do we use  
8 the core set? We use it in two primary ways,  
9 which have been prefaced already this morning.  
10 First, to better understand our programs. We  
11 work with states to help them collect and report  
12 the measures, to help us know who is getting what  
13 care when, and identify opportunities for  
14 improvement.

15 I'll talk a little about how we're  
16 working with states to help them collect and  
17 report the measures, specifically the HIV viral  
18 load suppression measure, which has also been  
19 called out so far this morning in just a moment.

20 Then second, we use the core set to  
21 drive improvement in the quality of care that is  
22 delivered, with the aim of improving health

1 outcomes. I'll use our work with states on  
2 diabetes management as an example of that.

3 So next I'll flesh out some of these  
4 examples and then we'll conclude with some  
5 considerations for using the measures for  
6 improvement based on what we have been learning  
7 as we're increasingly working with states in that  
8 capacity.

9 Next slide, please. So here's a  
10 familiar slide for those of you who have been  
11 paying attention and reading along this morning.  
12 This slide shows the number of states that  
13 reported each of the adult core set measures in  
14 FY '15.

15 You'll see as we have discussed that  
16 the A1c testing measure is right up there at the  
17 top, the most commonly reported, and the short-  
18 term complications for diabetes measure is also  
19 fairly commonly reported. I think it fell into  
20 the most commonly reported bucket of NQF's.

21 And this is partly a type -- partly a  
22 result of the type of measures they are, as drawn

1 from administrative claims. But I think it also  
2 reflects the attention to diabetes care as a  
3 result of the high burden and high cost of  
4 treating people with uncontrolled diabetes. The  
5 A1c poor control measure was a little bit less  
6 commonly reported as it falls into that middle  
7 bucket this year.

8 But that may be due to the fact also,  
9 as has been pointed out, that this was a new  
10 measure in fiscal year '15. So it was the first  
11 time the states were reporting it and sometimes  
12 there's a little ramp up period for some states,  
13 as they're, you know, looking at whether they  
14 have the capacity to report when measures are  
15 added.

16 And of course you'll note that the HIV  
17 viral load suppression rates is one of the least  
18 reported measures. So I'll talk a little bit  
19 about why that is on the next slide, please.

20 So let's look at the HIV viral load as  
21 a case of how we work with states to collect and  
22 report measures to improve our understanding of

1 the programs, of our programs. This is an  
2 example -- both the examples I'll give today are  
3 really examples of work in progress, work that  
4 we're doing now with states.

5           Viral load suppression is an indicator  
6 of effective disease management and better health  
7 for people living with HIV, as well as decreased  
8 risk of transmission. For these reasons,  
9 improving rates of HIV viral load suppression is  
10 a national goal. The National HIV/AIDS Strategy  
11 has an ambitious goal of 80 percent of people  
12 living with HIV are virally suppressed by 2020.

13           Alignment with national goals and  
14 commonly used indicators are among the reason why  
15 HIV viral load suppression is part of our core  
16 set, and why this body recommended it for  
17 inclusion some time ago. Additionally over the  
18 last several years, more individuals living with  
19 HIV have become enrolled in Medicaid, moved over  
20 from other programs or from being uninsured or  
21 under-insured, in some cases receiving care from  
22 multiple venues including Medicaid.

1           But as you have seen, very few states  
2           are reporting this measure, and the main reason  
3           for this is that reporting the measure requires  
4           linking data sets, most commonly one that is held  
5           by the public health agency in a state. Viral  
6           load is a reportable condition to public health.  
7           So the data are sitting somewhere, and they have  
8           to be linked with who is enrolled in Medicaid,  
9           which is sitting somewhere else.

10           For someone like me who is not a data  
11           linking person, I think all right, we should be  
12           able to do that. There's some sort of  
13           identifiers and you can just link the pieces and  
14           why is that complicated? Well, it's very  
15           complicated.

16           And I'm not going to get into all of  
17           the details here, but because it is complicated  
18           and we wanted to help states interested in  
19           collecting and reporting the measure and using it  
20           for improvement, CMS worked with CDC and HRSA, as  
21           well as the Office of the Assistant Secretary for  
22           Health in HHS, to launch an HIV Health

1 Improvement Affinity Group last fall, with one of  
2 the primary goals being to help states collect  
3 and report this measure, and/or to at least  
4 better figure out why it is so challenging to  
5 report.

6 All of our agencies really have a  
7 shared interest, as I mentioned, because of the  
8 different programs under which people living with  
9 HIV are receiving care, be it very critical  
10 importance of coordinating that care and  
11 identifying people who are out of care and  
12 helping to get them into care.

13 Nineteen states voluntarily expressed  
14 interest. There's no money associated with this  
15 affinity group. Nineteen states voluntarily  
16 expressed interest, and brought both their  
17 Medicaid agency and HIV/AIDS and public health  
18 programs to the table to work together, and most  
19 of these states are now working through  
20 strategies to link data sets, to identify those  
21 people enrolled in Medicaid who are virally  
22 suppressed or not.

1                   So through peer-to-peer exchange, as  
2                   well as directed individualized technical  
3                   assistance, states have been sharing their  
4                   approaches for developing data use or data  
5                   sharing agreements, memoranda of understanding.  
6                   They're talking through. There are various  
7                   different approaches for doing this, discussing  
8                   common challenges and helping each other work  
9                   through them.

10                  This process is also providing  
11                  invaluable feedback to us at CMS about those  
12                  challenges states face in collecting this  
13                  measure, and helping us think through how we can  
14                  make it easier for states to report.

15                  The HIV Health Improvement Affinity  
16                  Group thus provides multi-directional  
17                  opportunities for communication and collaboration  
18                  across federal agencies and states, to help us  
19                  better understand how the Medicaid program is  
20                  meeting the needs of people living with HIV, and  
21                  where there may be opportunities for improvement.

22                  Moving on to the next slide, so first

1 we use the measures to better understand our  
2 programs, and of course we still have a long way  
3 to be able to use the HIV viral load suppression  
4 measure to help us do that. But once we do, it  
5 will tell us a lot of important information about  
6 how we can then identify and act on opportunities  
7 to improve.

8 So now let's turn to some more  
9 commonly reported measures, and on this slide  
10 you'll see the geographic variation in  
11 performance on a hemoglobin A1c testing measure,  
12 which is that again everyone's going to really  
13 know by the end of the day. That was the most  
14 commonly reported measure in fiscal year '15, but  
15 it doesn't tell us that much information.

16 So moving on to the next slide,  
17 effective management of diabetes improves the  
18 health of individuals and reduces costs of  
19 treating preventable complications. There are  
20 many measures of diabetes care, as I'm sure many  
21 of you are familiar with, and just a few of them  
22 are included in our core set.

1                   So last summer, we launched a Diabetes  
2                   Prevention and Management Affinity Group as part  
3                   of our series of year-long voluntary  
4                   opportunities for states under our Medicaid  
5                   Prevention Learning Network. Five states are  
6                   participating actively in the affinity group,  
7                   working to identify and implement policy changes  
8                   and/or quality improvement efforts to improve  
9                   access to and delivery of diabetes prevention,  
10                  and/or management services.

11                  So it's a bit of a broad net. I'm  
12                  going to speak today about the diabetes  
13                  management components, because that's what we  
14                  have measures in our core set about. Anyone who  
15                  is interested in what we're doing on diabetes  
16                  prevention I will be happy to talk with you at  
17                  the break about that.

18                  So with respect to diabetes  
19                  management, again where we have indicators of  
20                  quality care in our core set, a few states have  
21                  focused on their improvement efforts on  
22                  increasing enrollment in the diabetes self-

1 management education services that are available  
2 in their states, that are under-enrolled and  
3 where a very, very small proportion of people who  
4 are diagnosed with diabetes actually participate  
5 in those.

6 So they've identified that as an  
7 opportunity, a low cost opportunity, an existing  
8 resource that they could make better use of, to  
9 hopefully improve care. We don't know yet.

10 Well, I'll say we don't even quite know what the  
11 best strategies for increasing enrollment are.

12 We've spent a lot of time reaching out to the  
13 national experts at the American Diabetes  
14 Association and the American Association of  
15 Diabetes Educators and the CDC to get intel on  
16 what are the best ways of getting people enrolled  
17 in these programs.

18 I'll tell you we've had them all  
19 present and we do not have any conclusive  
20 information. So it's a great place for state  
21 Medicaid agencies to really innovate and test out  
22 ways to increase enrollment and participation in

1       these programs, and then follow up and see if  
2       they have the impact that they have been  
3       demonstrated to have through studies.

4               But we still have a lot of room to  
5       better use those programs. So a couple of states  
6       have focused on that as their strategy, and then  
7       another state, West Virginia, added diabetes as a  
8       qualifying condition for their Health Home  
9       program. Missouri is participating in our  
10      affinity group as well. They've already had  
11      diabetes as a qualifying condition for their  
12      Health Home program.

13             We think West Virginia is going to be  
14      looking at the A1c poor control rate now over the  
15      -- now that they've established the Health Home,  
16      which has just started enrolling individuals over  
17      the next year, to see if that comprehensive,  
18      coordinated care approach that's provided through  
19      Health Homes has impact on control, on diabetes  
20      control.

21             So on to my last slide. So through  
22      our affinity groups and other engagement with

1 states, we're increasingly working to support  
2 state efforts to identify quality improvement  
3 actions to test, by connecting them with other  
4 states, experts and best practices, as well as  
5 providing some guidance on the quality  
6 improvement process.

7 And while we want states to focus part  
8 of their efforts on improving on at least one  
9 core measure or a set of them, we realize that  
10 the annual reporting cycle of the core measures  
11 doesn't necessary provide the kind of shorter  
12 term feedback that is really useful and needed  
13 for quality improvement. So we also work with  
14 states to identify some intermediate metrics or  
15 indicators that will give a signal as to whether  
16 the action they're testing is likely to have an  
17 impact on that core measure.

18 So finally I want to conclude with a  
19 few reflections on using the measures for  
20 improvement, now that we're doing more of that  
21 work with states, and thinking about where we  
22 might focus our future efforts in working with

1 states on quality improvement.

2 So one, some process measures are more  
3 useful for quality improvement than others. I  
4 already alluded to the Alc measure. Process  
5 measures that indicate solely whether a test was  
6 done or whether something was documented in a  
7 chart, while important for the care of those  
8 individuals aren't ideal measures to pin quality  
9 improvement efforts to because they don't  
10 indicate whether or not the care that will  
11 improve health was delivered.

12 So in the case of Body Mass Index, for  
13 instance, the obesity community agrees, research  
14 community and provider community agrees and we  
15 were just on a call about this last week, that  
16 documenting BMI serves an important role as a  
17 screening for people who are overweight or who  
18 have obesity.

19 So it's an essential step. But you  
20 could in theory have a 100 percent of people with  
21 their BMI documented in a chart, and zero percent  
22 of them actually getting services that can help

1       treat the obesity, right. It's a little bit of  
2       hyperbole, but it's entirely possible --

3                       (Telephonic interference)

4                       I don't think that's me, okay. There  
5       we go. Effective evidence-based treatment for  
6       obesity, it's very much under-utilized.

7                       The diabetes A1c testing measure is  
8       another one, where we have a lot of people. It's  
9       an easy to report measure and there is certainly  
10      room for improvement. People need to have an A1c  
11      test to know if they're in or out of control.

12                      But again, you could have 100 percent  
13      of people with diabetes getting their A1c test,  
14      but a large percent of them are out of control  
15      and at risk of major complications, right. It  
16      doesn't give us an indicator of whether they're  
17      getting the follow-up care.

18                      So it's important to have those  
19      screening measures, but to pair them with more  
20      outcomes or meaningful process measures, and  
21      those are the types of measures that states  
22      really want to do quality improvement around, not

1 just improving a testing rate or improving  
2 documentation of something in a chart.

3 So related to that, we're also hearing  
4 from states that they prefer to use outcome  
5 measures, the meaningful process measures, or  
6 better yet, outcome measures to drive their  
7 improvement efforts, and there are a lot of  
8 reasons for this and we won't go into great depth  
9 and we haven't done a lot of research on it, but  
10 I think there are a couple of key things we're  
11 hearing from states.

12 One is the increased attention to  
13 value-based purchasing and the movement in that  
14 direction. As Karen noted, our measures are not  
15 designed for payment purposes, but states are  
16 doing a lot more work in that area and they're  
17 looking for alignment in their measures, and what  
18 types of measures they could use for multiple  
19 purposes or maybe sets of measures.

20 So they're thinking a lot in that  
21 frame, and also have states have state health  
22 improvement plans or other sort of broader state

1 objectives that are outcome oriented. They're  
2 not increase the rate of people with diabetes who  
3 got an A1c test; they're increase the outcomes  
4 for people living with diabetes; decrease  
5 complications, decrease hospitalizations, or even  
6 higher level than that. Prevent diabetes  
7 probably more.

8 So the interest in states and really  
9 if they're going to take on a quality improvement  
10 effort is around improving outcomes for the  
11 people enrolled in their Medicaid programs. So I  
12 will stop there. I think that's all I have.  
13 Thank you again, and happy to take questions.

14 CHAIR PINCUS: Any questions for  
15 Deirdre?

16 MEMBER OSBORNE-GASKIN: So I have two  
17 questions. Just one of our -- I'm just curious  
18 about the fact that the affinity group for HIV  
19 has 19 states participating, but then you only  
20 have three states that actually reported. So I'm  
21 assuming those three states are in the affinity  
22 group?

1 DR. STOCKMANN: I think two of them  
2 are in the affinity group, and I did not give the  
3 time line. So the affinity group launched last  
4 fall. We're about midway, and so we're hoping to  
5 see a bit of an uptick of reporting next year and  
6 an even bigger uptick in reporting the year after  
7 that. So a bit of a long process, but yes, we do  
8 have some of those states that are reporting.

9 My understanding is they're not using  
10 exactly the technical specifications, because the  
11 tech specs are hard to meet, and so that is  
12 something that we're really considering. Like I  
13 said that back and forth communication with the  
14 states, better understanding of what those  
15 challenges are and how they might be able to be  
16 changed.

17 But yes, we have some of the states  
18 that have done it, that have at least established  
19 data linkage agreements and they're helping other  
20 states look at, you know, they're sharing their  
21 experience with other states that are trying to  
22 build those agreements.

1                   MEMBER OSBORNE-GASKIN: And I guess my  
2 second question is related to the diabetes. So  
3 the testing, you said that the states are  
4 interested in outcome measures. So I'm curious  
5 about if any of the states are even looking at  
6 the HbA1c testing in relation to pre-diabetes.  
7 So you talked about conventional diabetes, but  
8 you know, prevention probably would be an HbA1c  
9 prior to getting that, just the ones with poor  
10 control.

11                   So if you have an HbA1c that's, you  
12 know, pre-diabetic, what is -- I think the states  
13 probably would be interested in traveling back  
14 with people, to look at how do we actually reduce  
15 the HbA1c in folks who are pre-diabetic, so they  
16 don't actually have it.

17                   But you know, we know that's a group  
18 that you can definitely work on to prevent  
19 actually more people being, you know, becoming  
20 diabetic. So I just was curious about that, if  
21 that was part of the discussion in the affinity  
22 groups, I mean besides the other challenges that

1       you have?

2                   DR. STOCKMANN:  Absolutely, and  
3       there's a lot of discussion in the affinity group  
4       around diabetes prevention and getting people who  
5       are at risk for developing diabetes enrolled in  
6       or engaged in diabetes prevention programs and  
7       services.  It is my understanding that our  
8       testing measure is for people with diabetes,  
9       right?  The denominator is for people who already  
10      have diabetes.

11                   So it is a sort of ongoing whether  
12      those people are receiving ongoing care.  So it  
13      can't really be used for that prevention piece,  
14      but that it's an opportunity for consideration.  
15      Are there measures available that would help us  
16      identify people who are at risk for diabetes and  
17      drive more improvement, you know, delivery of  
18      care and preventive services so that they don't  
19      develop diabetes?

20                   MEMBER OSBORNE-GASKIN:  I mean I  
21      guess, you know, to kind of follow up, it's just  
22      interesting that, you know, one of the -- and I'm

1 a new member so I don't know if I'm not supposed  
2 to be saying this.

3 DR. STOCKMANN: You're doing your job.

4 MEMBER OSBORNE-GASKIN: But it's  
5 interesting that we do have a measure that looks  
6 at adult BMI calculations.

7 So is there any way -- is there a  
8 link, you know? If you have an adult BMI, just  
9 not being able to check a box and see that you  
10 actually did it. But if it is elevated, you  
11 know, has there been a HbA1c test, because that  
12 actually would make, you know, be clinically  
13 appropriate to do anyway. So --

14 DR. STOCKMANN: Yep.

15 MS. GORHAM: Just a bit of more  
16 housekeeping for our new members. If you would  
17 like to speak, if you could raise your tent, your  
18 name tent, so that way we know to -- Harold will  
19 call on you. We can only have three mics active  
20 at a time. So after you speak, if you can be  
21 sure to cut your mic off.

22 CHAIR PINCUS: Helen.

1 DR. BURSTIN: If you call me, I'll  
2 call on you. That was really interesting.  
3 Deirdra, I have two questions for you, I guess  
4 one of which if you look at the HIV measure in  
5 particular, and I will say having sat through the  
6 infectious disease meeting, that was by far the  
7 most important measure everybody agreed at the  
8 table related to HIV.

9 All the other process measures had  
10 lots of arguments about them, visit rates, et  
11 cetera, because everybody just wanted to know  
12 this one. This one was most important and  
13 clearly got the best reviews. So if it's already  
14 required as part of all of these sort of Ryan  
15 White programs at community health centers, I  
16 guess I'm having a little bit of trouble  
17 understanding the link to state reporting.

18 Is there an opportunity to roll up  
19 what's already been collected, and I guess my  
20 second question, I apologize if these are naive,  
21 the second one is has Medicaid taken an  
22 opportunity to talk to any of the major labs or

1 the IT standards folks? I mean the both the  
2 diabetes control and the HIV viral load require a  
3 lab result. You can't get that from a claims.  
4 You can't -- claims will only say you ordered it.

5 Have you had any discussions directly  
6 with, since it's basically, you know, two big  
7 monster labs in the country if we do most of this  
8 for the United States, as a way to potentially  
9 think about alternative pathways to getting those  
10 data?

11 DR. STOCKMANN: Well I can start, and  
12 then Karen if you can add. So great questions,  
13 it's not naive. We've certainly been discussing  
14 your first question internally as well, and it is  
15 my understanding that the data all exist. But  
16 whether or not they are attached to somebody  
17 enrolled in Medicaid is not in that data, that  
18 existing data set.

19 So you have to -- you have to connect  
20 them, and that there -- and there's lots of  
21 challenges about going back and forth. But  
22 you're right, and we have been very much thinking

1 about the data are there. How can we make it --  
2 is there some way that we can make it easier in  
3 our partnerships with HRSA that runs the Ryan  
4 White Program, to somehow add an indicator.

5 I don't know the answer to that, but  
6 we're absolutely having those conversations  
7 because there's, as you said, broad agreement  
8 that this is an important measure and especially  
9 as more of these individuals have become enrolled  
10 in Medicaid.

11 And as for the second one about  
12 discussion with labs, I have not been in any part  
13 of those conversations. But if anybody else  
14 would like to chime in on that.

15 MS. ZERZAN: So Alabama is really  
16 close to getting that contract to do exactly  
17 that, and I think Tennessee has one. But those  
18 are the only two states that I know of that do  
19 that. But it is a great idea.

20 MEMBER JONES: Yeah. I would just  
21 share from the managed care perspective, you're  
22 hitting a lot of our struggles to get the data

1 reported exactly, you know, because the lab  
2 results come in separately from the claim and  
3 they're not linked. So you have to -- I know,  
4 and it sounds like an easy fix, but it is not.

5 (Off mic comments.)

6 MEMBER JONES: Right. Now we're  
7 hoping with the electronic medical records and  
8 more of the autofeeds that we can start grabbing  
9 some of those a little easier. We are working  
10 with the two big labs. A lot of the Medicaid,  
11 also though, is from little mom and pop labs,  
12 which is very challenging to get datafeeds from  
13 there.

14 So a lot of work, at least, in our  
15 world is being done or trying to be done to grab  
16 those, but it's hard.

17 CHAIR PINCUS: Rachel and then  
18 Deborah.

19 MEMBER LA CROIX: Thank you. I know  
20 in Florida Medicaid, we have not yet reported.  
21 We're one of the 11 states that hasn't reported  
22 adult core set measures. But we have been

1 requiring our plans to report on 16 of those  
2 measures to us for their populations. One of the  
3 ones we have required since it's been available  
4 is viral load suppression.

5 We're not confident that the data  
6 we're getting from our plans is fully accurate or  
7 contains all of the data, and to echo Mary Kay's  
8 point. One of the issues that our plans have  
9 told us about is not being able to get those lab  
10 values even for their members. Even if they're  
11 the payer to the lab companies, labs are often  
12 requiring a higher level of signing of a  
13 confidentiality agreement, where the patient  
14 would allow the plan to get their lab values  
15 related to HIV and AIDS.

16 And so we are trying to look into that  
17 as well, and we are aware that our Department of  
18 Health, which is a separate agency from our  
19 Medicaid agency, does have some of those data.  
20 So we will be looking into whether we're able to  
21 get those data shared. We know our plans get  
22 immunization data from the Department of Health,

1 and do get that for their panels of members, but  
2 we're looking into whether we can do that for the  
3 viral load values as well.

4 CHAIR PINCUS: Deborah.

5 MEMBER KILSTEIN: I was just going to  
6 weigh in on the same, pretty much the same thing,  
7 which is getting information from the two large  
8 labs is less of an issue, except for when you're  
9 talking about HIV, and but the reality is so many  
10 labs are done not only in physician offices but  
11 hospitals and clinics and other places where it  
12 is much harder to get that lab feed from.

13 DR. MATSUOKA: Can I just add one more  
14 thing just to kind of add even more complication  
15 to this?

16 CHAIR PINCUS: Sure.

17 DR. MATSUOKA: So for exactly those  
18 reasons, I think, you know, one of the key  
19 strategies that we're trying to think through in  
20 the affinity group is the public health data,  
21 because you know for surveillance reporting  
22 purposes, no matter what lab you use, the data

1 does, in theory anyway, go to a public health  
2 agency.

3 But as it turns out, many public  
4 health agencies don't necessarily use LOINC. But  
5 of course LOINC is how we have specified our  
6 measure, because we use the HRSA measure. So it  
7 just -- it's just layers and layers and layers of  
8 complexity for something that really should not  
9 be that hard. Yeah.

10 CHAIR PINCUS: So I had a question  
11 that's more of the kind of 30,000 foot level.  
12 You know, when I think of, you know, why are we  
13 collecting data for quality measures, I think of  
14 it as there are sort of three buckets. Primarily  
15 we've been talking about, you know, for purposes  
16 of quality improvement or for the purposes of  
17 accountability.

18 But there's also a third purpose,  
19 which is really for understanding, in terms of  
20 looking at, you know, without necessarily knowing  
21 that a measure might be fully validated, but to  
22 understand variation, variations in care and I'm

1 just sort of wondering, you know, especially as I  
2 think of a Medicaid reporting program, in a way  
3 it can be more experimental because it's  
4 voluntary, because the results are not publicly  
5 reported.

6 And so that, you know, that you can  
7 kind of fool around with it more. I mean not to  
8 say that, you know, but it's -- and to try to  
9 understand are there any kind of case reports of  
10 how states have utilized these measures for  
11 either understanding or quality improvement that  
12 could be generated, to sort of in a sense  
13 bringing some of the quality improvement programs  
14 you've been describing, Deirdra, and actually  
15 publishing sort of case reports of it, how --

16 You know, I was thinking about the  
17 obesity example that you gave, in terms of  
18 thinking about what could states do in terms of  
19 collecting data about whether, you know, whether  
20 providers are in fact assessing BMI, to see what  
21 could be done to improve sort of preventive  
22 diabetes care, you know.

1                   Are there sort of any case studies  
2       where that's been applied in terms of sort of a  
3       theory of what's a theory of change for doing  
4       that. Whether it's, you know, looking at  
5       variation in, you know, across providers or  
6       across different areas of the state in terms of  
7       reporting and seeing whether that, you know, what  
8       there might be some relationship with other sort  
9       of social mediators and different types of  
10      interventions that might be applied, whether any  
11      of that stuff is going on.

12                  Because I think that would help to  
13      illuminate how states could use these data in  
14      different ways.

15                  DR. STOCKMANN: Sign language from the  
16      peanut gallery over here. Great question. Every  
17      time I talk about this, people ask for case  
18      studies and written documentation, and my bosses  
19      all say I don't have time to write these things  
20      up. But we do want to do that. But we do, over  
21      the last several years, Gigi is reminding me, we  
22      had the Adult Medicaid Quality Grant, which was

1 very much what you just described, as sort of a  
2 laboratory for states, as we were kicking off the  
3 core measure, the adult core measure set, for  
4 states to test them out and test them out both in  
5 terms of reporting.

6 We required a minimum level of  
7 reporting and Judy is here, I think, can also be  
8 a part of our case study right here in person if  
9 not written down, and as well as using those  
10 measures for improvement. So that was over that  
11 two, three, four, five year grant, depending on  
12 how long states wanted to hang around with us.

13 We gathered a lot of that information  
14 and have not yet publicly released some of the  
15 written case studies and examples. So we do have  
16 some and we're working on that, and at least  
17 internally did use a lot of that information to  
18 help inform a lot of the things that I've just  
19 described here today.

20 So we will work on getting more things  
21 shared, but I'll also put up -- Judy will give a  
22 little bit of the in-person case study for this

1 for you here today.

2 CHAIR PINCUS: Any other questions?

3 (No response.)

4 CHAIR PINCUS: So with that, Judy.

5 MS. ZERZAN: Excellent, good morning.

6 So I'm going to talk a bit about Colorado and  
7 what we're up to. I'm going to start with giving  
8 some lay of the land.

9 Next slide, please, of who we cover.  
10 So we cover 1.3 million Coloradans. It's  
11 somewhere between 22, 23 percent of the Colorado  
12 population. We're an expansion state that  
13 expanded January 1st, 2014, and you can also see  
14 because it's in the news, about 75 percent of our  
15 adults who can work do work. However, they  
16 mostly work in minimum wage jobs and so they  
17 still qualify for Medicaid. About 80 percent of  
18 our population live in cities. The rest are  
19 rural.

20 Next slide. This is a bar chart made  
21 famous by the Kaiser Family Foundation, but I  
22 think it's useful to understand case load versus

1 expenditures. So the first two bars are people  
2 on Medicare, individuals with disabilities and  
3 older adults, and they drive a large part of our  
4 expenditures in the blue bars. The sort of  
5 purple color is non-expansion adults, and by that  
6 I really mean pregnant women, so that is a pretty  
7 small bit.

8 So then there are kids and I wanted to  
9 spend a moment on the expansion adults, which is  
10 a little over 30 percent of our population, and  
11 it's a little over a quarter of our expenditures.  
12 That amount is going down since this slide. This  
13 is fiscal year '15-'16, although not super-  
14 dramatically.

15 But I would say that the expansion  
16 population has a very high degree of both mental  
17 health and addiction needs, and some of those  
18 behavioral health conditions drive a lot of  
19 physical health conditions, and so they're pretty  
20 expensive.

21 Also, we definitely saw, as Medicare  
22 sees, there was a lot of demand, sort of pent-up

1 demand for health care in this population, that  
2 now has gone down. Since we spent a lot of time  
3 talking about diabetes, I'll say we have fewer  
4 than 30,000 diabetics in Colorado Medicaid. So  
5 for us, diabetes not so much of an issue.

6 Smoking, 30 percent of our adults smoke. So  
7 every state, I think, has different needs. West  
8 Virginia has a super-high rate of diabetes, but  
9 in Colorado our diabetes rate is relatively low.

10 This is one my favorite slides. We  
11 recently made this. This is where the money  
12 goes, and I think to understand where to measure  
13 and where to think about things, it's helpful to  
14 think about what are we paying providers for.  
15 Colorado Medicaid, as I'll get to on the next  
16 slide, we are what we call a managed fee for  
17 service state.

18 We have very little managed care  
19 plans, but we're not straight up fee for service  
20 and we pay less than three percent of our total  
21 budget in administrative costs. So for the most  
22 part, all of our money goes to these providers,

1 and you can see hospitals is sort of the biggest  
2 chunk of that, but there's also big chunks of  
3 home and community-based providers, nursing  
4 facilities, things like that.

5 Next slide. So we have this  
6 Accountable Care Collaborative that's been in  
7 place since 2011 when we started it as a pilot.  
8 It has seven regional organizations in the state,  
9 and these regional organizations are broadly  
10 responsible for the health of their Medicaid  
11 population. So they get paid a per member per  
12 month for managing that. They provide care  
13 coordination, they provide practice support, they  
14 help find specialists, all those sorts of things.

15 The second piece of it is primary care  
16 providers. Primary care providers also get a per  
17 member per month, and then both these regional  
18 organizations and primary care can earn  
19 incentives for what we call key performance  
20 indicators. So sort of quality metrics, although  
21 from the beginning a lot of them were more  
22 utilization-based metrics.

1                   And then all of this is on a floor of  
2                   data and analytics platform that's a portal that  
3                   you can log into as a regional organization or as  
4                   a primary care provider, and see some of your  
5                   metrics and drill down.

6                   This model, next slide, has been very  
7                   successful for us. So in the last five years,  
8                   our inpatient admissions have gone down. Our  
9                   high-cost imaging has gone down. Our emergency  
10                  room visits have gone down, and our prenatal care  
11                  rate has gone up quite a bit. We've done an  
12                  external evaluation with the university. Both  
13                  patients and providers really like this model.

14                 Providers like it a lot because most  
15                 of the responsibility is put in their hands for  
16                 creating change. We've also got evaluated and  
17                 compared to Oregon, who has a similar regional  
18                 model that started at the same time, although  
19                 theirs is in managed care. That was published  
20                 recently in JAMA Internal Medicine, and we both  
21                 save about the same amount of money, and we have  
22                 similar results on quality.

1                   Some things Colorado's better in;  
2           other things Oregon's better in, but net it's a  
3           wash. In terms of saving money, I didn't put  
4           this on there, we save about \$60 million a year  
5           net from this program. So we feel like this is a  
6           great model for Colorado, and as I mentioned  
7           before, it's kind of a hybrid. It's not pure fee  
8           for service, but it's not totally managed care  
9           either.

10                   Next. So adult core set measures.  
11           Next slide. So we report what we can, which is  
12           most everything, and why we report what we can is  
13           we believe in transparency, we believe in  
14           improvement, and if you don't have numbers then  
15           you can't really do anything with that. I will  
16           definitely say from some of the conversation this  
17           morning that all of these are beautiful, and  
18           we're not completely sure the data's correct.

19                   But I think that I certainly have a  
20           philosophy if you don't report anything, then you  
21           can't make the data better. And so we report  
22           what we can.

1                   Next slide. So the handful of  
2 measures that we don't report have also been  
3 discussed already. So the screening for  
4 depression follow-up plan, we do report the  
5 screening but not the follow-up. We have paid  
6 for depression screening for about five years,  
7 and one of the -- one of the problems with using  
8 claims data, we pay \$10 on top of a visit for  
9 depression screening, and almost no one bills us  
10 for it.

11                   In our total population, we have about  
12 2.67 to be very exact percent of people that  
13 reported a depression screening in the last year,  
14 and we know that it's much higher than that, but  
15 they don't bill is for that. It's a similar  
16 problem. Advanced care planning, we pay \$50 on  
17 top of Visit 4. Zero people bill us for that.  
18 It's a really hard thing to get into the practice  
19 flow and to sort of understand what's going on.

20                   And so the follow-up is even worse  
21 than the screening, but we do report the  
22 screening. Second is the timely transmission,

1 and I guess the theme about all of these is these  
2 are things we just don't have data for, and much  
3 of them, as was in the last thing is we don't  
4 have the clinical data for.

5 So the timely transition of transition  
6 record is super-important, but there is just no  
7 way that we can calculate it. So having this  
8 come off, I think, is right. For a bit of the  
9 discussion about data feeds, in the past year  
10 we've gotten from our public health department,  
11 after a few years of work I'll say, both birth  
12 certificate data feeds and death certificate data  
13 feeds.

14 I would argue death is the ultimate  
15 outcome, and we should know who dies and why.  
16 But until about a year ago we had no idea. So I  
17 think we will be able to report this elective  
18 delivery, but it was quite a feat and a fair  
19 amount of work on both of our agencies' parts to  
20 get that datafeed connected and correct.

21 Next slide. So implementation  
22 challenges, reporting issues. We currently have

1 a behavioral health carve out. We've heard that  
2 in our behavioral health managed care plans, that  
3 they have better depression screening data, but  
4 it's hard to sort of link of what happens there.

5 In our Accountable Care Collaborative  
6 Phase 2, which the RFP just went out a couple of  
7 weeks ago, we are going to merge those physical  
8 health and behavioral health organizations  
9 together, and so I think that that data will  
10 improve.

11 The second thing that we've had some  
12 troubles with is AHRQ's PQI measures. We have  
13 not been able to do the appropriate risk  
14 adjustments in the measures. So we report on  
15 these, but they're not exactly perfect. We have  
16 a new MMIS, Medicaid Management Information  
17 System, that just started March 1st.

18 It is not without its challenges, but  
19 I think that we'll be able to do this in the new  
20 world. But I would say one thing that states are  
21 probably going to struggle with, and this will be  
22 certainly true for us, moving to that new system

1 has given us a lot of data issues, and a number  
2 of states are moving to new billing systems. So  
3 there will probably be a bit of hiccup from that.

4 We moved from a state of the art  
5 1970's system into the new world, and so it's  
6 going to allow us to do a lot more things. But  
7 there is absolutely data messiness, particularly  
8 it's helpful that it's on a statewide level,  
9 because a number of our clinicians through  
10 revalidation now have multiple sites.

11 So sorting out who's where, while it's  
12 helpful for us that we have more granular data,  
13 it's hard to match up exactly what that looks  
14 like.

15 Measures that come from CAHPS data.  
16 We are changing to the PCMH version of CAHPS  
17 because we're starting to look at what happens at  
18 the practice much more and think about that. And  
19 so, for example, we get our flu vaccine measure  
20 from the CAHPS data and we had to add that into  
21 the PCMH version, so that we could continue to do  
22 that.

1                   Then the last note is that we are  
2                   currently collecting administrative data only.  
3                   We have stopped collecting hybrid measures from  
4                   our EQRO, partially because of expense, partially  
5                   because of our bother to our practices and  
6                   partially because some day, someday soon, we will  
7                   have electronic health record data. So we have  
8                   just started. There are a handful of other  
9                   states that have also done this, to just report  
10                  administrative claims data.

11                  Next. So I think suggestions from my  
12                  view of the world: alignment, alignment,  
13                  alignment. We are a state that got the  
14                  Comprehensive Primary Care Initiative in the  
15                  first round. We are also a CPC + state, and we  
16                  have a Statewide Innovation Model grant.

17                  All of those have led us to create a  
18                  pretty robust multi-payer collaborative that have  
19                  all the payers in the state at the table, and I  
20                  think figuring out both from those perspectives  
21                  and MACRA that's coming down the pike, how do we  
22                  have the same measures across health plans?

1                   It's one of the things that the multi-  
2           payer collaborative has really bought into in  
3           Colorado. So to the extent that this core set  
4           kind of overlaps with that, it's helpful. The  
5           second piece, as I just mentioned, I think eCQMs  
6           are coming. They're not quite there yet, and  
7           figuring out how to collect that data from  
8           practices, we're doing that with SIM right now.

9                   We have about 100 practices that just  
10          reported their first set of data, and it is in an  
11          Excel spreadsheet. It is like so super-basic,  
12          granular. There is no fee, there is no nothing,  
13          but I think that's sort of the first step to get  
14          there.

15                   So measures that I wish existed and/or  
16          were collected. We're doing a lot of work in  
17          Colorado and I know other states too are around  
18          the social determinants of health and social  
19          needs screening and things like that. How do we  
20          get better data on our population so that we can  
21          help them more, because a lot of their health  
22          issues are related to some of these social needs.

1                   Second is more functional outcomes.  
2       How do we keep people at home if that's where  
3       they want to be? How do we keep people working  
4       if that's what they want to do? How do we keep  
5       people doing what we want to do? That's a very  
6       sort of nebulous concept and we don't have great  
7       ways to measure it.

8                   Related to that is sort of prevention  
9       and more outcomes. Outcomes are really hard,  
10      because things generally don't happen in a year  
11      and yet you need to measure them. You need to  
12      start somewhere. We have a preliminary churn  
13      analysis done from our expansion population, and  
14      from 2014 over half of our people are still on  
15      the Medicaid rolls.

16                  So that's helpful to understand that  
17      there's some stability in that population, but I  
18      think also thinking about outcomes in terms of  
19      not just health but sort of how do we help people  
20      be economically successful and how do we help  
21      people move up and out of poverty if we can and  
22      how do we use our health benefits as a tool to do

1 that, and those are things that we're sort of  
2 interested in.

3 Similar to Clarke's question earlier,  
4 looking at patient experience and patient and  
5 family engagement is very important to us. I  
6 think CAHPS is a pretty blunt tool to do that.  
7 There's just not a lot of variation in it.  
8 People generally like their clinician and that's  
9 why they keep going to them, whether or not their  
10 clinician is good or not.

11 It doesn't really sort of measure that  
12 good experience, and so how do we get to patient-  
13 reported outcomes and how do we collect that data  
14 I think is very hard, and there's a lot more work  
15 that needs to be done in that space. And then  
16 shared decision-making. We've had patient and  
17 family engagement work going on for a while. Co-  
18 pays in Medicaid are a lot in the news.

19 I think co-pays are a very blunt and  
20 not very effective stick for patient and family  
21 engagement, and that more what you want to get to  
22 is sort of shared decision-making. How do you

1 help people express their preferences and make  
2 decisions, and so figuring out how to do that.

3 Then this age breakout is really for  
4 the child bit, and since there aren't too many  
5 child bits here, but how Medicaid looks at kids,  
6 how HEDIS looks at kids is not exactly lined up.

7 Next slide. So how are we using  
8 quality data to drive improvement? I think to  
9 change our numbers, we really need practices and  
10 clinicians to be engaged in this work and so  
11 we're doing a few things around this. And  
12 looking at I would say what our levers are, which  
13 is three, and although these are not designed for  
14 payment, payment is the lever that we have to  
15 help practices move along in this direction.

16 In particular, I'm going to talk about  
17 a bit about a value-based payment model that we  
18 are starting for primary care. Second I think is  
19 competition. I'm also going to show an example  
20 of that. Both states and practices, I would say,  
21 are motivated by competition and wanting to be  
22 the best. Our executive director always like

1 every time there's a ranking report, you know,  
2 sort of says hey, Colorado's here.

3 So I think that that is a useful  
4 motivator and tool, and then the third thing is I  
5 really do think clinicians want to do the right  
6 thing. But without data and without information,  
7 it's hard to sort of know. You think you're  
8 doing the right thing, but without data, you  
9 don't know how you're doing.

10 So next slide. So our primary care  
11 payment model, we have just started to develop  
12 this and our communicating this statewide right  
13 now. The goal is really to provide sustainable,  
14 appropriate funding for primary care that rewards  
15 high value, high quality care. So what we are  
16 doing from the 1202 bump in the Affordable Care  
17 Act, which was an increase in primary care codes  
18 for two years that was federally funded, we  
19 continued that on the state level and now we're  
20 morphing that funding into this model.

21 So practices collect a certain number  
22 of points, and then they can -- they have four

1 percent at risk of a primary code set that we've  
2 developed. So they can either earn an additional  
3 four percent on those codes, or they can lose  
4 four percent on those codes or sort of somewhere  
5 in between as a continuous variable.

6 So next slide. So practices can  
7 choose up to ten measures, and we've given them a  
8 fair bit of choice. There are sort of three main  
9 groups of measures. The first is structural  
10 measures, of which we have sort of six different  
11 domains with 30 choices that you can see on the  
12 screen, and most of these structural measures are  
13 aligned with patient-centered medical hominess  
14 stuff, and some are definitely easier than  
15 others.

16 So under access, for example, there is  
17 a patient can call somewhere 24/7 and talk to  
18 somebody. Most primary care practices have that.  
19 That's a pretty easy check the box. But then it  
20 gets much harder.

21 Your patient panel is open to Medicaid  
22 most of the time, and for specialists, you have a

1       consult and you close the loop and you have sort  
2       of a back and forth communication, which I think  
3       are all things that we agree are helpful but are  
4       really hard to measure and don't always get done.

5               Next slide. So we also have claims-  
6       based clinical performance measures, and this is  
7       one place where there's some alignment with the  
8       adult and child core set. Also we've looked to  
9       figure out what measures went into this. We  
10      looked at the CPC measures and we looked at our  
11      SIM measures.

12             We looked at MACRA, so that we can  
13      find sort of the greatest amount of overlap,  
14      recognizing it can be complicated for practices  
15      and particularly practices that take Medicaid as  
16      only a piece of their business. We need  
17      alignment with the private payers.

18             So next slide, and we also took that  
19      alignment approach for these eCQM measures. So  
20      there's ten adult measures and four pediatric  
21      measures that we're looking at.

22             Next slide, and to get credit in this

1 model is you really have to close the gap. So  
2 this is an example of what that looks like, oops,  
3 and I'm not sure what the text is there, sorry.  
4 But we are in the process of figuring out what  
5 the goal will be for statewide Colorado. So in  
6 this example, the goal is 80 percent of this  
7 measure, and this particular practice is 50  
8 percent.

9 So to earn credits to get to their  
10 four percent increased rates, they need to  
11 improve that gap by ten percent. So their gap is  
12 30 percent, so they need to improve by three  
13 percent, and every year they need to improve by  
14 ten percent of whatever their next gap is. So in  
15 this way, we're hoping to sort of incent moving  
16 along, moving along that spectrum.

17 Next slide. So that's sort of our  
18 payment stick and carrot that we are doing with  
19 primary care practices. This is our move the  
20 competition lever, and is our report card that  
21 we're doing. This is the report card for  
22 Federally Qualified Health Centers, and we are

1 also doing this for primary care in general and  
2 for hospitals.

3 I recognize it's microscopic, so I'll  
4 walkthrough it a little bit or you can use the  
5 zoom on your slides. But the first column we've  
6 arbitrarily divided the Federally Qualified  
7 Health Centers in Colorado into four quartiles.  
8 So green is good, red is bad and the rest is in  
9 the middle. If you go across, we have a number  
10 of measures, some of which are quality and some  
11 of which are utilization measures.

12 So that first column is ER visits per  
13 thousand. The second column is total cost of  
14 care, which I think is something we haven't  
15 talked about, but for the Medicaid population I  
16 think is important, and particularly if there are  
17 funding cuts coming along the pike, figuring out  
18 how to do that a bit better.

19 The third column is the diabetes Alc  
20 measure that has been oft-talked about today, and  
21 you can see there's a fair bit of variation even  
22 in this one, which should be a pretty easy, basic

1 kind of thing. The next one is LARC insertion.  
2 It has a lookback of five years, but we've had an  
3 emphasis on this in Colorado for a while and  
4 really particularly decreasing our teenage  
5 pregnancy rate and having women have planned  
6 pregnancies, so LARC insertion is on there.

7 The next one is prenatal visits. Then  
8 there's readmissions, which aligns with the adult  
9 core set. That next one is a new chronic opiate  
10 users measure. This is something that Minnesota  
11 has perfected. Connecticut's looking into it,  
12 we've looked into it, of when you get your first  
13 opiate prescription, how many people move on to  
14 using opiates non-stop on a daily basis within  
15 the next year.

16 Actually, I think Minnesota's looked  
17 at it, and if you are still on opiates in 60 days  
18 you are still on opiates in a year. So as  
19 everywhere else, Colorado has a problem with  
20 opiate addiction and so we are looking at this.  
21 That sort of tan column, there is almost zero  
22 variation. That's the depression screening

1       measure, and it's super-low if you pull it  
2       together, and then the last column is well child  
3       visits.

4               And so at the bottom, that first white  
5       row across is the average, and then the second  
6       one is sort of the weight of that. There is a  
7       sort of final column that I didn't include in  
8       this, but this has been -- we've had some great  
9       conversations with the Federally Qualified Health  
10      Centers on this. Everyone wants to know like why  
11      is that.

12             A lot it is billing issues. They're  
13      doing depression screening, they're just not  
14      billing for it. So I think that this is sort of  
15      an interesting way that states can use core  
16      measures to kind of help practices get the day-  
17      to-day need to change performance, that then will  
18      eventually lead to changed performance for us at  
19      the statewide level. That is all. I'll take any  
20      questions. Thanks.

21             CHAIR PINCUS: Let me just kick it off  
22      with just two quick questions. One is why if

1       they're billing they can actually make money for  
2       this, why don't they bill? Have you explored  
3       that? And number two is just among the different  
4       measures you describe, how many of them are  
5       actually measures from the Medicaid core, from  
6       the Medicaid core measure set?

7               MS. ZERZAN: In the APM model?

8               CHAIR PINCUS: Yeah, in the APM model,  
9       and are there reasons why you are or are not  
10      using measures from the core measure set?

11              MS. ZERZAN: Yes. So the first one,  
12      why aren't they billing? That is a fantastic  
13      question. I think a lot of it has to do with how  
14      practice work flow is set up and so that is a  
15      piece of it. We've heard from some practices  
16      that other payers don't pay for it, so like  
17      advanced care planning Medicare does know, and  
18      that you would think would help our rates,  
19      because we actually paid for that before.

20              But they don't have it set up and they  
21      don't bill everybody for it, and so then they  
22      just don't bill anyone, which is absolutely

1 leaving money on the table. Then the third piece  
2 I think, which is difficult and we thought adding  
3 money to it would help, is that I think adding --  
4 and actually I just thought of another reason  
5 why.

6 So I think adding it into the billing  
7 system but then being able to communicate with  
8 practices about it, we have provider bulletins.  
9 We put things that go out to practice managers,  
10 but that doesn't always get to the right people.  
11 So communicating about things in a busy practice  
12 can be really hard.

13 So I think that that is sort of a  
14 piece of it too. For depression screening, from  
15 our SIM eQOM measures, most practices are  
16 somewhere between 90 and 95 percent of depression  
17 screening. And so if you multiply that by \$10,  
18 that's a lot of money Medicaid could be paying  
19 you, but they just don't do it. And actually  
20 Children's Hospital has done a fair bit of, like  
21 come on, we've got to bill for this and it has  
22 taken them probably two years to start that.

1                   It's just -- it's just not there, and  
2 I agree. One of the things that providers always  
3 say is Medicaid doesn't pay enough and well, if  
4 you just paid me I would do it. But we have a  
5 lot of good examples where we pay for it and they  
6 don't do it, and I think the socially and  
7 medically complexity of the Medicaid population  
8 can be sometimes a barrier for that. But it is a  
9 lot more than money, I think, that is driving  
10 this.

11                   The second piece about the core set,  
12 I was going to look at this last night and then I  
13 forgot. So I think somewhere around a third is,  
14 but we are also aligning with SIM and CPC, and so  
15 there are measures that are not on the core set  
16 and that are being collected on a multi-payer  
17 basis, and so to align with those other private  
18 plans, we've done that.

19                   Medicaid has some -- we certainly have  
20 a unique population in many ways that is slightly  
21 different from the commercial payers. So we want  
22 to have focus on that. But I think there's

1 definitely a bit of a tension there, yeah.

2 CHAIR PINCUS: Just one comment. It  
3 might be useful to actually align those, you  
4 know, on these alignment issues, is actually to  
5 line up the measures of the different programs to  
6 that, you know, we can sort of see that and see  
7 whether there might be some, you know, relatively  
8 easy --

9 MS. ZERZAN: We have a ginormous fancy  
10 spreadsheet for that.

11 CHAIR PINCUS: Yes.

12 (Off mic comment.)

13 CHAIR PINCUS: That might be sort of  
14 a useful exercise. I mean we may not be able to  
15 fix it, but we could at least think about where  
16 the, you know, discrepancies are.

17 MS. ZERZAN: Yeah, and certainly I  
18 know the CMS people have thought about this some,  
19 but the CPC and SIM have come out of the  
20 Innovation Center and so they're not always  
21 connected, and also that the pediatric issue is a  
22 huge one for those, for CPC and SIM and MACRA.

1 They're all focused on adults, which that's the  
2 Medicare population.

3 But even the commercial payers  
4 recognize we need to have some pediatric  
5 measures. So on the pediatric core set, I think  
6 there's more that align there in our pediatrics.

7 CHAIR PINCUS: So Deborah, then  
8 Clarke.

9 MEMBER KILSTEIN: Just a comment and  
10 then a question. The comment is in terms of  
11 leaving money on the table for depression  
12 screening, what a lot of the plans are doing now  
13 is as part of the report cards, we actually tell  
14 the provider what they could have made had they  
15 billed, you know, done the screenings and done  
16 that work. So it's actually putting it in  
17 concrete terms for them, just as a suggestion.

18 The question I have for you is looking  
19 at the report cards, I find the last column on  
20 the right, well child visits, to be -- and I know  
21 this is the adult discussion, so maybe this is  
22 better for tomorrow, but I find that very

1 surprising and it's kind of a measure that people  
2 think we're kind of going past that now. But the  
3 amount of red in that column is just shocking to  
4 me.

5 MS. ZERZAN: Yes, yeah. Some of it is  
6 that states have done -- and I don't know if  
7 Karen you're here tomorrow or the next day to  
8 talk about that. Some states have done things  
9 and we're changing this now to allow for a sick  
10 visit and a well child visit at the same time.

11 So that may help, but I think overall  
12 well child visits nationally are like 68 percent  
13 if you look at all age ranges. So and it's  
14 pretty good in the zero to 15 month range and  
15 then it gradually drops off.

16 MEMBER KILSTEIN: And the adolescents  
17 I know --

18 MS. ZERZAN: The adolescents are not  
19 so much, yeah.

20 MEMBER ROSS: We will be talking about  
21 patient experience approaches this afternoon. My  
22 question is a frequent talking point, which I

1 think I heard you say, is that a significant  
2 proportion of the Medicaid expansion population  
3 are people with mental illness and substance  
4 abuse disorder, and advocates use it, governors  
5 Medicaid directors.

6 But usually the data I've seen is  
7 taking SAMHSA prevalence and just applying it to  
8 the Medicaid expansion population. Do you have  
9 precise numbers of the Medicaid expansion people,  
10 X have mental illness and Y have substance use  
11 disorder?

12 MS. ZERZAN: So I don't have those  
13 numbers off the top of my head, and some of it,  
14 it's a little bit complicated in some ways to  
15 measure it like that. Our -- so we have carved  
16 out managed care behavioral health services, and  
17 the encounter rate for the expansion population  
18 is around ten percent.

19 So for the most part, these people  
20 aren't getting addiction and behavioral health  
21 services through community mental health centers  
22 exactly. But if you look at our top diagnoses

1 for hospitalization and sort of who is spending  
2 the most when we look at that by adults, almost  
3 all of it is related to alcoholic liver disease,  
4 the effects of smoking, those sorts of things  
5 that are related to that.

6 And so a lot of our physical health  
7 spend is related to things, valve replacements  
8 from IV drug use, things like that that are  
9 physical health things. So they don't always get  
10 counted in the behavioral health bucket but are  
11 absolutely related. And so yeah, I'm not sure  
12 that we've looked at like -- and they're not  
13 always coded.

14 So that's also I think a part of it,  
15 is that you can have this hospitalization for  
16 alcoholic liver disease, but it's not coded as  
17 alcoholic liver disease or maybe far down alcohol  
18 use is coded.

19 But if you look at sort of what things  
20 are happening clinically, you're like there's the  
21 problem. And so I think that those things are  
22 not well joined together and, you know, I think

1 as we get more data it will become a bit more  
2 clear.

3 CHAIR PINCUS: Sue and then Roanne.

4 MEMBER KENDIG: The depression  
5 screening information I find the most intriguing,  
6 and having worked on maternal mental health  
7 patient safety bundle that was recently released,  
8 you know, we've had some groups looking at how to  
9 implement that.

10 The two things that have come up both  
11 at the state level and at the national level, and  
12 again these aren't hard and fast research  
13 studies, but what we keep hearing is return on  
14 investment, which we seem to have addressed, but  
15 also and if somebody's positive, I don't know  
16 what to do with them, with the implication that  
17 irregardless of what that screen says, I'm going  
18 to have to link that person to a mental health  
19 professional.

20 So I think that goes to your social  
21 determinants piece also. You know, the lack of  
22 depression screening or you getting requests for

1 payment, you know, I wonder if it just goes  
2 deeper than that, to those other issues. I find  
3 that piece the most concerning. How do we -- how  
4 do we help states support providers in that  
5 screening and linkage space?

6 MS. ZERZAN: Yeah. I agree that  
7 that's definitely a problem, and one of the  
8 things that we've done in the last few years is  
9 we opened that code up so that pediatricians  
10 could screen for postpartum depression, and  
11 that's the main thing that we hear from them.

12 First we heard well, pay us for it,  
13 and then we heard oh, well I don't know what to  
14 do if it's positive. I don't want screen. And  
15 so our regional entities are working on that, and  
16 helping to try and connect people to that. But I  
17 would agree, there's plenty of work in how to  
18 especially connect practices to community  
19 organizations and people that can help our  
20 population.

21 MEMBER OSBORNE-GASKIN: So I just had  
22 a question about the depression screening as

1 well, and you had mentioned that one of the  
2 things that may have been an issue was clinic  
3 workflow. So I'm surprised that in this kind of  
4 moving to what's value-based payment and team-  
5 based care, which is something that's been  
6 happening for a while now, you know, is there  
7 use of the team to necessarily do the depression  
8 screening, you know, the medical assistant? I  
9 mean just kind of looking at it from just a  
10 really ground level view.

11 I mean is it that people are not using  
12 members of the team to actually do the depression  
13 screening? I mean I thought we would have  
14 probably moved away from the physician has to do  
15 the screen as opposed to somebody else in the  
16 office. You find that that's part of the issue  
17 or that's kind of, you know.

18 MS. ZERZAN: I think it's more than  
19 it's being done. It's just not being billed, and  
20 so then we don't capture it. I can say certainly  
21 I practice a teensy bit sort of urgent care  
22 overflow two half days a month, and the practice

1 I'm in it does depression screening and the  
2 medical assistants do depression screening, but  
3 they don't bill us for it at all.

4 And yes, and they're like oh, we have  
5 to change that, yeah we should. But it's, you  
6 know, if the clinician doesn't put it in as a  
7 code then we don't get it, or do we do this. And  
8 so it is something that it seems like to me you  
9 ought to be able to figure out a way, especially  
10 since there's payment attached to it. But I  
11 would say that payment is not always the carrot  
12 that you think it is.

13 CHAIR PINCUS: Lisa.

14 DR. PATTON: Yeah. I was just going  
15 to mention that around the depression screening,  
16 I know NCQA has started a learning collaborative  
17 to understand more about the barriers and  
18 challenges associated with implementing that  
19 measure, and at SAMHSA we've also started looking  
20 at screening and brief intervention for alcohol  
21 misuse to do a similar learning collaborative and  
22 look at some of those challenges, and have some

1 deeper dives into what's preventing that uptake  
2 of these measures. We're seeing similarly low  
3 rates of adoption around alcohol misuse measures.

4 CHAIR PINCUS: Any other questions?

5 (No response.)

6 CHAIR PINCUS: So we're ready for a  
7 break? Okay. So if people can come back within  
8 -- by 11:15. Okay, thank you. Perfect job, Judy  
9 and Karen and Deirdre.

10 (Whereupon, the above-entitled matter  
11 went off the record at 10:58 a.m. and resumed at  
12 11:18 a.m.)

13 CHAIR PINCUS: Okay. Why don't we get  
14 started? So we have the slides working now? So  
15 now we are going to get into the specifics of  
16 individual measures and have a discussion about  
17 them and Shaconna is going to lead us through it.

18 MS. GORHAM: Thanks, Harold. So as  
19 Harold said, we are going to dive right into our  
20 measure by measure review.

21 Keeping in mind the presentations that  
22 we heard this morning, Judy is going to stay at

1 the table.

2           Although she is not a voting task  
3 force member, we welcome you to participate in  
4 the discussion as we, of course, think that the  
5 state experience is very important.

6           So first we are going to focus on the  
7 measures with low levels of reporting. What we  
8 can learn about the measures that are or are not  
9 a good fit for the program based on a handful  
10 reported by the few states.

11           Next slide. So I'll review a few of  
12 the reasons that you might consider when  
13 considering removal of measures from the core  
14 set. I won't read them all so please take a look  
15 at the slide.

16           But just to highlight a few, bullet  
17 number two - multiple years of very low numbers  
18 of states reporting the measure could be one  
19 reason. Bullet number four - measures that do  
20 not provide actionable information for state  
21 Medicaid programs, and then also superior  
22 measures on the same topic have become available

1 are just some reasons to highlight.

2 You were given a handout of our MAP  
3 Medicaid decision categories. The decisions are  
4 used to provide consistency and clear direction  
5 to HHS.

6 With each decision we ask you to  
7 provide a rationale behind that decision. For  
8 our MAP Medicaid review the two categories that  
9 you will most likely use are support and  
10 conditional support so support would be used in  
11 the cases of measures that are ready for  
12 immediate use and address the identified gaps.

13 Conditional support categories  
14 appropriate for measures that are still either  
15 going through the NQF endorsement process and are  
16 pending endorsement or there is something that  
17 needs to be changed or addressed by the measure  
18 steward or perhaps there are questions that the  
19 task force would like CMS to confirm when you  
20 think about feasibility before it would garner a  
21 full or strong support.

22 MAP can express the condition and we

1 ask you to do so when voting. The do not support  
2 decision is unlikely to come up during this  
3 review.

4 I would like you, if I were to use an  
5 analogy, you want to think of support as, like, a  
6 green light.

7 So we are saying or signaling to CMS  
8 that we can move forward, and conditional support  
9 is like a yellow support, kind of, you know,  
10 saying to CMS, we may want to proceed with  
11 caution and we need a little bit more  
12 information, and do not support is definitely a  
13 red light.

14 And again, you have a handout of the  
15 decision categories at your desk so that as we  
16 move through the slides you can easily remember  
17 the different categories.

18 So there are four measures, some of  
19 which we have had conversation about earlier with  
20 only zero to six states reporting. So the  
21 question to think about as I review some of these  
22 measures, is there a reason to remove any of

1 these measures at this time, how might  
2 participation be increased.

3 We know that CMS has already removed  
4 the care transition measures from the 2017 core  
5 set due to low numbers of states reporting this  
6 measure, also a decrease in the states reporting  
7 over time and the challenges states have  
8 described in collecting it.

9 So the first measure we want to look  
10 at and, again, we have had some discussion  
11 already, is 0418, screening for clinical  
12 depression and follow-up.

13 We discussed a number of states  
14 reporting. If I could direct your attention to  
15 some of your supplemental information.

16 If you remember, we sent a - and I am  
17 going to find you so give me one minute and I'll  
18 find the name of it. There was a document  
19 background information for the Measures  
20 Application Partnership task force.

21 Feel free to open that. It was in  
22 your supplemental material. If you are not

1 logged onto SharePoint, you can find it there on  
2 the - if you log on under your committee  
3 SharePoint page.

4 That document gives you some of the  
5 reasons why states did not report the measure.

6 Yes. And is everyone open - are you able to open  
7 your SharePoint pages? Is that a yes?

8 MEMBER SCHLAIFER: Yes.

9 MS. GORHAM: No. Okay. We will give  
10 you - give you a minute. Okay.

11 Yes, it's also an attachment so you  
12 can pull it up that way as well.

13 So while you're doing that, open that  
14 document, if you will, but also open your  
15 discussion guides, because that would be very  
16 important.

17 So your adult discussion guide - we  
18 will use that document as well. So I'll give you  
19 a few minutes for that.

20 That was the HTML. It was also sent,  
21 I think, as an attachment as well.

22 MS. KUWAHARA: It was distributed as

1 an attachment as well.

2 MS. GORHAM: So you can either find it  
3 as an attachment to an email or you can find it  
4 on your committee SharePoint page. If you need  
5 some assistance we can walk around and help you.

6 Okay. So as I see folks staring at  
7 their screen I am assuming that you all have it  
8 up. Okay.

9 So I'll walkthrough just some of the  
10 reasons that states gave for not reporting this  
11 particular measure.

12 One, data not available, measure  
13 requires a chart-intensive data collection  
14 process, state is working to get chart data via  
15 EMR data extraction by 2016, not reported by  
16 plans, requires chart data, measure was not  
17 calculated due to time constraints, state has  
18 determined that other measures better align with  
19 the strategic objectives for the Medicaid  
20 population. Again, that is just a few of the  
21 reasons and others can be found in that document.

22 Is everyone following me, before I go

1 on? Are we okay? Is that a yes? Okay.

2 And, again, for this measure, the  
3 measure remained unchanged for five states  
4 reporting for FY '13 and FY 2014. The number of  
5 states reporting increased to six states in FY  
6 2015.

7 Okay. I am sorry. Do you have a  
8 question?

9 MEMBER OSBORNE-GASKIN: So the  
10 question is, there's a screening for clinical  
11 depression and the follow-up plan, right, and  
12 they were supposed to use claims to try to figure  
13 out what the follow-up plan is because I didn't  
14 understand that piece of the measure, how are  
15 they going to actually document the follow-up  
16 plan and with the states having issues with  
17 documenting the follow-up plan and that was why  
18 the reporting was low. I am - I don't know.

19 MS. GORHAM: So I'll answer the first  
20 part and then maybe Karen can answer the second  
21 part.

22 The specs for the measure are located

1 on the screen. So yes, the description in  
2 numerator denominator and the data sources claims  
3 on the registry. There is a process data.

4 I don't have any more information  
5 about what part and why the states reported what  
6 they reported so maybe -

7 DR. MATSUOKA: I think, if I am  
8 understanding correctly, it's a lot of the same  
9 kinds of things that I think Judy talked about in  
10 her panel of - it's not necessarily that things  
11 aren't happening, it's just that the workflow in  
12 which the data could be captured for reporting is  
13 not always streamlined or, I guess, facilitating  
14 the state's ability to report that measure.

15 MEMBER OSBORNE-GASKIN: So I guess I  
16 am talking from a clinician point of view. So if  
17 I - I am a primary care physician and I give  
18 somebody Selexor and they are going to come back  
19 to see me in six weeks, my visit is going to be a  
20 99213 or 4 or whatever but unless I polled that  
21 initial thing, you know, I am just trying to  
22 figure out how would that be translated as a

1 claim - as a follow-up and I just think it's very  
2 difficult just thinking about it at the practice  
3 level and also at the plan level to be able to  
4 pick up that this person - you'd have to link  
5 that the prescription of an anti-depressant to a  
6 follow-up visit.

7 MS. MUKHERJEE: And so just to get to  
8 your point, when we talk about core set measures  
9 here and present you with this data, we are  
10 talking about it more from sort of a measure the  
11 quality aspect and we are not really - and though  
12 codes are important and payment is important and  
13 sort of being able to capture that, especially if  
14 it's claims, we don't always get into sort of  
15 that granularity.

16 CHAIR PINCUS: Harold knows this  
17 measure well because you just reviewed it - we  
18 reviewed it as an e-measure in the Behavioral  
19 Health Project.

20 But, again, the requirements here  
21 would be that a screening - a standardized  
22 screening tool was done and that would be coded

1 for and actually pharmacologic interventions is  
2 one of the outcomes.

3 But you'd still have to have used a  
4 standardized screening tool. There are several  
5 ways for that to be done, yeah, in the measure  
6 itself. I think the bigger issue is just where -  
7 you know, are people using the e-measure yet. It  
8 sounds like probably not. So it's still - the  
9 data still has to be collected to figure out did  
10 you use a tool and did you do anything about it.

11 So it would capture what you're  
12 talking about. It's just not clear how that data  
13 is actually collected to document you did that.

14 MEMBER OSBORNE-GASKIN: Right, but  
15 that's kind of what I am focusing on - how are  
16 you going to capture follow-up and is that - if  
17 you are not able to capture a follow-up  
18 accurately, how are you going to be able to  
19 report on it.

20 DR. MATSUOKA: Maybe to flip it  
21 around, maybe - are you saying that perhaps  
22 something for the group to consider is whether -

1 if it's not able to be reported in some kind of  
2 reliable way is it -- is it not as useful of a  
3 measure even if, you know, the particular thing  
4 that it's trying to measure is important.

5 I don't know. I don't want to put  
6 words into your mouth. But I don't know if  
7 that's what you're suggesting.

8 MEMBER OSBORNE-GASKIN: Yeah. So --  
9 so I guess I am trying to get at -- I am not  
10 explaining myself properly. But the follow-up --  
11 I am wondering if the follow-up that is part of  
12 that measure is the barrier to states not  
13 reporting because I -- you know, I work in  
14 Medicaid as well, so I am trying to figure out if  
15 I was a plan how would I capture -- how would I  
16 be able to pull the data out from a claim or  
17 registry -- how would I be able to pull it out  
18 that they had a follow-up visit.

19 I am just not sure even from the plan  
20 level how I would do that. And, I mean, you  
21 know, as a -- as a provider what I would build --  
22 how would the plan pick that up.

1 I don't -- I don't know and that may  
2 be the barrier to actually, you know, states  
3 reporting on it. That's what I was trying to  
4 say.

5 CHAIR PINCUS: Deborah?

6 MEMBER KILSTEIN: Just a comment.

7 Generally, I think that in states where there is  
8 a heavy managed care penetration, I think the  
9 further you deviate from using HEDIS, which plans  
10 are generally reporting, the more difficult it is  
11 to collect the measure because the states have to  
12 kind of develop the measure independent of what  
13 plans have to do anyway generally.

14 Also, I think that the idea of having  
15 the screening and then the follow-up if it's  
16 positive may make this more complicated and then  
17 the idea if you had a measure that was looking at  
18 screening and then a separate measure that looked  
19 at the follow-up you might get better reporting  
20 on the screening.

21 And then, you know, it's the -- the  
22 follow-up I think is probably what makes this a

1 little bit more complicated in terms of  
2 reporting. But I'd have to hear from a state to  
3 confirm that.

4 CHAIR PINCUS: I thought I would,  
5 like, maybe comment about this. So, you know,  
6 the U.S. Public Health Service preventive task  
7 force does not endorse depression screening as a  
8 whole. It endorses it in the context in which  
9 you have the capacity for follow-up and tracking  
10 people.

11 And so that's why screening in and of  
12 itself, you know, has typically not been, you  
13 know, thought of as an acceptable measure. And  
14 it's really part of a -- kind of, if you will,  
15 sort of a basket of measures that follow along  
16 with the notion of sort of treating depression as  
17 a chronic disease in terms of measurement-based  
18 care so that the screening, follow-up and, you  
19 know, administering a PHQ-9 or some other similar  
20 kind of measure tool that can -- that can be used  
21 for looking at response to treatment over time  
22 and making sure people don't fall through the

1 cracks so that there is -- and Minnesota  
2 Community Measurement has developed a set of  
3 measures around -- that have been endorsed by NQF  
4 that, you know, go from, you know, essentially  
5 screening and follow-up with, you know, an  
6 initial PHQ-9 and then follow-up in terms of  
7 process measures in terms of use of PHQ-9 for  
8 follow-up at six months and 12 months and then  
9 actual scores in terms of both clinically  
10 significant improvement at 50 percent or more or  
11 remission.

12           So those -- you know, that exists as  
13 kind of a basket. The issue is that that's --  
14 you know, the bulk of that information is not  
15 collected routinely in claims and so there needs  
16 to be -- you know, there are e-measure developers  
17 -- development and there is also, you know, the  
18 use of registries for collecting this  
19 information.

20           You know, and so the question I have  
21 is, you know, in terms of as a part of the core  
22 set I am pleased that there is something around

1 depression in here.

2 But is it sufficient? Because  
3 screening in and of itself, you know, is really  
4 more of a balancing kind of measure in terms of,  
5 you know, if you're looking at performance in  
6 terms of these -- what I believe are more  
7 important process and outcomes measures -- how  
8 are they determining the denominator.

9 You know, places that don't screen as  
10 compared to places that do screen will have an  
11 entirely different denominator. And so that's,  
12 you know, really where, you know, I see this  
13 playing a role.

14 So in an ideal world you would want to  
15 have the Medicaid adult core set go beyond  
16 screening and follow up and actually include  
17 further follow-up in terms of outcomes.

18 But that may be a bridge too far in  
19 terms of the current availability. But, you  
20 know, but that's something worth discussing.

21 MEMBER OSBORNE-GASKIN: So that may be  
22 a way to look at it, looking at -- maybe looking

1 at the PHQ-9 and its repeated score six months  
2 later, and that may be easier once it's built, of  
3 course. You know, that may be easier to look at  
4 from just getting the data.

5 So if I could draw a parallel, if you  
6 look at the FUH measure, which is a follow-up  
7 after hospitalization for behavioral health there  
8 is a definite claim for a hospital visit. There  
9 is a definite claim seven days later for an  
10 outpatient visit.

11 That is easy for me as a plan to  
12 collect and -- because they are two different  
13 codes. But the code for follow-up for behavioral  
14 health for PHQ-9 is not as defined as the code  
15 for follow-up behavioral health visit.

16 It could just be a regular office  
17 visit. And so maybe looking at, if you have a  
18 positive PHQ-9 and having screening later on with  
19 a reduction in the PHQ-9 code or if it's PHQ-2 --  
20 I am not sure how that -- but that may be easier  
21 to track or measure.

22 CHAIR PINCUS: It's a G code.

1 MEMBER OSBORNE-GASKIN: Okay.

2 CHAIR PINCUS: There does exist a G  
3 code for, you know, administering a PHQ-9 that  
4 could be used.

5 So, I mean -- so, you know, I am kind  
6 of, you know, agnostic about this measure is part  
7 of it.

8 But I think if it could be used in  
9 conjunction with some further measure that would  
10 look at sort of further follow-up using a  
11 standardized instrument, that may be a step  
12 moving ahead to have something that's more  
13 valuable.

14 DR. BURSTIN: And just to mention as  
15 well that the measure that Harold mentioned, the  
16 Minnesota Community Measurement, is now being  
17 adapted by NCQA as part of HEDIS.

18 So, again, there may be greater uptake  
19 because it's coming down the health plan route  
20 anyway. But, again, it's still going to be --  
21 you know, you have to collect the data twice to  
22 get at whether the PHQ-9 was done and then see

1 the effect over time.

2 But, certainly, that could be, you  
3 know, I think an important recommendation of this  
4 group to look towards measures that would be more  
5 reflective of the outcome rather than just  
6 screening and referral but actually did you  
7 improve.

8 CHAIR PINCUS: Even just, you know --  
9 because it is an additional step to get the  
10 actual value of the PHQ-9 as compared to whether  
11 it was administered.

12 So even, you know, sort of, you know,  
13 a six-month administration of a PHQ-9 after  
14 initial, you know, depression assessment, you  
15 know, would be a step forward -- you know,  
16 understanding some of the, you know, greater  
17 difficulties of getting the actual value of the  
18 PHQ-9.

19 You know, it's kind of, you know, in  
20 a little bit -- a little bit -- it's sort of like  
21 the diabetes in terms of, you know, you know,  
22 whether you administer the hemoglobin A1C and

1 then what the value is.

2 I mean, you -- in some ways the idea  
3 is to treat depression like you would  
4 hypertension, like you would diabetes.

5 DR. PATTON: Yeah. So I was just  
6 looking at 711 and 710 so depression remission at  
7 six months and 12 months and, you know, if there  
8 might be some interest in, you know, putting  
9 forth something like that to add into the mix.

10 CHAIR PINCUS: Other comments? Go to  
11 the next one.

12 MS. GORHAM: So we will move on to  
13 0476, which is the PC03 antenatal steroid. I  
14 just want to say that this measure is part of a  
15 set of five nationally implemented measures that  
16 address perinatal care.

17 So the 0471 PC02, caesarian section  
18 measure, is reported already on the child core  
19 set and the PC01 elected delivery measure is  
20 reported on the Medicaid adult core set.

21 So just an overview of the state  
22 reporting already shared earlier and the measure

1 decreased from five states for FY 2013 and three  
2 states for 2014 and 2015.

3 Some of the reasons 37 states did not  
4 report this measure and a few of those reasons  
5 include, again, data not available, our state  
6 does not calculate the measure nor does it  
7 require the health plans to calculate chart  
8 review testing this year, plan to report next  
9 year, not selected by state as a measure to be  
10 reported through the adult Medicaid quality grant  
11 and then that last one that I have here.

12 But, again, this is not an inclusive  
13 list -- not -- the state does not calculate the  
14 measure, not reported due to need for EHR's  
15 access to meet technical specification  
16 requirements.

17 Again, the specs for the measure are  
18 listed on your screen and I will stop there to  
19 see if there is any conversation about this  
20 measure.

21 CHAIR PINCUS: Rachel?

22 MEMBER LA CROIX: We did try to have

1 our Medicaid health plans report on this measure  
2 for a couple of years and they ran into a lot of  
3 difficulties with it.

4 One of them, unless I am mistaken or  
5 it's changed recently, I believe it required  
6 record review to even identify the denominator,  
7 not just the numerator for this measure, which  
8 made it very resource intensive for the plans to  
9 try to collect data.

10 Didn't get a lot of bang for their  
11 buck on it and so we got very, very low reporting  
12 in terms of denominators and numerators for this  
13 measure.

14 So we didn't feel it was -- we think  
15 it's a really important area but the measure  
16 itself just didn't seem to be providing useful  
17 data to us. So we ended up dropping it from our  
18 health plan reporting.

19 It did seem like more of a hospital  
20 level measure to us and we do think it's  
21 important. I know that our Florida quality --  
22 Florida perinatal quality collaborative is doing

1       some initiatives around this.

2                       So we will be encouraging our health  
3 plans to be involved with and supportive of that  
4 and trying to provide patient and provider  
5 education.

6                       But it was very hard for us to collect  
7 the data at a health plan level and to report on  
8 this.

9                       CHAIR PINCUS: Mary Kay, did you have  
10 a comment?

11                      MEMBER JONES: Well, she covered most  
12 of my comments because I was going to comment on  
13 the record piece of it and just how resource  
14 intensive anything that is only collected by  
15 medical records is and also it really lends  
16 itself to data gaps because sometimes we can't  
17 get into the offices to get the records, et  
18 cetera.

19                      So that's a whole different set of  
20 challenges to report on those types of measures.

21                      CHAIR PINCUS: Helen, and just maybe  
22 you might want to comment, and maybe Karen about

1 -- so the bigger issue of, you know, the  
2 application of e-measures derived from electronic  
3 health records within the context of Medicaid --  
4 you know, how realistic is that?

5 DR. BURSTIN: I may leave that for  
6 Karen but I will say that the question I actually  
7 had about this, I mean, it was a really good  
8 point Rachel made. This is pretty much -- and I  
9 see Sean here from ACOG -- this is a hospital  
10 level measure.

11 So I guess the question would be is  
12 there a way to think about how data that's  
13 already collected for hospitals could somehow be  
14 applied and I guess that would be a question I'd  
15 have back for Karen or Judy or others.

16 I mean, the data -- you shouldn't have  
17 to recollect the data if the data has been  
18 collected at the hospital level. The question is  
19 how can it be applied to suit your needs.

20 DR. MATSUOKA: Well, we -- internally  
21 in CMS we are certainly looking into that overall  
22 in general.

1                   Turns out there is a lot of  
2                   information, because if you think about  
3                   institutions and settings of care there are not  
4                   just either Medicare bennies that get care at  
5                   hospitals or skilled nursing facilities. And so  
6                   it turns out that some part of CMS is already  
7                   measuring in that facility and maybe even  
8                   actually collecting information on Medicaid  
9                   bennies.

10                   So it is something that we are looking  
11                   into internally to see what data might we be  
12                   actually sitting on already that we might be able  
13                   to feed back to the state.

14                   But, you know, in the meantime, if you  
15                   at the state level have ideas on how you might be  
16                   able to get information from the hospitals to  
17                   report to you also approaching or thinking about  
18                   it from both approaches might not be a bad idea.

19                   MS. ZERZAN: So we pay for our  
20                   hospitals on APR DRGs and so we don't have any  
21                   information about sort of what else goes into  
22                   that. So that's hard from our collection

1       standpoint.

2                       We do have a hospital quality  
3       incentive program, where the hospitals report  
4       quality measures to us, and it is very difficult  
5       for us to get them to come along with some of  
6       these things, and I would say that their number-  
7       one complaint would be we don't collect this  
8       separately on Medicaid versus everybody else and  
9       we don't want to report on everybody else to you.  
10      It took us three years through that committee to  
11      get a rehospitalization measure when Medicare was  
12      already taking money back and measuring it.

13                     But there was a lot of -- there was a  
14      lot of pushback on the administrative burden from  
15      the hospitals. So this is a really hard one, I  
16      think, because as you guys said for states to be  
17      able to measure even though it's important.

18                     MEMBER KILSTEIN: In looking at  
19      hospitals overall without separating out  
20      Medicaid, do we know what the performance level  
21      is when they report overall to, like, departments  
22      of health and that type of thing?

1 I mean, is this still an issue and is  
2 there any identified data that Medicaid -- that  
3 there may be disparities for Medicaid compared to  
4 other lines of business for hospitals?

5 DR. BURSTIN: It's a core measure for  
6 the Joint Commission, so hospitals are collecting  
7 it even if they are not giving it to you, yes,  
8 Sean?

9 Or Sean's going to come tell us. Sean  
10 is from ACOG, so if it's okay we will let him  
11 give us some information. So antenatal it looks  
12 like it's about up to -- it's way up there now.

13 What is it, 97.2 percent for -- in  
14 2015, up from 91.8 in 2014? So pretty big jump  
15 from 73.6 in 2011. So measurement, clearly, has  
16 had an effect there.

17 I guess it would be interesting to  
18 know -- I assume the Joint Commission should have  
19 those data stratified, one would hope. I could  
20 take a look.

21 CHAIR PINCUS: And that doesn't  
22 distinguish Medicaid from other -

1 DR. BURSTIN: That reporting just  
2 showed we did not distinguish Medicaid versus  
3 non-Medicaid but I guess that's a logical  
4 question back from Medicaid.

5 If you know a measure overall is at 97  
6 percent nationally, is it worth at least trying  
7 to stratify the data by Medicaid before it gets  
8 required as a state level measure and I -- I  
9 wonder if it's something -- we'd be happy to talk  
10 to the Joint Commission. My guess is they  
11 probably have those data. They are required to  
12 submit the disparity stratification to us. I'll  
13 see if I can find it.

14 CHAIR PINCUS: Other comments on this  
15 measure? Okay.

16 MS. GORHAM: The HIV viral load  
17 suppression -- sorry. The HIV viral load  
18 suppression -- of course, we have had  
19 conversations again about that this morning.

20 This measure is currently under review  
21 by our infectious disease standing committee, and  
22 it has been recommended for endorsement, and you

1 heard earlier from CMS that they have spent some  
2 time working with states and federal partners to  
3 help states collect, report, and use this  
4 measure.

5 Just an overview of the state  
6 reporting again, FY '15 was -- three states  
7 reported this measure, which is an increase from  
8 -- or decrease from 2014 where four states  
9 reported the measure.

10 Thirty-seven states did not report  
11 this measure. A few of the reasons, again,  
12 include some of those that have already stated,  
13 in addition to we heard earlier the state HIV  
14 privacy laws do not allow for linkage to state  
15 department of public health.

16 So I'll stop there and invite  
17 discussion.

18 CHAIR PINCUS: So one question I had  
19 -- do HIV privacy laws actually do prevent -- do  
20 the laws themselves actually prevent sharing that  
21 information with the state? Or is that simply an  
22 urban myth?

1 DR. MATSUOKA: I think, certainly,  
2 federal privacy laws don't talk about that but I  
3 think state laws may be more -- often are  
4 stricter than the federal floor.

5 So in some states it may very well be  
6 the case. But, certainly, we do have states that  
7 have been able to do data linkages and sharing.  
8 So I think it -- I think it's doable.

9 MS. ZERZAN: My guess is it may be  
10 more urban myth but maybe policies that state  
11 public health departments have taken.

12 I know as an example we have been  
13 working with ours on this C-section -- elective  
14 C-section rates and early induction stuff and  
15 they have the data.

16 But they feel like they can't report  
17 it to anyone unless they got permission from the  
18 hospital and there is no state law that prohibits  
19 it. There is no nothing. But they feel like  
20 that's the hospital's information and they can't  
21 report. So -

22 CHAIR PINCUS: They're not giving you

1 individual patient information. They are giving  
2 you aggregate information at the hospital level.

3 MS. ZERZAN: No. Hospital level --  
4 yes. But they feel like they are not allowed to  
5 do that unless the legislature specifically tells  
6 them to or unless the hospitals tell them to and  
7 that is a much less privacy-laden issue. So I  
8 suspect it may be a similar thing.

9 CHAIR PINCUS: Rachel, what's your  
10 experience?

11 MEMBER LA CROIX: I would -- to  
12 reiterate something I mentioned earlier. Florida  
13 is largely managed care. It's about 82 percent  
14 of our population of managed care.

15 So we are primarily interested in  
16 measures that are meaningful at the health plan  
17 level, not just at the state level. And so we  
18 have wanted to be able to use this measure at our  
19 health plan level.

20 And so for that we would need to be  
21 able to link individual lab results data, if  
22 available, from our department of health since

1 the plans have not been able to always get it  
2 from their lab vendors, we would need to look  
3 into that and we have discussed it briefly with  
4 some of our sister agency folks at our department  
5 of health but haven't really figured out if we  
6 can share all of those data yet.

7 We have been for other areas like  
8 childhood immunization data and things like that  
9 but for the HIV/AIDS lab values we haven't done  
10 that yet.

11 CHAIR PINCUS: Other comments from  
12 others? So one question I have -- I don't know,  
13 Karen, whether there has ever been precedent for  
14 you guys in the Medicaid program to meet with  
15 ASTO to think about, you know, how, you know --  
16 again, whether these barriers really do exist and  
17 how they can be overcome.

18 DR. MATSUOKA: I think -- I don't know  
19 if Deirdre wants to come up and say -- I mean, I  
20 think this is an area of active exploration  
21 that's been happening through the HIV Affinity  
22 Group.

1 MS. ZERZAN: Yeah, that's right. I  
2 don't -- I guess I didn't have to run over here  
3 because I don't think I have that much more to  
4 add.

5 I mean, in terms of the state laws,  
6 there do seem to be -- there is variation from  
7 state to state, and whether it's the spirit or  
8 the interpretation of the law is a little  
9 unclear.

10 So that's where the question of is  
11 this urban myth or just a misinterpretation or a  
12 historical interpretation where, you know, the  
13 field has been changing a lot and how people are  
14 covered has been changing a lot over the last  
15 several years and I think some of the laws  
16 haven't necessarily caught up with it.

17 So there might just be some antiquated  
18 laws or just outdated and -- that had good  
19 intentions at one time and less good now.

20 So what we have heard from the  
21 Affinity Group is a variety of interpretations of  
22 what -- whether their state laws allow them and

1        what their state laws allow them to do or not to  
2        do.

3                So some have said well, we could  
4        establish -- even among the few states that have  
5        reported it, the four that have at least at some  
6        point reported it, one of them has, like, a full  
7        exchange of information, actually delivers the  
8        viral load value back to Medicaid.

9                But the other two or three just do a  
10       yes or no and said that well, we couldn't get an  
11       agreement approved to actually deliver the value  
12       itself but could at least say suppressed or not  
13       suppressed.

14               So for our measure that's fine,  
15       suppressed or not suppressed. In terms of care  
16       delivery and whether that linkage can be used for  
17       improving delivery of care it would be more  
18       valuable for coordination of care and delivery to  
19       actually have the viral load.

20               But, you know, for the measurement and  
21       for an indicator that little piece is okay. So  
22       we are hearing a mix and we will try to maybe --

1       you know, we still have several months of the  
2       Affinity Group and we will try to get a little  
3       bit more clarity on exactly what the issues are.

4               CHAIR PINCUS:   Are public health  
5       departments sort of involved in these meetings?

6               MS. ZERZAN:   Absolutely.   So every  
7       state, it was a requirement of participation to  
8       have, like, both your public health and their  
9       Medicaid leadership approve participation and  
10      have people from both components participate  
11      actively.

12              I'll say that there is a little bit of  
13      a mix and most of the work is really being led on  
14      the public health side.   But in general the  
15      Medicaid agencies are engaged.

16              CHAIR PINCUS:   Mary Kay?

17              MEMBER JONES:   Yeah, just another  
18      thought if -- and I am not really up on the  
19      details of this but if these people are being  
20      seen at clinics, a lot of times there is not a  
21      claim submitted or billed or anything.

22              It's all covered in the clinic.   So we

1 don't have access to the data. And, again, it'd  
2 be a broken record with the medical record  
3 collection and laboratory data, it just continues  
4 to be difficult.

5 CHAIR PINCUS: Deborah, did you have  
6 a comment? Any other comments on this measure?  
7 Move on to the next one.

8 MS. GORHAM: All right. The last  
9 measure, as we know, 0648 care transition, we  
10 won't discuss this measure because it is no  
11 longer on the 2017 core set. But we wanted to  
12 list it since we are talking about 2015  
13 reporting.

14 But, as I said, we won't discuss that  
15 so we can move to the next slide. And as we  
16 think -- as Karen stated earlier, the purpose of  
17 the task force is to, one, look at the core set,  
18 look at the measure's low reporting and see  
19 whether or not the task force feels that there  
20 should be a recommendation for removal.

21 So that is where we are in our  
22 schedule today -- in our agenda today. So I will

1 turn it over to Harold so that we can entertain  
2 questions or comments about the measures with low  
3 reporting -- low levels of reporting and take a  
4 few minutes to see if task force members would  
5 like to propose a measure for removal.

6 CHAIR PINCUS: So we have had  
7 discussion of these sort of low level of  
8 reporting measures and does anybody want to  
9 recommend removal of any of these measures?

10 So let me try to interpret that so  
11 that the -- so my sense is that as we discussed  
12 them, there was some level of perceived value  
13 with regard to the intent of the measures.

14 But what's preventing people from  
15 actually reporting the measures are sort of  
16 various sorts of practicalities, and we have had  
17 discussions about, you know, ideas about how to  
18 potentially overcome those practicalities either  
19 in the short range or the long range.

20 And so that's -- so people would like  
21 to keep this on the discussion agenda going  
22 forward should there be some advances in being

1       able to overcome those practicalities. Does that  
2       sound like a -- the interpretation? Deborah.

3               MEMBER KILSTEIN: I'm going to bite  
4       the bullet here. I would recommend that the  
5       antenatal steroids be considered for deletion  
6       from the set.

7               I mean, you have few states that are  
8       reporting it. The number of states reporting it  
9       is actually dropping rather than increasing,  
10      which doesn't -- makes it seem like states aren't  
11      looking to try and better report this.

12              While I think it's an important issue,  
13      if it's not -- if we have no indication that it  
14      is an ongoing performance issue or that there are  
15      disparities that would make it important to  
16      report for Medicaid versus otherwise business I  
17      am not sure why it would still be included.

18              CHAIR PINCUS: And at least what we  
19      kind of understand from the Joint Commission that  
20      -- what was it, 97 percent?

21              DR. BURSTIN: Yes. Overall  
22      performance. Actually, Sean was able to find a

1 chart for us from 2015 at least showing that the  
2 vast majority of states are over 95 percent.  
3 These are state level estimates and only four  
4 states are 90 to 95 percent and no one is below  
5 that with the exception of one state that has too  
6 few numbers to report.

7 Again, we don't have data by state  
8 Medicaid/non-Medicaid. But given overall rates  
9 of performance like that, usually the estimate we  
10 would look at is, you know, is there really any  
11 difference between the 75th percentile and the  
12 100th percentile and it's sort of unlikely to  
13 find anything here, I would guess.

14 But we could certainly follow up and  
15 confirm that with the Joint Commission and see if  
16 they have Medicaid/non-Medicaid data.

17 CHAIR PINCUS: Roanne?

18 MEMBER OSBORNE-GASKIN: So I guess I'd  
19 like to ask a question because I -- or so the  
20 screening for clinical depression and follow-up  
21 plan is the measure that I wanted to focus on for  
22 possible removal and the only reason is because

1 we had the discussion previously. Screening is  
2 not something that the -- that the task force  
3 wanted to focus on.

4 We wanted to focus on screening and  
5 the follow-up plan. And so I am wondering if  
6 that would be addressed by the NQF measure 0105,  
7 which is antidepressant medication management, to  
8 address the follow-up of depression, I think was  
9 mentioned by Deborah, that, you know, it may have  
10 been easier for plans to report if there was the  
11 screening for clinical depression separate from  
12 the follow-up plan and the issues associated with  
13 trying to measure that.

14 So I am wondering if that follow-up  
15 plan would be addressed in that measure and I  
16 don't know if I could do that.

17 CHAIR PINCUS: Could we maybe put that  
18 on hold? Could we maybe finish with the  
19 antenatal -

20 MEMBER OSBORNE-GASKIN: Okay.

21 CHAIR PINCUS: -- steroid thing first  
22 -

1 MEMBER OSBORNE-GASKIN: Okay.

2 CHAIR PINCUS: -- and see if because  
3 -- and come back to that one, okay?

4 MEMBER OSBORNE-GASKIN: Okay. Sure.

5 CHAIR PINCUS: So any -- anybody want  
6 to speak sort of against removing the antenatal  
7 steroid? Oh, we need -- we need a second for  
8 removal of the antenatal steroid.

9 MEMBER LA CROIX: I would second.

10 MEMBER JONES: I would, too.

11 CHAIR PINCUS: Huh?

12 MEMBER LA CROIX: I'll second.

13 MEMBER JONES: I would give it a third  
14 then.

15 CHAIR PINCUS: Okay. Does anybody  
16 want to speak in favor of keeping it in the core  
17 set?

18 Okay. So I guess we can vote on it,  
19 correct? Do we need to go through this? Can we  
20 just raise our hands? Okay.

21 MS. KUWAHARA: Okay. So our voting  
22 members have clickers at their stations. We are

1 going to try a little test run here. If you  
2 wouldn't mind answering the question, did you  
3 have coffee this morning, and you'll want to  
4 direct your clickers in this direction towards  
5 this computer.

6 One is yes and two is no. Okay. We  
7 are waiting on four more responses. Captured,  
8 uh-huh. And if there is just a horizontal line,  
9 that means it's problematic and we will get you a  
10 new clicker.

11 All right. So we are going to move on  
12 to the antenatal steroid measure. Polling is now  
13 open.

14 CHAIR PINCUS: Okay. So just to be  
15 clear, so a yes means it should be removed.  
16 Right. So you're not saying no to the measure.  
17 You're saying yes to removal.

18 DR. MATSUOKA: It may be worthwhile to  
19 repeat which measure it is that they are voting  
20 on, too.

21 MS. KUWAHARA: This is measure number  
22 0476, PC 03 antenatal steroids, and we are still

1 waiting on three responses. Two more responses.  
2 Okay.

3 Seven individuals responded that we  
4 should move this measure from the adult core set  
5 and that's 100 percent of voters.

6 CHAIR PINCUS: Okay. So okay. Yeah,  
7 so just to summarize, it seems that based on the  
8 discussion that the sense was that this measure  
9 is already being collected in other ways and  
10 based upon the data from that it's been pretty  
11 much topped out. Okay. Anybody want to add to  
12 that rationale? Okay. Let's -

13 MEMBER JONES: I was just going to add  
14 that what we are hearing as far as the rate --  
15 the current rate, to me, is significantly high,  
16 so that's another reason.

17 CHAIR PINCUS: Okay. So Roanne, let's  
18 come back to the depression one. So what you are  
19 proposing was essentially eliminating that -- the  
20 screening and follow-up because the medication  
21 persistence measure is already in the core set?

22 MEMBER OSBORNE-GASKIN: The

1 antidepressant medication management --

2 CHAIR PINCUS: Right.

3 MEMBER OSBORNE-GASKIN: -- is in the  
4 core set and if the focus is on follow-up then we  
5 may be not so much on depression screening than  
6 we may be capturing some of that and that may be  
7 easier for states to report on. And I can't  
8 remember -- I think it's -- okay.

9 I thought it was also part of the  
10 HEDIS measure but it's not. But it may be easier  
11 for them to do it -- to measure the follow-up of  
12 depression using the medication measure.

13 CHAIR PINCUS: Okay. And just -- the  
14 medication management so, Debjani, can you say  
15 something, just to say what that actually  
16 measures so everybody's on the same page for  
17 that.

18 MEMBER OSBORNE-GASKIN: It's 0105.

19 CHAIR PINCUS: Then once we get that  
20 up -- okay. Clarke, why don't you --

21 MEMBER ROSS: Well, my point's the  
22 same that you're trying to get an answer to.

1       There are two different intents and I think we  
2       need to be clear what the intent is.

3               Once one is identified as having a  
4       diagnosable depressive disorder then the  
5       medication measure applies.

6               But the vast universe of people who  
7       are not identified, that measure that you're  
8       addressing doesn't deal with that. So the  
9       question is, you know, is this an important  
10      enough partial incremental placeholder. Almost  
11      all of the behavioral health measures are  
12      inadequate.

13              They are a little -- one diagnosis or  
14      two and one population group by age and one  
15      setting and yet they are there because we don't  
16      have anything else that's better and we want the  
17      placeholder.

18              So that's the -- in my mind that's the  
19      question on depression screening is the place --  
20      as an advocate, not as someone who has to pay for  
21      it or administer it -- is the need to screen  
22      people for A, B, and C or depression significant

1 enough, important enough to retain it in its  
2 current status, or not.

3 CHAIR PINCUS: So Debjani, do you want  
4 to say just specifically what this alternative  
5 medication --

6 MS. MUKHERJEE: Can you turn off your  
7 mics if you're not speaking? Thank you.

8 So the measure description is the  
9 percentage -- and this is 0105, antidepressant  
10 medication management, and the description is the  
11 percentage of patients 18 years of age and older  
12 with a diagnosis of major depression and were  
13 treated with antidepressant medication and who  
14 remained on an antidepressant medication  
15 treatment.

16 And it's reported with two rates.  
17 Rate A is effective acute phase treatment and  
18 that's the percentage of patients who remained on  
19 an antidepressant medication for at least 84 days  
20 or 12 weeks.

21 And then Rate B is effective  
22 continuation phase treatment, and that's the

1 percentage of patients who remained on an  
2 antidepressant medication for at least 180 days,  
3 or six months. And then I also have the  
4 numerator and denominator.

5 The numerator is adults 18 years of  
6 age and older who were treated with an  
7 antidepressant medication, had a diagnosis of a  
8 major depression and who remained on an  
9 antidepressant medication treatment, and the  
10 denominator is patients 18 years of age and older  
11 with a diagnosis of major depression and were  
12 newly treated with antidepressant medication, and  
13 they exclude hospice services and in-patient --

14 CHAIR PINCUS: I think we have got the  
15 idea. Marissa?

16 MEMBER SCHLAIFER: I think, you know,  
17 historically from a -- from a health plan point  
18 of view this is a measure that's been used long  
19 term, long time. I am wondering if I could just  
20 get some information from the -- from the  
21 Medicaid statewide point of view, especially in  
22 states that aren't -- that may be more fee for

1 service.

2 I know in the past we have talked  
3 about the PQA adherence measures, and CMS chose  
4 not to adopt those. So even though I think from  
5 a health plan point of view this is a really  
6 useful measure and from a pharmacy point of view  
7 it's a -- it's a great measure. I'd like to get  
8 any feedback on how doable this is on fee for  
9 service.

10 CHAIR PINCUS: Well, just to clarify,  
11 we are not voting on -- we are not discussing the  
12 medication management measure. The argument is,  
13 as I understand it, Roanne, is that we can, you  
14 know, eliminate the screening measure because we  
15 have this other measure.

16 MEMBER SCHLAIFER: Oh, okay. Okay.

17 CHAIR PINCUS: Yeah. So that's --

18 MEMBER SCHLAIFER: Okay. Sorry. I  
19 apologize.

20 CHAIR PINCUS: But -- you know, but I  
21 do think -- well, Lisa, do you want to -- oh,  
22 Gigi.

1 MS. RANEY: I just -- this is Gigi  
2 Raney at CMS. I just wanted to jump in real  
3 quick because I think Clarke's point that these  
4 measures serve different purposes is really  
5 important.

6 The medication adherence or the new --  
7 the AMM measure is for people that are newly  
8 diagnosed with depression.

9 So what we find that and what states  
10 found when they were working with this is that -

11 CHAIR PINCUS: Newly diagnosed and  
12 treated with medication.

13 MS. RANEY: And treated with  
14 medication. So if you have someone that has been  
15 on medication for a long time or has been  
16 diagnosed and untreated, they fall out of this  
17 measure. So it's not actually tracking those  
18 individuals, which is a really large percentage  
19 of the population that have depression.

20 So when we were working with states  
21 through the adult Medicaid quality grants or  
22 through reporting, what they were finding is

1 oftentimes the number of individuals that  
2 actually qualified for this measure was fairly  
3 small.

4           Whereas if you have a measure such as  
5 the depression screening and follow-up measure  
6 that's an annual measure seeing how many people  
7 were actually screened in a year. It doesn't  
8 matter whether they tested positive or negative  
9 the prior year. It's an annual measure.

10           So you're not -- you're looking at a  
11 much larger population that you're screening for  
12 the potential for depression and follow-up.

13           So I am not going to speak to the  
14 ability to collect and report on that but they do  
15 -- they do serve two different actual populations  
16 of individuals -- those that might be newly  
17 coming into the larger -- the larger Medicaid  
18 population being screened versus those that are  
19 being really diagnosed and treated. Does that  
20 help at all or just raise more questions?

21           MEMBER OSBORNE-GASKIN: It does help,  
22 but it doesn't help if it's not being reported.

1       So that's kind of how I am -- you know, if the  
2       states are having difficulty not doing the  
3       screening because I think, you know, sort of  
4       across the board doing the screening is  
5       considered something that you're supposed to do  
6       in a clinical setting but that's not being  
7       translated into reporting.

8               And so, you know, the helpfulness of  
9       the measure is kind of -- and I understand what  
10      you're saying because, you know, the people who  
11      are actually taking antidepressant medicine is a  
12      smaller group than the wide body of people who  
13      are being screened.

14             But I am just trying to figure out how  
15      would this help in terms of quality if we are not  
16      getting the data. But that may be a different  
17      discussion.

18             MS. RANEY: Right. I almost feel like  
19      they need to be looked at separately because it's  
20      a separate population.

21             So not getting rid of one because we  
22      have another one but if there is another measure

1 for consideration that might be easier to collect  
2 and report.

3 But just considering them separately,  
4 not in lieu of, would be what I would encourage.

5 CHAIR PINCUS: Lisa, and then Sue.

6 DR. PATTON: Yeah, and I was just  
7 going to agree with Clarke in terms of different  
8 populations, you know, already diagnosed. It  
9 really feels like kind of a step back to not be  
10 getting at screening and that broader population.

11 You know, I think that, you know, it  
12 may not be sending a message that we intend and  
13 there is also strong evidence for treatment of  
14 depression that does not involve medication. And  
15 so I think that's also a huge issue for this  
16 group to consider is we don't necessarily want to  
17 only be able to track people who are provided  
18 medication for depression.

19 And, you know, there is also, you  
20 know, it's not a large number but we have gone  
21 from five to six and I think the conversation  
22 around the table last year was that CMS was very

1 willing to see where growth occurred. And so  
2 although, again, small, to have another state,  
3 you know, engaged in this process and reporting  
4 on this is very good news for us.

5 Some of these behavioral health  
6 measures, as Clarke said, are often more  
7 placeholders as we move forward with this. And  
8 so I think it's important to us to try to keep  
9 that placeholder in there for now.

10 CHAIR PINCUS: Okay. Sue?

11 MEMBER KENDIG: Yeah. I would agree  
12 with that as well. It concerns me if we let the  
13 screening measure go even though it is imperfect  
14 and, you know, my only comment would be that I  
15 would advocate that if there are measures coming  
16 that add pregnant and postpartum women to that  
17 measure that would be important to look from a  
18 population perspective.

19 I am concerned with what Judy  
20 presented about the lack of reporting in Colorado  
21 but in my view that -- I think that provides the  
22 opportunity for states to consider plans for

1       quality improvement because even though I, as a  
2       clinician, don't see how you can do an assessment  
3       without including behavioral health, I know that  
4       across the board that may not be the case. So I  
5       think, in my view, that's a warning bell and it's  
6       an opportunity where we can intervene to support  
7       providers. So I would advocate for having some  
8       type of screening.

9               CHAIR PINCUS: Yeah. I may have sort  
10      of just -- I may have sort of jumped ahead with  
11      an assumption in terms of the process.

12             But let me just interrupt by saying,  
13      you know, Roanne, do you or does anybody else  
14      want to make a motion or propose that we remove  
15      the depression screening and follow-up measure?

16             MEMBER OSBORNE-GASKIN: I mean, it's  
17      -- I understand the arguments that other folks  
18      have made and so I am wondering if there is room  
19      for even a modification then even -- because I  
20      understand there are two different groups of  
21      people that are being addressed. So, I mean, I -  
22      - you know, I just -- my thing is that --

1 CHAIR PINCUS: Well, but are you --  
2 are you -- do you want to make a motion -- but  
3 the issue at hand is do we recommend removal.

4 MEMBER OSBORNE-GASKIN: I guess I may  
5 have been convinced otherwise.

6 CHAIR PINCUS: Okay.

7 MEMBER OSBORNE-GASKIN: I mean, you  
8 know, it's just that, you know, is there -- this  
9 is my first time -- but is there a way to even  
10 modify it? You can't modify it. Well, then --

11 CHAIR PINCUS: Yeah.

12 MR. CURRIGAN: The -- Sean from ACOG  
13 -- I think you might be caught up on the follow-  
14 up and the actual measure specification is  
15 follow-up plan that is documented when you do the  
16 screen and not actually -- technically it's a  
17 lower bar than you think.

18 It's actually having the follow-up  
19 happen is not in the measure so, like, I think  
20 that might allay your concerns about how -- you  
21 know, like, do you have a referral plan -- do you  
22 have a follow-up visit plan.

1                   That's what has to be documented when  
2                   you do the screen and have a positive or,  
3                   whatever, high PHQ-9 or however that scores. So  
4                   that might -- does that help?

5                   But also I wanted to mention there is  
6                   an e-measure version of this that went to the  
7                   behavioral health panel.

8                   So if we are getting rid of the  
9                   antenatal steroids can we double down on the  
10                  depression because now we have an e-measure  
11                  version that might be easier for plans to be able  
12                  to collect from electronic sources.

13                  MS. RANEY: Just to speak to the e-  
14                  measures because one of the things that we have  
15                  resolved to do and we did it last year but this  
16                  year is that if there is an e-specification that  
17                  is NQF-endorsed for a measure that's already part  
18                  of our core set we just plan to add that e-  
19                  specification to the core set not as a change but  
20                  as providing an additional way for states to be  
21                  able to collect and report on measures.

22                  So we don't consider that an addition

1 to the measure. It's just kind of an enhancement  
2 to the availability to do that.

3 So if there is an actual -- if that e-  
4 measure goes through that would be great and we'd  
5 be happy to include it as part of the core set.

6 CHAIR PINCUS: So by policy we don't  
7 need to make a formal motion for doing that.

8 MS. RANEY: There is no vote -- right.  
9 So there is no need for a motion for recording.

10 CHAIR PINCUS: Okay.

11 MS. RANEY: I know last year we voted  
12 on that but we had just decided --

13 CHAIR PINCUS: Okay.

14 MS. RANEY: -- through our internal  
15 discussions not to -- not to require additional  
16 voting for that.

17 CHAIR PINCUS: Okay. No, that makes  
18 sense. So, Roanne, so my interpretation now is  
19 that you're not advocating a removal of that  
20 measure.

21 Does anybody else want to make a  
22 motion for removal of the depression screening

1 and follow-up plan measure?

2 Okay.

3 MS. GORHAM: And just to add to Gigi's  
4 comment, the e-measure version is still going  
5 through the process -- the endorsement process so  
6 it is not yet endorsed. But it was recommended.  
7 So at the conclusion of that project and the  
8 endorsement is actually final then we will share  
9 that information with CMS.

10 CHAIR PINCUS: Yeah. And actually I  
11 just literally got an email saying that the CSAC  
12 is meeting June 21st on this issue. So --

13 MR. CURRIGAN: Just to clarify, so the  
14 version that -- the version of both of these  
15 measures that you mentioned, the regular version  
16 that went to the behavioral health plan does not  
17 include maternal perinatal depression but the new  
18 version that did not go to the behavior health  
19 panel does that's in the 2018 specs and the -- so  
20 that will be more closely mirrored in NCQA's  
21 HEDIS measure that also includes perinatal  
22 depression.

1                   So I know this gets really complicated  
2                   but -- and wonky but if you want to make it  
3                   easier for health plans to implement it should  
4                   more closely probably look like the HEDIS spec,  
5                   which includes maternal depression screening. So  
6                   you should want the 2018 version, not the one  
7                   that went to NQF two months ago.

8                   CHAIR PINCUS: Well, I leave it to  
9                   sort of -- well, there is two recommendations. I  
10                  mean, I leave it to NQF to figure out how they,  
11                  you know, deal with that in terms of the  
12                  endorsement process and it's something to  
13                  consider in terms of, you know, for Karen and  
14                  Gigi as you go ahead to think about how you  
15                  incorporate that information going forward.

16                  But in terms of the business of the  
17                  task force it sounds like there is no  
18                  recommendation to remove that measure.

19                  And are there any other  
20                  recommendations or that people want to make a  
21                  motion to remove any measures?

22                  So Deborah? And Sue, do you -- is

1 your thing up there for comment?

2 MEMBER KILSTEIN: Just one other  
3 comment on the depression screening. Other than  
4 the fact that Karen's sitting here, will this --  
5 will it go in the report that people support  
6 depression screening and the need for a measure  
7 but that there was some concern at least whether  
8 this is the best measure or whether it's more of  
9 a placeholder at this point?

10 CHAIR PINCUS: I think that -- you  
11 know, what I think our discussion reflected was  
12 the fact that screening is really part of a --  
13 sort of a basket of relevant depression measures  
14 and doesn't fully capture, you know, the full  
15 intent.

16 So are we supposed to bring up these  
17 discussion questions next or -- I think we have  
18 touched on these. Okay. So we can move ahead.

19 So now we have an opportunity for  
20 public comment. So can we open the lines for  
21 public comment on our discussion of potential  
22 measures to be removed?

1 OPERATOR: Ladies and gentlemen, if  
2 you'd like to make a public comment press star  
3 one on your telephone keypad.

4 There are currently no public comments  
5 at this time.

6 CHAIR PINCUS: Can we leave it open  
7 for a couple of more seconds?

8 OPERATOR: Yes. And once again, if  
9 you would like to make a public comment press  
10 star one on your telephone keypad.

11 And still no public comments.

12 CHAIR PINCUS: Okay. Okay. Okay.

13 So any further comments from anybody  
14 on the task force in terms of sort of issues such  
15 as how might participation in reporting these low  
16 reported measures be increased?

17 And are there any sort of general  
18 points that you want to make about, you know,  
19 what are the issues faced by states in terms of  
20 not being able to report, you know, on these  
21 measures? We had a lot of discussion about this  
22 already but it's worth just summarizing in some

1 way. So Clarke, Lisa, Mary Kay.

2 MEMBER ROSS: So I mentioned this  
3 morning that the National Health Council has a  
4 PCORI grant and the whole purpose is to get the  
5 52 voluntary health agencies -- heart, cancer,  
6 diabetes, et cetera -- to train their citizen  
7 volunteers about what quality is, quality  
8 measures, how to influence it.

9 And so PCORI recognizes that that's a  
10 missing element in this whole arena is the  
11 informed active engagement of consumers and  
12 families.

13 And so there is this project to try to  
14 activate folks and that might increase  
15 participation in certain measures. I know some  
16 state agencies and health plans don't want more  
17 consumer advocates coming.

18 But that's the purpose of the -- of  
19 the grant from PCORI is to have the American  
20 Heart Association more engaged on quality  
21 measurement. And so this is just one little FYI  
22 piece.

1 CHAIR PINCUS: Okay. Lisa?

2 DR. PATTON: Yeah. I was just going  
3 to say I was so struck by Judy's presentation in  
4 terms of financial incentives not making a  
5 difference because we have heard for so long how  
6 that financial incentive would make all the  
7 difference.

8 And so I just wanted to say, you know,  
9 for our part as we move forward with these  
10 learning collaboratives, you know, we will  
11 certainly keep that in mind and, you know, any  
12 kind of additional work that we can do on that  
13 front to better understand what's happening with  
14 that I know we'd be happy to engage in. That  
15 would be great.

16 MEMBER JONES: My suggestion would be  
17 for those that have been able to report on this  
18 measure because it's a difficult measure to  
19 report is it NQF or someone could share what they  
20 did, kind of helpful tips or best practices on  
21 how to implement, how to measure, you know, what  
22 not to do, what to do that might make people more

1 inclined to try to report on it.

2 CHAIR PINCUS: Other comments? So I  
3 think it's time for us to take a lunch break. Is  
4 it ready?

5 PARTICIPANT: Lunch is not here yet.

6 CHAIR PINCUS: It's not here yet?  
7 Okay.

8 Can we go -- could we go start to --  
9 can we start to tackle some of the after lunch  
10 things now?

11 PARTICIPANT: Why don't we take, like,  
12 a five-minute break and then we will have any  
13 lunch issues ironed out by then.

14 CHAIR PINCUS: Okay. So we are taking  
15 a five-minute break? Okay. So take a five-  
16 minute break.

17 (Whereupon, the above-entitled matter  
18 went off the record at 12:26 p.m. and resumed at  
19 12:27 p.m.)

20 CHAIR PINCUS: So we can move ahead on  
21 this?

22 So we're continuing to go through the

1       measure-by-measure reviews. And what the intent  
2       was for us to get into this afternoon, but we can  
3       start now, is to actually look at potential  
4       additions to the core set that have been proposed  
5       by either yourself or by other groups that have  
6       come forward. So we want to go over the  
7       potential additions.

8               MS. GORHAM: So I think what we'll do,  
9       we're a little bit above schedule, and that is  
10      okay. Our lunch just arrived, but until then,  
11      you all have to bear with me for a couple of more  
12      slides. Then once they have that out, then we  
13      can take a break, because I'm sure we all need  
14      one.

15             So if we go, okay, we're at the right  
16      place. So if we look at our -- continue our  
17      measure-by-measure review, and we look at the  
18      potential gap-filling measures, we want to look  
19      at the potential measures to add to the core set.

20             So the annual recommendations are  
21      guided by the measure selection criteria that  
22      Miranda reviewed a little earlier. We also want

1 to think about the feedback from state  
2 implementation, and then also the gap areas  
3 identified by the task force numbers during last  
4 year's deliberation.

5 This year, as we continually try to  
6 improve the process, we have incorporated a  
7 preliminary analysis and a discussion guide that  
8 you all received a couple of weeks ago, both  
9 instituted to help organize and standardize the  
10 discussion.

11 So if you would just bear with me and  
12 open your discussion guides so we can kind of  
13 navigate through that. It is a little different  
14 for those of you who serve on the Coordinating  
15 Committee and Work Group, different work groups.  
16 Little tiny bit different, so I just want to kind  
17 of navigate through that if you have that open.

18 So there are several tabs in the gray  
19 bar to your right. So you will see the agenda  
20 tab, it nicely lays out the agenda for you. At  
21 the end of day one, you will see the measures  
22 recommended by task force members.

1                   So you see the two gap areas listed at  
2                   the end of the agenda for day one. Now you want  
3                   to open your discussion guide.

4                   CHAIR PINCUS: Trying to find where  
5                   that would be.

6                   MS. GORHAM: It was sent as an  
7                   attachment. We can email it to everybody. Okay,  
8                   so for those of you who have it open, you'll see  
9                   the gap areas. And what we did was organize this  
10                  discussion guide according to gap area, because  
11                  that is the way that we identify measures to add.

12                  We look at the gap areas that we want  
13                  to add according to those gap areas to the gap  
14                  areas that were identified last year,  
15                  Beneficiary-Reported Outcomes and then the other,  
16                  New Chronic Opioid Use.

17                  And your task force member peers have  
18                  recommended measures in those gap areas. If you  
19                  click on any one of those gap areas, it will  
20                  direct you to the actual measure that was  
21                  recommended.

22                  You can then click on measure

1 specifications to see the specs for that measure.  
2 And then you can also click on the summary of NQF  
3 endorsement review for that measure. And there  
4 you will see some of the questions that we use in  
5 the preliminary analysis algorithm.

6 Okay. So I just want to kind of lay  
7 that out, because as we discuss those measures,  
8 then it would be nice to kind of click and have  
9 all of the information in front of you, which is  
10 what we tried to do this year, and have  
11 everything electronic-based. Last year we had  
12 the kind of big, bulky, cumbersome Excel sheets,  
13 so we know you prefer a little bit better  
14 navigation.

15 The other tabs in the gray bar, you  
16 can click on the measures again, it will get you  
17 to what I just said in a different way. If you  
18 click on the tab that says Gap Area, it lists all  
19 of the gap areas in which we found measures.

20 So you did receive the measure  
21 universe, which is the Excel sheet, and all of  
22 the measures under each gap area were listed in

1       that Excel sheet. If you click on the measure  
2       repository tab in that gray bar, will take you  
3       back out to the Excel sheet. Just for some  
4       strange reason if you want to pull up all of  
5       that, you definitely can.

6               And then of course we do have a tab  
7       for the web meeting comments. So that was quick  
8       kind of walkthrough of the discussion guide. Any  
9       questions about that? Okay, so we can go back to  
10      the slide deck.

11             So the task force members who  
12      submitted recommendations will also be your lead  
13      discussant for the measures that they  
14      recommended. Okay, so to just kind of review  
15      what we used for the preliminary analysis  
16      algorithm, which is not different from what they  
17      use in MAP.

18             We have added a few subcriteria to  
19      address more Medicaid-specific things, and we'll  
20      go over that on the next slide. But things to  
21      consider when we completed the PA. Does the  
22      measure address a critical quality objective not

1 currently addressed in the program set? The  
2 measure, was it a outcome measure?

3 We know that outcome measures are the  
4 decided preference in the quality community.

5 Does the measure address a quality challenge?

6 Does the measure support efficient use of  
7 resources and alignment?

8 Can the measure be feasibly reported?

9 Is it a NQF-endorsed measure? If the measure is  
10 in current use, no implementations issues have  
11 been identified with that measure.

12 And then considering, next slide,  
13 considering some of the Medicaid subcriteria when  
14 completing the PAs we looked at, you know, the  
15 Medicaid adult and child population, the high-  
16 impact areas in health conditions.

17 Data collection and measure  
18 implementation, again, was it feasible? Because  
19 we know that feasibility is very important.  
20 Issues related to resource needs for  
21 implementation. A threat to variation, the  
22 potential need for varying a measure prior to

1 implementation at the state level.

2 So again, the information that we have  
3 as a result of the PA can be found in your  
4 discussion guide, and we just went over that.

5 So a little bit more on voting. We  
6 voted a little earlier. We are using the  
7 clickers, and they so far have been nice to us,  
8 so we hope that they continue. The voting  
9 requirements, so we need to have 66 percent of  
10 the task force present in order to vote. So for  
11 us that is seven members.

12 And then you need a greater than 60  
13 percent of the vote to denote support. And the  
14 beauty of the clickers is they calculate that for  
15 us. So I think that might be the only beauty, as  
16 we often have problems with our clickers. But  
17 fingers crossed.

18 And again, we want to definitely  
19 continue to have robust discussion, but we also  
20 want to make sure that we are mindful of time.  
21 Harold will crack the whip on us if we go too far  
22 off. So we want to ask you all to just refrain

1 from repeating points that have already been  
2 made. But again, we encourage robust discussion.

3 You are allowed to re-vote, we can re-  
4 vote. Some of the reasons that you may have for  
5 re-voting: new information that is brought forth;  
6 post-task force discussions, so maybe in public  
7 comment; and voting and/or confusion as to  
8 information related to the measure.

9 CHAIR PINCUS: When you say re-vote,  
10 do you mean like after this meeting at some other  
11 --

12 MS. GORHAM: No, no, no, during this  
13 meeting. So just if for some reason, you know,  
14 we vote and something ground-breaking is  
15 discovered right after the vote, then we can. So  
16 it's allowed, but often we don't need to do it.  
17 And so we, you know, don't want to if we don't  
18 have to. But it is allowed, so I just wanted to  
19 state all of the rules.

20 So with that being said, when we have  
21 a, and we did this earlier as well, when there is  
22 a recommendation for a measure, we just want to

1 have a second before we proceed on voting. Okay.  
2 So again, you have your decision categories at  
3 your seat, and you can refer back to that.

4 And then on the next slides, we have  
5 all of the gaps that were recommended during the  
6 2015 and 2016 deliberations, the asterisked and  
7 those newly identified gaps in 2016. I won't  
8 call out all of the gap areas because we have  
9 discussion on the agenda for gap areas later on  
10 in the afternoon. So we can move through those.

11 One more, okay. So, as requested last  
12 year, we have listed those measures recommended  
13 by the task force in 2015 and 2016, but these  
14 recommendations were not accepted by CMS. So we  
15 listed those on your slide. And the next slide.

16 We have the measures that were, and  
17 one concept, that were recommended by your peers.  
18 So I'm going to just --

19 CHAIR PINCUS: Can you say a little  
20 bit about what you mean by recommended by your  
21 peers?

22 MS. GORHAM: So recommended by task

1 force members.

2 CHAIR PINCUS: Okay.

3 MS. GORHAM: And so the first measure  
4 is not NQF-endorsed, Concurrent Use of Opioids  
5 and Benzodiazepines. It's a PQA measure. And  
6 then we have an endorsed measure, 2967, The CAHPS  
7 Home and Community-Based Services Measure, CMS is  
8 the steward.

9 And then we have a Personal Outcomes  
10 Measure, and that is not endorsed, that is a  
11 concept. And we as task force members do not  
12 vote on concepts, but we wanted to include it as  
13 a future consideration. And we will speak more  
14 about that in a little while.

15 But let me go back a slide and just  
16 state the measures that were recommended in 2015  
17 and 2016. You have them on your slide, but just  
18 for purposes of the record. So 2152, the  
19 Preventive Care and Screening: Unhealthy Alcohol  
20 Use: Screening and Brief Counseling was  
21 recommended.

22 The next measure, 0541, Proportion of

1 Days Covered: 3 Rates by Therapeutic Category.  
2 That again is a PQA measure. 2951, Use of  
3 Opioids from Multiple Providers and at High  
4 Dosage in Persons Without Cancer is another PQA  
5 measure. Use of Opioids from Multiple Providers  
6 in Persons Without Cancer is a PQA measure.

7 I will say that the two opioid  
8 measures that I just mentioned, 2951 and 2950, at  
9 the time, it was conditionally recommended by the  
10 task force because it had not went through, those  
11 two measures had not been through the endorsement  
12 process. Since then, those two measures have  
13 been endorsed.

14 2602, Controlling High Blood Pressure  
15 for People With Serious Mental Illness, a NCQA  
16 measure. And 1927, Cardiovascular Health  
17 Screening for People With Schizophrenia or  
18 Bipolar Disorder Who Are Prescribed Antipsychotic  
19 Medications, also a NCQA measure. So just wanted  
20 to kind of read those four.

21 CHAIR PINCUS: Yeah, but I guess one  
22 question is, is this an appropriate time to get

1 some feedback from CMS about why they were not  
2 accepted?

3 MS. GORHAM: Sure.

4 DR. MATSUOKA: So I'm having, I need  
5 new prescription glasses, I guess. I'm having  
6 trouble seeing the screen. Which one do you want  
7 me to start with? Or are there ones that you're  
8 more curious about than others?

9 CHAIR PINCUS: Well, maybe you could  
10 just give a -- maybe go through each of them,  
11 because I think they're --

12 DR. MATSUOKA: But I can't -- I can't  
13 see.

14 CHAIR PINCUS: Okay, you can't, okay,  
15 so.

16 MS. GORHAM: So I'll read them off,  
17 Karen, and then you can respond to them. So the  
18 first one is 2152 is not as important to you as  
19 the measure name, which is the Preventive Care  
20 and Screening: Unhealthy Alcohol Use: Screening  
21 and Brief Counseling is an AMA Measure.

22 DR. MATSUOKA: So maybe I'll start off

1 with a general statement, which is, so we're at  
2 the 30 measure mark with the adult core set. I  
3 will tell you that to get to that number was, you  
4 know, a big move for us, because we try very  
5 hard, because of all the concerns about data  
6 reporting burden, to be parsimonious. We hear  
7 that word a lot.

8           So the fact that we're already at 30  
9 tells you something about the internal kind of  
10 heartburn that we had to even put in that much.  
11 That should also give you a sense for when we add  
12 measures, it comes at the expense of taking a  
13 measure out.

14           And I think for a wide swath, I'm now  
15 kind of recollecting last year's process, for a  
16 wide swath of many of these measures, it really  
17 just came down that. It was we can't -- we think  
18 all of these particular issues areas and  
19 conditions and patient populations, they're all  
20 important, and they always are.

21           But if we're going to add all six,  
22 which six would come out? And sometimes it is

1 as, you know, as hard but as simple as that. And  
2 so in the case of, I would say, unhealthy alcohol  
3 use, we were thinking we have a couple of  
4 substance use disorders in our set already, one  
5 about initiation of treatment for alcohol and  
6 substance abuse kinds of disorders.

7 So the kinds of conversations that we  
8 would have internally at CMS were, as well as  
9 with states, you know, is this a measure, given  
10 the populations that we serve that we would want  
11 to measure, and if so, at the expense of what  
12 measure? What measure would come out?

13 And I think how the conversation shook  
14 out and the decision-making shook out was really  
15 kind of, for many of these measures, at that  
16 level.

17 CHAIR PINCUS: So can I challenge your  
18 assumption?

19 DR. MATSUOKA: Mm-hm.

20 CHAIR PINCUS: In some ways, because  
21 this is a voluntary program, it seems that that  
22 would, to my mind, make the notion of there being

1 a finite set of measures causing burden to sort  
2 of be eliminated. Because states can choose  
3 which ones they make their determination of  
4 whether it's burdensome, you know, or whether  
5 it's worth the burden. So that's sort of --

6 DR. MATSUOKA: Two things to that.

7 CHAIR PINCUS: Number one, and then  
8 number two is, I mean, these are all behavioral  
9 health measures, in one form or another, that has  
10 been often acknowledged as being sort of one of  
11 the major gaps.

12 DR. MATSUOKA: So I'll take that  
13 second one first, which is that actually because  
14 we know that we have such a behavioral health  
15 issue with the patient populations that we serve,  
16 we do have the wealth of the, you know, that  
17 behavioral health domain is quite, it's at least  
18 comparable with the number of measures we have in  
19 other domains, and more than some other domains.

20 So your second issue I addressed  
21 first. The first issue is I think there are  
22 considerations that come into play in two

1 different ways, even though this is a voluntary  
2 set of measures. One is, you know, of course  
3 when the states voluntarily report these measures  
4 to us, it's not because they want to know how  
5 they're doing, because that they already know.

6 What they want to know is how their  
7 performance relates to how their peer states are  
8 performing. And so to a certain extent, the more  
9 measures that you have for states to choose from  
10 dilutes the potential that there are going to be  
11 a critical mass of states voting on any  
12 particular one.

13 And the reason why that becomes doubly  
14 important is because the MPR contract, the  
15 technical assistance support contract that we  
16 talked about earlier in the day, because of the  
17 resources and the limited resources that we have  
18 at the federal level, we are only able to provide  
19 that kind of technical assistance to measures  
20 that at least 25 or more states report.

21 And that's why that threshold that  
22 Miranda had in her chart of all the different

1 measures on our core set, how many of those  
2 measures did 25 or more states report, that's why  
3 that becomes critically important.

4 So again, the issue of, you know,  
5 critical mass of states in this voluntary program  
6 becomes important. It has resource implications  
7 maybe not necessarily for the state, but actually  
8 at the federal level.

9 But also in terms of opportunity cost  
10 in terms of I think diluting signal strength is  
11 another kind of opportunity cost when it comes to  
12 having more measures than would fit on one page.  
13 That's another way that we think about this too.

14 CHAIR PINCUS: Let me push back a  
15 little bit on that response. Because in some  
16 ways, I can understand that there's a limited  
17 sort of, you know, bandwidth, as you might want  
18 to put it. On the other hand, you know, like you  
19 said, states do know their own performance, but  
20 they may not be looking at it.

21 I mean, what we've heard from some of  
22 the states is that, you know, they often don't

1 know their own performance, because it's not sort  
2 of put up as something they should be looking at  
3 in terms of setting priorities.

4 So that's sort of issue number one,  
5 that it does sort of add to that. In terms of  
6 burden, at least the two that have to do with  
7 controlling high blood pressure for people with  
8 serious mental illness and cardiovascular health  
9 screening for people, those are really segmenting  
10 existing measures that might be, you know.

11 So it's simply a matter of taking a  
12 measure that's already being reported and just  
13 looking at a different sub-population. And so  
14 the burden is not as great, you know, in the --

15 DR. MATSUOKA: I think we've got folks  
16 in the peanut gallery who'd like to make a  
17 comment.

18 CHAIR PINCUS: Yeah, and I can  
19 understand that there are multiple sort of opioid  
20 measures, and maybe, so one of the questions is  
21 coming in, you know, what's the best of class in  
22 terms of thinking about the opioid measures. And

1       that's maybe something that we may want to talk  
2       about.

3                   And just push back on one other  
4       comment, which is the preventive care and  
5       screening for unhealthy alcohol use. I mean, one  
6       of the problems with the initiation or the  
7       identification and engagement measures for  
8       substance use is that they are highly variable  
9       depending upon whether people are being screened.

10                  So that if you, basically if you  
11       screen, you're likely to get a worse outcome, I  
12       mean a worse measure result, on initiation and  
13       engagement, as compared to if you don't screen.  
14       So that this is kind of, you know, both a quality  
15       measure and also balancing measure.

16                  DR. MATSUOKA: So I'll just say that  
17       parsimony is a driving force here, and we never  
18       make these decisions without consulting with our  
19       state partners. And ultimately what ends up  
20       shaking out of that whole process ends up being  
21       the 30 measures that to the best of our ability  
22       we think represent the spirit of what the core

1 measures are meant to be. But I'll turn it over  
2 to Gigi.

3 MS. RANEY: I just wanted to speak to  
4 Harold's comment about the segmentation of the  
5 measures being more specific.

6 Because as Karen just said, we do have  
7 a lot of stakeholder feedback after we get the  
8 MAP recommendations, with both internal and  
9 external stakeholders, to see what they think is  
10 actually going to apply in real life, like  
11 whether or not they think they're going to be  
12 able to collect and report on measures that are  
13 proposed by the MAP.

14 And one of the things that we heard  
15 about those measures, like the controlling high  
16 blood pressure for people with serious mental  
17 illness, and the other, and the diabetes screen  
18 for individuals with schizophrenia, or however  
19 that one's shaken down, is that they actually  
20 thought those measures were going to be difficult  
21 for them to report sometimes.

22 We actually got mixed feedback from

1 the stakeholders about their ability to collect  
2 and report on those measures. Because they don't  
3 always get the additional diagnostic codes that  
4 would tell them about those different groups.  
5 And so it wasn't as easy as we thought it would  
6 be when we were talking about that, for people to  
7 collect and report on those.

8 So for us it was like, oh, we're  
9 already doing this, they've already got this.  
10 It's just a matter of them breaking the  
11 information a different way. But not all states  
12 have the ability to do that, and it took a lot  
13 more work from some of them in trying to  
14 negotiate that.

15 So, you know, I think it speaks to  
16 it's still a separate measure, even though it's a  
17 lot the same. We have to consider that there was  
18 a lot of additional resources for that. So  
19 behavioral health is my background, and as most  
20 people here probably know if they know me at all,  
21 like I'm always pushing for the behavioral health  
22 part.

1                   But we do have to remember there are  
2 other groups in here. So as we're trying to grow  
3 that, you know, we added three measures last  
4 year, and two of those are behavioral health,  
5 with a focus on that to the adult core set, so.

6                   DR. PATTON: So Gigi, I wanted to ask  
7 you and Karen, because 1932, the diabetes screen,  
8 was really developed as sort of a companion  
9 measure with the cardiovascular. So I was just  
10 curious, I mean, we saw the rates on the diabetes  
11 measures earlier and, you know, obviously they're  
12 quite high.

13                  But I was curious about, you know, the  
14 discussion why the cardiovascular wasn't included  
15 although the diabetes screen for people with SMI  
16 was. I mean, you may not recall.

17                  MS. RANEY: I think part of it had,  
18 again, to do with parsimony, which was like our  
19 word of the day last year, was trying to figure  
20 out where we could get the most bang for our buck  
21 in terms of state reporting and the population we  
22 serve.

1 DR. MATSUOKA: And the only thing I'd  
2 just add, so yes, everything Gigi said. But  
3 also, in some ways these measures are also  
4 signals for us for broader things. And so for  
5 us, what we really liked about this kind of  
6 measure was it kind of got to the issue of  
7 behavioral health integration.

8 DR. PATTON: Absolutely, co-physical  
9 health co-morbidities, that's the intent.

10 DR. MATSUOKA: Exactly. And so apart  
11 from measuring the subset of individuals with SMI  
12 who also had diabetes, we had sort of a broader  
13 kind of like monitoring interest in seeing the  
14 extent to which that's happening.

15 And so I don't think it was so much is  
16 it going to be diabetes or cardiovascular. I  
17 think it was sort of, given parsimony, let's go  
18 with one, so.

19 DR. PATTON: Yeah, and just one other  
20 point. 2152 has moved into hiatus, so just to  
21 make you aware that, so.

22 MEMBER ROSS: So Karen, you mentioned,

1 after discussions with your state partners, some  
2 state mental health authorities are the Medicaid-  
3 administering agent in their state for that  
4 defined population, and some state IDDD agencies  
5 are the state-administering agency.

6 Did you consult with the state alcohol  
7 and drug abuse directors, the state mental health  
8 authority commissioners, in making your decision?

9 DR. MATSUOKA: We -- I want to say we  
10 had three main groups of state stakeholder  
11 outreach efforts. One was to our CHIPRA grantees  
12 for the child core set, one was to our adult  
13 Medicaid quality grantees for the adult core set.  
14 We had our quality tag, which are also state  
15 representatives from each of the ten regions.

16 And I think we also consulted  
17 internally with the Medicaid organizational lead  
18 on these substance use disorder kinds of things,  
19 which are the Disabled and Elderly Health  
20 Programs Group, as well as the Medicaid  
21 Innovation Accelerators Program Group.

22 And I think our hope was that by

1 canvassing those broad channels for input, that  
2 either the states themselves or through our CMS  
3 partners internally that their feedback will have  
4 to some extent represented those individuals that  
5 you've talked about.

6 But I don't know that we've kept track  
7 of exactly who from what states were on these  
8 calls. But we can definitely start to do that  
9 moving forward? No, okay. I'm looking at Gigi.  
10 We do the best that we can for sure. Yes, that's  
11 right.

12 CHAIR PINCUS: Other comments?

13 MS. GORHAM: Okay, before we actually  
14 continue our discussion with the task force  
15 member recommendations, I think we should break  
16 for lunch. Okay, agreed? So we will see you  
17 back at the table at 1:30, all right.

18 (Whereupon, the above-entitled matter  
19 went off the record at 12:54 p.m. and resumed at  
20 1:36 p.m.)

21 MS. GORHAM: Okay, as task force  
22 members come back to the table, we are going to

1 start with the task force recommendations for  
2 strengthening the adult core sets. So again, the  
3 task force members who recommended the measures  
4 will be the lead discussants, so we'll start with  
5 the lead discussant.

6 We have developers, either on the line  
7 or in the room, and it is always helpful to have  
8 the developers here to answer any type of  
9 technical questions about the measures that we  
10 are discussing.

11 We ask the developers to only respond  
12 to questions from the task force members. And  
13 with that, our first measure is the concurrent  
14 use of opioids and benzodiazepines. That is a  
15 PQA measure and Marissa is our lead discussant.

16 MEMBER SCHLAIFER: So this measure  
17 was, when we looked at the gaps determined in the  
18 last couple of years' discussions we've had,  
19 there were two gaps that were identified, one  
20 being polypharmacy, and one that was opioid use,  
21 and it was identified as early opioid use, 45  
22 days, which I'm not sure we can squeeze that into

1       45 days, but as close as possible.

2               So this measure was - so I selected  
3       this measure for recommendation because it hits  
4       two gaps in one, so for that, you know, I felt  
5       that since trying to use the word "parsimony," in  
6       a sentence, we're looking at this from that point  
7       of view by trying to address two gaps with one.

8               So this measure is a PQA measure that  
9       was endorsed by PQA in December 2016. It has not  
10      yet been submitted for NQF endorsement. It's  
11      waiting for the next go around of patient safety  
12      measures, and will be submitted for NQF  
13      endorsement at that time, so I just thought I'd  
14      hit those questions before they get asked.

15              So this measure examines the  
16      percentage of individuals 18 years and older with  
17      concurrent use of prescription opioids and  
18      benzos, benzodiazepines. Most of the  
19      information, or all of the information is on the  
20      slide as far as the numerator and denominator.

21              The denominator, the group of patients  
22      are those with two or more prescription claims

1 for any opioid filled on two or more separate  
2 days for which the days supply is 15 or more a  
3 day, so you're looking at more chronic use, more  
4 than acute use during the measurement period, and  
5 then the numerator is the number of individuals  
6 from the denominator with two or more  
7 prescription claims for any benzodiazepine filled  
8 on two or more separate days, and concurrent use  
9 of opioids and benzodiazepines for 30 or more  
10 cumulative days.

11 So, you know, while benzos and -  
12 benzodiazepines and opioids are used together  
13 often, that's not necessarily a good thing, but  
14 approximately half of the patients receive both  
15 opioids and benzodiazepines from the same  
16 prescriber on the same day, and that's not  
17 necessarily something we want to see.

18 And in addition, when you look at  
19 fatal use of opioids, there's this concurrent  
20 benzodiazepine use in 31 to 61 percent of those  
21 fatalities with opioids, so that's kind of the  
22 trigger that this is an area that we should be

1 looking at.

2 Is there any other information you  
3 want to share?

4 MS. GORHAM: Well, I just wanted to  
5 point out I neglected to say that Marissa  
6 provided handouts for those of us who -

7 MEMBER SCHLAIFER: Oh, sorry.

8 MS. GORHAM: - like the feel of paper  
9 in our hand.

10 MEMBER SCHLAIFER: Yes.

11 MS. GORHAM: You do have handouts.

12 MEMBER SCHLAIFER: The complete  
13 specifications with the drug lists and  
14 everything, sorry, I meant to say that too, is on  
15 the table, and it's got all of the drugs, and all  
16 of the exclusions, and anything else you may  
17 want.

18 And we do have Lisa Hines from PQA is  
19 on the phone and Woody Eisenberg's in the room,  
20 so between the two of them, we should be able to  
21 answer any questions.

22 CHAIR PINCUS: Questions or comments

1 from the task force?

2 MEMBER KILSTEIN: I have a question.  
3 So you are including buprenorphine in as an  
4 opioid because I know some of the other measures,  
5 it's been excluded, so?

6 MS. HINES: I'd be happy to answer  
7 that question. This is Lisa Hines with PQA.  
8 Only buprenorphine that is indicated for pain is  
9 included in the measure. If it is indicated for  
10 opioid use disorder, it is not included.

11 CHAIR PINCUS: So I had two questions.  
12 One is what actually is the current prevalence of  
13 opioid and benzodiazepine use simultaneously?

14 MEMBER SCHLAIFER: Okay, Lisa, Woody's  
15 taking that one.

16 MS. HINES: Okay, it's 17 percent in  
17 2013.

18 CHAIR PINCUS: 17 percent of what?

19 MS. HINES: So there's a recent  
20 publication by Sun and colleagues, so this isn't  
21 our measure benchmarking, looking at the  
22 association between opioids and benzodiazepines

1       prescribing in overdose, and this is out of  
2       privately insured individuals, over 300,000  
3       individuals.

4               PARTICIPANT: But in addition to that,  
5       we did testing in some Medicaid populations and  
6       came up with almost 20 percent consistently.

7               CHAIR PINCUS: But 20 percent of what?

8               PARTICIPANT: Patients on opioids also  
9       having -

10              PARTICIPANT: That's right, patients  
11       who were on opioids who also had a prescription  
12       for a benzodiazepine.

13              CHAIR PINCUS: And I guess the  
14       question, the second question is among the range  
15       of sort of opioid-related quality measures, why  
16       this and not one of the others?

17              MEMBER SCHLAIFER: The reason, when we  
18       looked at the opioid - and I'll answer my reasons  
19       and then - at least my reason for putting this  
20       one forward rather than other things.

21              Last year, we looked at several opioid  
22       measures that really target people misusing

1       opioids that when you look at those measures that  
2       are multiple prescribers and multiple pharmacies,  
3       I think that's where you identify some of the  
4       true, for lack of a better word, abusers.

5               When looking at the gap areas, the gap  
6       was opioid use in the first 45 days which is -  
7       there aren't a lot of measures that identify  
8       potential misuse in the first 45 days, and this  
9       is -

10              So that was why this rather than some  
11       of the other things that do look at chronic  
12       opioid misuse, and also because this measure also  
13       hit the polypharmacy measure, so that was my  
14       reasoning. I don't know if Woody or Lisa, you  
15       want to -

16              PARTICIPANT: I would add that this  
17       combination of opioids and a benzodiazepine has  
18       been targeted by CDC as a particularly deadly  
19       combination, and that recently, the FDA has also  
20       come out with new box warnings on both benzos and  
21       opioids warning strongly against the use of both  
22       together.

1                   And there have also been recent  
2       studies, some of them that have been carried out  
3       by the FDA, that have shown increased prescribing  
4       of opioids and benzos independently increased  
5       prescribing together, and correlating that with  
6       increased emergency room, hospitalization, and  
7       death.

8                   CHAIR PINCUS: Other comments or  
9       questions? One thing maybe, Judy, if I could  
10      address something to you, is you had mentioned  
11      this Minnesota measure, and, you know, as a  
12      potential user of this, you know, these measures,  
13      how would you say this measure as compared to the  
14      Minnesota measure in terms of, you know, relative  
15      value?

16                  MEMBER RHYS JONES: Yes, so for  
17      Colorado, this is on our radar, and we were on a  
18      bit of a pause as we implemented our new billing  
19      system, but this is one of the things that we're  
20      going to prior-authorize or not allow, and I  
21      think before the CDC came up with their report,  
22      we had also run some things about the risk of

1 death, and this is on that list.

2           So I don't know. I think it's a good  
3 question about how, like, what's the most  
4 important measure? And so as we were sort of  
5 discussing offline preventing people to get  
6 addicted as one of our pieces, and so that's why  
7 we've looked at the Minnesota measure and also  
8 the Washington Labor and Industry does it too as,  
9 "How do we promote good opiate use at the  
10 beginning so we don't get all the way down this  
11 path?"

12           And if I can take the pleasure of the  
13 mic, I think in general, if I were to say, "Are  
14 there new measures that should be added?" I'd  
15 want them to be measures that are in CPC, or  
16 MACRA, or like things that go towards the maximum  
17 overlap of things that are happening.

18           And I also think parsimony at this  
19 level isn't a problem. This is a claims measure  
20 that's pretty easy to do, but parsimony in terms  
21 of how many things can a practice realistically  
22 address and how many things realistically can we

1 even drive quality improvement projects on is a  
2 much more narrow spectrum.

3 Probably somewhere in the range of six  
4 to 10, I think, is a practice's bandwidth, and it  
5 takes a couple of years of working at something  
6 for a practice to make a difference, and so while  
7 ease of collecting measures is pretty easy, I  
8 think figuring out what to focus on or what to  
9 change is something to think about also.

10 CHAIR PINCUS: Other comments or  
11 questions? Oh, Diane?

12 MEMBER CALMUS: Is there any  
13 information looking at kind of the regionality of  
14 this? Is this something that's more common in  
15 certain areas versus others as a prescribing  
16 practice?

17 MS. HINES: Indeed, there's wide  
18 geographic variation, and we have a manuscript  
19 pending, but I could share some preliminary  
20 information on that.

21 CHAIR PINCUS: Okay, so do we have a  
22 second for considering this to be a

1 recommendation to be added? Okay, any other  
2 comments before we vote? Lisa?

3 DR. PATTON: Yes, I was just going to  
4 say, so some of my staff have published in this  
5 area in the past year, and looking at market scan  
6 data, and, you know, so there is some good  
7 literature out there, and, you know, when -  
8 because we're so interested in reducing opioid  
9 deaths, you know, I think this measure is one way  
10 to really get at that.

11 You know, we've had a lot of  
12 discussions about, you know, some very  
13 straightforward ways to get at that kind of  
14 issue, so I think this measure does help with  
15 that or could potentially help with that.

16 And, you know, we do see - I mean, in  
17 terms of guidelines around good care for these  
18 issues, you know, there just aren't a lot of  
19 strong guidelines that, you know, measures have  
20 been developed around or could be developed  
21 around.

22 So, you know, this one seems, again,

1 to kind of hit the mark in terms of clear  
2 guidelines for providers, you know, with the  
3 concurrent prescribing issues.

4 DR. BURSTIN: Wasn't this discussed at  
5 MAP? Was this the same measure that was  
6 discussed at MAP? There was a measure on  
7 concurrent administration of opioids and benzos.  
8 I'll find it.

9 PARTICIPANT: It's not ringing a bell.

10 PARTICIPANT: Could I add one other  
11 comment? This isn't a measure of addiction.  
12 This is a measure of overlapping use because even  
13 short term use can be deadly.

14 CHAIR PINCUS: Yes, I mean, it seems  
15 this is more of a measure, you know, to prevent  
16 mortality.

17 PARTICIPANT: Right.

18 CHAIR PINCUS: Okay, I think we're  
19 ready to vote.

20 MS. KUWAHARA: All right, the same  
21 routine as last time. For measure concurrent use  
22 of opioids and benzodiazepines - oh, I'm sorry,

1 one more question.

2 MEMBER SCHLAIFER: Sorry, I'm assuming  
3 that because this is not yet NQF endorsed, that  
4 full support isn't on the table?

5 MS. GORHAM: So as Marissa said - I  
6 think my computer's about to do something crazy.  
7 You will be voting to conditionally support this  
8 measure because it is not NQF endorsed yet.

9 MEMBER SCHLAIFER: And then once it's  
10 -

11 MS. GORHAM: Right, so again,  
12 conditional support signals to CMS kind of,  
13 again, if we use my - is a yellow light. CMS can  
14 choose to add the measure before endorsement.  
15 That is their prerogative. However, we're  
16 conditionally supporting.

17 Once the measure is fully supported,  
18 if it has not already been adopted by CMS, then  
19 it will be on the list next year with the actual  
20 NQF number, and in the event that it is not  
21 endorsed, then of course, it will not have one.  
22 So for the purposes of voting today, you are

1 using two or three, so two for conditional  
2 support and three for do not support.

3 MS. KUWAHARA: All right, please feel  
4 free to cast your votes. All seven members  
5 selected number two, conditional support, to add  
6 this measure to the adult core set.

7 CHAIR PINCUS: Okay.

8 MS. GORHAM: Okay.

9 CHAIR PINCUS: Move onto the next one.

10 MS. GORHAM: So we can move onto the  
11 next measure recommended, and that measure is an  
12 NQF endorsed measure. That is the 2967. It is  
13 the CAHPS home and community-based services  
14 experience measure.

15 Again, that is NQF endorsed. You have  
16 a few supplementary presentations on this measure  
17 that can be found in your committee's SharePoint  
18 page. Clarke is our lead discussant on that  
19 measure, and so I will turn it over to Clarke.

20 MEMBER ROSS: Thank you very much.  
21 What you have in the PowerShare is the March 30  
22 CMS presentation to the work group on persons

1 dually eligible for Medicare and Medicaid, going  
2 through the evolution and the details of this  
3 CAHPS trademark, already National Quality Forum  
4 endorsed, home and community-based service  
5 experience survey.

6 This was a request of the work group  
7 on persons dually eligible for Medicare and  
8 Medicaid and a request of the National Quality  
9 Forum committee on home and community-based  
10 services to develop an experience survey, and CMS  
11 and AHRQ, the Agency for Healthcare Research and  
12 Quality, collaborated. CMS financed, and the  
13 consulting partners were Truven Health Analytics  
14 and the American Institutes for Research.

15 This first came through the Person and  
16 Family-Centered Care Committee and was endorsed  
17 by that committee. Then it was endorsed by the  
18 full National Quality Forum, and subsequently in  
19 March, was endorsed by the work group on persons  
20 dually eligible for Medicare and Medicaid, so  
21 we're hoping that this task force can fully  
22 support this survey which is already endorsed by

1 the National Quality Forum and two of its  
2 component organizations.

3 This meets the April 2017 MAP report,  
4 the CMS that identified six high-value needed  
5 measures, two of which are patient reported  
6 outcomes and measures addressing patient  
7 experience.

8 This is a CAHPS endorsed patient  
9 experience survey. Another unmet need gap area  
10 of the MAP in addition to patient experience is  
11 home and community-based services, so it  
12 addresses those areas.

13 This survey instrument was pilot  
14 tested in 10 states, Colorado being one, Arizona,  
15 Colorado, Connecticut, Georgia, Kentucky,  
16 Louisiana, Maryland, Minnesota, New Hampshire,  
17 and Tennessee, and the eligible persons to  
18 participate are recipients enrolled in a  
19 Medicaid-funded home and community-based service  
20 program, and the individuals - there's a chart in  
21 the PowerShare slides.

22 The individuals who were interviewed

1 had labels of intellectual or developmental  
2 disability, serious mental illness, brain injury,  
3 frail, elderly, and physically disabled, so each  
4 state had a different cluster and arrangement of  
5 the target population that was served.

6 There are eight domains in the survey.  
7 Those domains are staff reliable and helpful,  
8 staff listen and communicate well, case manager  
9 is helpful, choosing the services that matter to  
10 you, transportation to medical appointments,  
11 unmet needs, personal safety, and planning your  
12 time and activities, and I think - I can't  
13 remember precisely, but I think there are 21  
14 questions that address these eight domains.

15 So that's an overview, and my motion  
16 is that we fully support this National Quality  
17 Forum endorsed survey measure.

18 CHAIR PINCUS: Is there a second?

19 MEMBER LA CROIX: I second.

20 MEMBER RHYS JONES: Could I ask a  
21 question? First, why this one? So we may have  
22 done this in the past, although I don't know. We

1 now do the National Core Indicator Survey from  
2 NASUAD, the National Association of State  
3 something -

4 MEMBER ROSS: State Directors of  
5 Directors of Developmental Disability Services.

6 MEMBER RHYS JONES: Yes, and they have  
7 an aging and disabled one, and also an IDD one,  
8 so, and it may not be NQF endorsed. I'm not  
9 sure.

10 MEMBER ROSS: It's being presented.

11 (Simultaneous speaking)

12 MEMBER ROSS: After this topic, I'm  
13 presenting on the personal outcome measures which  
14 is a survey instrument that's been around for  
15 two-and-a-half decades. June 6 and 7, the  
16 Accelerating Medicaid Innovation group of the  
17 National Quality Forum is meeting.

18 MEMBER RHYS JONES: I'm on that.

19 MEMBER ROSS: And the national core  
20 indicators are being presented at the June 6 and  
21 7 meeting. So both the national core indicators  
22 and the personal outcome measures have been

1 presented to the Home and Community-Based Service  
2 Committee and the work group on persons dually  
3 eligible. We're more formally presenting them  
4 today, the personal outcome measures, and June 6  
5 and 7, the national core indicators.

6 Both national core indicators and  
7 personal outcome measures have been in operation  
8 for two-and-a-half decades, so there's a track  
9 record. We'll talk about the populations when we  
10 get to the personal outcome measures.

11 MEMBER KILSTEIN: I have a question,  
12 well, actually two questions. One is how many  
13 states are currently doing this CAHPS survey for  
14 home and community-based services? Do we know  
15 that?

16 And then two, are we getting ahead of  
17 the other - I know there's a number of other  
18 panels that are recommending measures specific to  
19 the dual eligibles and disabled population, and  
20 are we getting ahead of that?

21 MEMBER ROSS: No, we're not getting  
22 ahead. I'm on the duals work group. I've been

1 on it since 2012, and this is already a National  
2 Quality Forum endorsed survey, and the duals work  
3 group and the person and family centered care  
4 committee both endorsed it, but it's also by the  
5 parent body endorsed, and it's a -

6 It fills the gap of how do we measure  
7 home and community-based services for people with  
8 a variety of disabilities and the label some of  
9 us don't like of frail elderly, but the  
10 vulnerable elderly that need home and community-  
11 based services?

12 So we're not getting ahead. We're  
13 asking you to endorse what three other entities  
14 of the National Quality Forum have already  
15 endorsed, and it's endorsed by the parent body,  
16 oh, and a number of states.

17 So CMS, the people who work on this at  
18 CMS aren't here. Ten states that I read the list  
19 from were engaged in the piloting of it, but I  
20 can't answer, personally I can't answer the  
21 question, "How many states are actually going to  
22 use it today or next week?"

1 CHAIR PINCUS: Rachel?

2 MEMBER LA CROIX: As I understand it,  
3 it only got its CAHPS designation last summer,  
4 and then was just endorsed by NQF in the fall, so  
5 I'm not sure if many states have had the  
6 opportunity to use it yet, but I know we're  
7 planning to start using it in Florida now that  
8 there is a standardized survey available.

9 CHAIR PINCUS: So I had a question.  
10 So there are no other CAHPS surveys that are part  
11 of the Medicaid core set?

12 DR. MATSUOKA: There is.

13 CHAIR PINCUS: Oh, there is?

14 DR. MATSUOKA: The health plan CAHPS  
15 is on the core set.

16 CHAIR PINCUS: That would be -

17 DR. MATSUOKA: CAHPS 5.0, yes.

18 CHAIR PINCUS: Health plan CAHPS, and  
19 so is that - what's been the experience with  
20 that?

21 DR. MATSUOKA: It's funny you ask.  
22 It's one of those things that I think has had a

1 history. So it's been on our core set, I want to  
2 say, from almost the beginning, but I'm going to  
3 look to - yes, so almost from the beginning, but  
4 because it's a health plan CAHPS, I think state  
5 reporting and who is reporting what to whom has  
6 varied over time.

7 So we don't actually report out the  
8 same kinds of data information we do for these  
9 other measures like the MAPS and how states are  
10 performing in different parts of the survey  
11 instrument because of that, because, you know,  
12 some states are having the data flow to AHRQ, and  
13 we started work, I want say, multiple years back,  
14 even before I started working at CMS, on how can  
15 we leverage AHRQ to do some data analysis of the  
16 information that they have?

17 There's also, of course, the  
18 information that NCQA sits on to the extent that  
19 plans are required to do CAHPS as part of  
20 accreditation, but there doesn't seem to be - you  
21 know, if the CAHPS measure is meant to be an  
22 experience of care measure for the Medicaid

1 population served in a state, I don't know that  
2 there are many states who have reporting on their  
3 full state beneficiary sample in the way that we  
4 would want.

5 So we have it as part of our core set  
6 because we think patient experience of core  
7 measures, to the earlier speaker's point, is very  
8 important. We know that states, multiple states,  
9 are measuring it to some extent, but not in an  
10 even enough way that we've been able to really  
11 analyze the data. So we do have the health plan  
12 CAHPS, but of course, you know, to that point, if  
13 you're a mostly fee for service state, you're not  
14 necessarily fielding the health plan CAHPS. So,  
15 anyway, it's been a mixed, a storied past.

16 CHAIR PINCUS: So I also want to get  
17 a sense. That made me think about what are the  
18 issues or barriers in getting the survey out to  
19 the appropriate denominator?

20 MEMBER RHYS JONES: Money.

21 CHAIR PINCUS: Expand on that maybe a  
22 little bit.

1                   MEMBER RHYS JONES: It's really  
2 expensive and you have to pay your EQRO or  
3 someone else to do it, and so, yeah, it's just,  
4 it's more expensive. I don't know how much this  
5 one is, but it's money.

6                   MEMBER ROSS: This addresses the gap  
7 of if one wants to have an experience measure of  
8 people participating in home and community-based  
9 services, is there a standardized National  
10 Quality Forum endorsed gap?

11                   Several of the CMS-funded  
12 demonstrations for persons dually eligible for  
13 Medicare and Medicaid have used, starting with  
14 Massachusetts, have used the experience survey,  
15 and according to the Medicare and Medicaid  
16 Coordination Office of CMS, they're hopeful to  
17 expand the use of the HCBS experience survey and  
18 the dual demos program because a vast something -  
19 I can't remember the exact number, but something  
20 like 68 percent of dually eligible people in the  
21 demos are HCBS participants also.

22                   CHAIR PINCUS: So Marissa, Mary Kay,

1 Rachel, did you - or any - and Deborah, oh, and  
2 then Roanne.

3 MEMBER MARY KAY JONES: I was going to  
4 ask, there is a great need, I think, for home and  
5 community-based measurements and metrics.  
6 There's not much that is out there for us and  
7 it's becoming more and more of a larger  
8 population that really needs to be measured and  
9 make sure that it's being taken care of properly,  
10 so I'm all for having a standard measurement.

11 From the managed care perspective,  
12 what we find frustrating with the CAHPS is that  
13 it's not very actionable. It gives you a very  
14 high level result, but as far as being able then  
15 to drill down or do more work with the  
16 information you have, you have to do additional  
17 focus groups or surveys, etcetera.

18 So is this one more actionable? Will  
19 it give you enough information that you can then  
20 go forward to do improvements? Has that been  
21 looked at?

22 MEMBER ROSS: If you look at the eight

1 domains, this is a very helpful instrument. One  
2 of the eight domains is unmet needs, so what do  
3 individual recipients of current home and  
4 community-based services say are unmet needs?

5 That's a helpful tool to the state and  
6 hopefully to the health plan in figuring out,  
7 "Oh, these are gaps that a significant proportion  
8 of our recipients have identified, and how can we  
9 develop or modify programs to meet those needs?"  
10 as one example.

11 And I probably shouldn't say this, but  
12 the 17 representatives of the duals committee  
13 voted to endorse this, right, so, and thought  
14 this, again, incrementally addressed a big gap as  
15 you have said.

16 MEMBER KILSTEIN: Just one more  
17 question. You mentioned in MMP, the Medicare and  
18 Medicaid demos, that they're using CAHPS. Are  
19 they using this CAHPS or are they using the adult  
20 CAHPS or the existing CAHPS?

21 MEMBER ROSS: My understanding is that  
22 the Massachusetts demo has used this survey -

1 MEMBER KILSTEIN: Massachusetts has?

2 MEMBER ROSS: Massachusetts demo, and  
3 because of that experience and the endorsement of  
4 the National Quality Forum, the MMCO hopes that  
5 other demo programs will use this survey for home  
6 and community-based services.

7 The challenge is the demos do a lot  
8 more than home and community-based services, and  
9 so I think they're having - CMS is having the  
10 discussion on, "How far do we push this and in  
11 what component ways?" and I'm not an advocate. I  
12 don't know any of that.

13 MEMBER KILSTEIN: Okay, thank you.

14 MEMBER OSBORNE-GASKIN: So I agree  
15 with Mary Kay that we definitely need  
16 standardization of, you know, these community and  
17 home-based services, but CAHPS, I think, has  
18 previously had not that great a response when we  
19 sent it out to, you know, in terms of like actual  
20 responses we got back.

21 So is it that - and I don't know if  
22 there has been a projected response from these

1 patients, you know, because I don't know what,  
2 you know, the rates are, but we've seen rates as  
3 low as, you know, 15, 20 percent sometimes,  
4 really not a lot of people responding to the  
5 survey.

6 MEMBER ROSS: Well, again, the people  
7 who ran the pilot should be the ones to answer  
8 the question. The 10 participating states had a  
9 very high participation rate.

10 Now, pilots usually have a higher  
11 participation rate than mainstreamed programs  
12 over time, so I can't answer your question other  
13 than there was a high participation rate in 10  
14 state Medicaid programs by recipients of home and  
15 community-based services.

16 MS. GORHAM: If I could just read a  
17 comment to your question about how many states  
18 are using the measure, I can't answer all of the  
19 states, but someone just chatted that Arizona  
20 currently uses the instrument as its de facto  
21 instrument. I'm sorry.

22 So I can't answer how many states in

1 total, but someone just chatted that Arizona  
2 currently uses the instrument as its de facto  
3 instrument.

4 MEMBER SCHLAIFER: As Judy leaves the  
5 room, I wanted to make sure - I had two parts of  
6 the question, but what the second part is, Judy  
7 had asked the question why this measure instead  
8 of another measure?

9 And I know there was a reference to  
10 the following measure which I don't think is  
11 related at all, so I think it may just be my lack  
12 of knowledge. I'm confused about did we get an  
13 answer of why this measure rather than the  
14 measure you were asking about?

15 So the next measure I'm looking at -  
16 and I know we probably shouldn't jump ahead.  
17 Does the next measure have - they seem like two  
18 very different measures to me, but on this -

19 Oh.

20 MEMBER ROSS: No.

21 MEMBER SCHLAIFER: Okay.

22 MEMBER ROSS: I'm presenting as an

1       introductory - what's the phrase -

2                   MEMBER SCHLAIFER:   Okay.

3                   MEMBER ROSS:   - future consideration -

4                   MEMBER SCHLAIFER:   Okay.

5                   MEMBER ROSS:   - for personal outcome  
6       measures.   The personal outcome measures and the  
7       national core indicators that are each two-and-a-  
8       half decades old were predominantly developed for  
9       people with intellectual and developmental  
10      disabilities, and that's the population served  
11      until recent years.

12                   And in recent years, because of the  
13      absence of home and community-based service  
14      measures, both the national core indicators and  
15      the personal outcome measures have expanded to  
16      other populations.

17                   Something like 40 percent of people  
18      served by state intellectual and developmental  
19      disability agencies have a co-occurring mental  
20      illness, so both national core indicators and  
21      personal outcome measures have developed an  
22      expertise and experience with mental illness.

1 Under a grant from the Administration  
2 on Community Living, the National Association of  
3 States United for Aging and Disability piloted,  
4 modified and then piloted the national core  
5 indicators for physically disabled and "frail  
6 elderly" folks.

7 So these are long-standing instruments  
8 that are expanding in settings and populations,  
9 and again, June 6 and 7 at the Medicaid  
10 Innovation Committee meeting, the national core  
11 indicators will be presented.

12 MEMBER SCHLAIFER: Okay, and just the  
13 other comment I just wanted to make that may or  
14 may not apply to this, I think as I'm trying to  
15 understand that this may be a really good  
16 measure, but I'm trying to understand if it's a  
17 really good measure for the Medicaid core measure  
18 set.

19 I know it was mentioned that it's been  
20 NQF endorsed, and I think that's one of the  
21 things we keep coming back to is NQF endorsement  
22 means it's a good measure, and that what we're

1       trying to get today is, "Is it a good measure for  
2       this purpose?" and I'm still trying to get my  
3       head around that, so anyone who's in the Medicaid  
4       world, I'd love to learn more.

5               MEMBER ROSS: Well, if you looked at  
6       Judy's slide, 6.6 percent of the Colorado  
7       Medicaid population are people with disabilities,  
8       but they account for almost 30 percent of the  
9       expenditures, so this is what we're talking  
10      about, the most vulnerable severely engaged  
11      population who spends a lot of money. That would  
12      be a partial response to why should home and  
13      community-based services be part of a core  
14      Medicaid measure set?

15             MEMBER SCHLAIFER: And I was not  
16      questioning whether there is a need for a measure  
17      at all. I think you have explained, and I think  
18      from Judy's presentation, I totally recognize the  
19      need. I guess my question is is this CAHPS  
20      measure the right measure?

21             MEMBER ROSS: The right measure for?

22             MEMBER SCHLAIFER: Just this program,

1 just this measure. From some of the comments  
2 I've heard earlier, I guess I'm still trying to  
3 figure out just from what I've heard from people  
4 in the room whether this measure is usable in  
5 their setting, in the - yeah.

6 CHAIR PINCUS: Well, let me say,  
7 Rachel, do you want to say something to that  
8 issue?

9 MEMBER LA CROIX: Sure, I actually was  
10 just talking to Karen about this during our lunch  
11 break. We've had Medicaid managed care for long-  
12 term care for several years now, and there has  
13 been a dearth of measures or surveys available.  
14 So as a state, we've had to create some of our  
15 own measures, our own surveys, and so having this  
16 survey available now and be able to be used, and  
17 knowing that CMS is also working with Mathematica  
18 on some measures that can be used for HCBS waiver  
19 programs and managed long-term care, I know I'm  
20 personally very glad these standardized and  
21 tested measures are available to use.

22 In Florida, I think we have at least

1 80,000 people in our managed long-term care  
2 program, and so this would go ahead and provide  
3 some measures as part of the core set that would  
4 cover that population, whereas all of these other  
5 measures in the adult core set don't really  
6 address the services provided through our long-  
7 term care program.

8 Okay, glad I could help.

9 CHAIR PINCUS: Diane?

10 MEMBER CALMUS: Well, that actually,  
11 I think it went a long way in answering my  
12 question as well. So I guess my concern, and I  
13 was kind of in the same place as Marissa, as not  
14 sure if this is the best measure. You know, my  
15 concern is taking what Mary Kay said about  
16 concern about response rates and adding that to  
17 how actionable is what comes out of this?

18 And then saying, okay, so we have -  
19 you know, if we have a low response rate, you  
20 know, and the data is or is not actionable, does  
21 that, you know, provide useful enough feedback to  
22 the agency to really know what improvements that

1 we're making?

2 I mean, I know Judy brought up the  
3 concern of, you know, kind of limited bandwidth  
4 to be able to respond and kind of make  
5 improvements, and so making sure that if we're  
6 going to add something to the data set, that it  
7 really is providing something actionable that  
8 really does represent this population, which I  
9 absolutely agree we need a measure for.

10 They're a particularly vulnerable  
11 population and it is concerning that we don't  
12 have anything, but does this provide something  
13 that's actionable and useful in the end is, I  
14 guess, my question?

15 MEMBER LA CROIX: I believe it will,  
16 at least more than what we've had, and I think  
17 especially being able to go ahead and start  
18 gauging responses to these items, and track  
19 progress over time, and also being able to see  
20 how your state is doing or how your plans might  
21 be doing relative to other states or at a  
22 national level as more folks start using some of

1       these measures, I think that will definitely be  
2       useful.

3               Up to this point, we have been using  
4       a state-created survey, so we're able to look at  
5       our plans compared to each other using that  
6       survey, but not really know how that fits in, if  
7       it's good or bad compared to things at a national  
8       level or in other programs.

9               Also just one comment, and Clarke, I  
10       don't think you had mentioned, the administration  
11       methods for this survey are a little different  
12       than for health plan CAHPS. For health plan  
13       CAHPS, the NCQA protocol is to do the mail out  
14       with a telephone follow up for it, but this  
15       survey is actually intended to be done either in  
16       person or as a telephonic interview where someone  
17       is interacting with the respondent, and so I  
18       think that also should improve the quality of  
19       responses for this population.

20               MEMBER ROSS: Thank you, Rachel. I'm  
21       glad you're here to answer this. You haven't  
22       studied the eight domains, but one of the

1 domains, "Are staff reliable and helpful?" If 62  
2 percent of the beneficiaries say, "no," that is a  
3 clue to the health plan that's managing the  
4 population and to the state Medicaid agency. You  
5 know, we have some staffing challenges in home  
6 and community-based service programs, and we  
7 should take some action to do it.

8 Now, you don't have to act as either  
9 the plan or the funder, but there is data here  
10 that will reinforce that we're doing a sort of  
11 okay job, or we'll red flag three or four areas  
12 that require, the advocates would say require  
13 additional action.

14 CHAIR PINCUS: So do we have - oh,  
15 Helen?

16 DR. BURSTIN: I just want to make one  
17 point. I think this is a common conversation for  
18 any new measure that comes forward. We don't  
19 have that much experience. The beauty of this is  
20 it is new entering in a space where, frankly,  
21 there have not been very many measures. I just  
22 want to also point out though that it is

1 specifically only for beneficiaries who receive  
2 these services for three months or longer, right,  
3 Clarke?

4 I mean, I'm looking and I pulled up  
5 the specs, so it is not everyone, so it is  
6 already just the subsection of those persons who  
7 receive these services. So again, it's not  
8 universal, but I think it would be potentially  
9 just for that subset of persons for whom these  
10 services are received.

11 MEMBER ROSS: But as Rachel said, I  
12 think it was Rachel who said, it's the managed  
13 long-term services and supports program. Well,  
14 by definition, one would think at least three  
15 months, if not for a lifetime, in an area of  
16 intellectual disability and serious mental  
17 illness. So, but you're right. There are  
18 boundaries in all of these measures, and there's  
19 a boundary in this one.

20 CHAIR PINCUS: So do we have a second?

21 MEMBER LA CROIX: I seconded it  
22 earlier.

1 CHAIR PINCUS: Okay, that's fine. So  
2 are we ready to vote?

3 MS. KUWAHARA: All right, for NQF  
4 number 2967, CAHPS at home and community-based  
5 services experience measures, to select support,  
6 please press one, conditional support, press two,  
7 and three, do not support.

8 MS. GORHAM: Just to clarify, so this  
9 is an NQF endorsed measure, so you would either  
10 be supporting or not supporting the measure.

11 There are, there are other reasons.  
12 So with that said, we usually choose, but if you  
13 are voting support, then one, and then  
14 conditional support, two.

15 DR. BURSTIN: Although usually we  
16 would ask groups to vote on conditional support  
17 when you have a condition before the committee.  
18 So you would ask somebody if you want to have  
19 people potentially have the ability to use the  
20 conditional option, you need to actually state  
21 what you'd like people to view that conditional  
22 on.

1 CHAIR PINCUS: So maybe just to make  
2 that point, I mean, is there anybody that would  
3 put forward conditions that they would want to be  
4 considered in the voting?

5 MEMBER KILSTEIN: I would love to hear  
6 CMS actually, you know, the condition in terms of  
7 CMS looking at feasibility and, you know, in  
8 terms of using a measure that they want to use  
9 consistently that's going to align across all of  
10 their programs, not just the adult core set  
11 measure, but the MMP measures, and the dual set,  
12 and, you know, to make sure that there is  
13 alignment across all of the measures. So for me,  
14 that's a condition.

15 Without CMS, you know, weighing in on  
16 that alignment, I would be a little bit hesitant  
17 in terms of the support, not that I don't think a  
18 measure is absolutely necessary, but in terms of  
19 ensuring that there's an alignment across the  
20 different measure sets.

21 CHAIR PINCUS: Okay, so people can  
22 choose to vote support, conditional support with

1 that consideration, or do not support. Okay,  
2 we're ready to vote.

3 MS. KUWAHARA: So it looks like we're  
4 still waiting on one response, okay, great. 38  
5 percent of our eight respondents supported it.  
6 50 percent of our eight respondents selected  
7 conditional support, and 13 percent chose not to  
8 support this measure.

9 CHAIR PINCUS: Conditional support?

10 DR. BURSTIN: Yes, because anything in  
11 MAP world, and this is MAP world, rolls up, rolls  
12 down to the lowest one, so that it would be 50  
13 plus. Its support plus conditional support is  
14 over the 60 percent, and then it rolls down to  
15 conditional.

16 CHAIR PINCUS: Okay, so let's move on  
17 to the next item, Clarke.

18 MEMBER ROSS: Thank you. So the  
19 developer, Cathy Yadamec, is coming to the mic in  
20 the back of the room. She's the director of  
21 training and certification for the Council for  
22 Quality and Leadership, which is the organization

1       that has developed and implements the personal  
2       outcome measures.

3               So I already tried - we have the  
4       national core indicators, which is two-and-a-half  
5       decades old, developed by the National  
6       Association of State Directors of Developmental  
7       Disability Services, which looks at the entire  
8       statewide system of services and supports,  
9       predominantly for individuals with intellectual  
10      and developmental disability, but evolving into  
11      other populations.

12              We also have the personal outcome  
13      measures, two-and-a-half decades of experience,  
14      focused on community-based organizations, so more  
15      like an accrediting body, and this topic is not -  
16      I'm not seeking anybody's vote.

17              This is the introductory presentation  
18      to this group of the personal outcome measures,  
19      and indirectly, the relationship to national core  
20      indicators, and the CMS, HCBS experience survey.

21              Personal outcome measures are used in  
22      over 700 community-based agencies, and Medicaid

1 is the primary financier of these community-based  
2 agencies, and the vast majority of beneficiaries  
3 in these community-based agencies, again,  
4 predominantly intellectual and developmental  
5 disabilities, but evolving into other disabled  
6 population groups, are Medicaid beneficiaries,  
7 and so that's why we're bringing this to you, and  
8 personal outcome measures have been used in over  
9 30 states.

10 There are five domains and 21  
11 indicators for the personal outcome measure, so  
12 Cathy can answer questions you have on those.  
13 The categories are similar to both the national  
14 core indicators and the CMS home and community-  
15 based service indicators.

16 The five factors are my human  
17 security, my community, my relationships, my  
18 choices, and my goals, and then there are 21  
19 indicators for these five factors. This is a  
20 person to person interview process.

21 I won't take the time to laundry list  
22 the 21 indicators, but they're in the PowerPoint

1 presentation and the PowerShare that you have  
2 previously been downloaded.

3 Also, someone asked in this morning's  
4 discussion about personal stories. Personal  
5 stories would enhance. The former president and  
6 executive director of the Council for Quality and  
7 Leadership has published a book. It's a brief  
8 book that I downloaded to the SharePower site,  
9 and it's called A Sample of One.

10 And it basically is a series of  
11 personal stories to explain the personal dynamic  
12 of individuals who are served in community  
13 agencies and who have gone through the personal  
14 outcome measures process, so this is a nice  
15 additional piece to have.

16 I guess that's all I want, given the  
17 previous discussion. We want all of the  
18 appropriate entities of the National Quality  
19 Forum to be aware that the national core  
20 indicators have a two-and-a-half decade  
21 experience. The personal outcomes have a two-  
22 and-a-half decade experience.

1                   They're evolving, and the national  
2                   core indicators and personal outcome measures  
3                   actually complement one another because NCI is  
4                   focused on statewide systems, and personal  
5                   outcome measures are focused on individual  
6                   community agencies, and they both have a personal  
7                   interview process. So please ask lots of  
8                   questions and Cathy can answer them.

9                   MS. GORHAM: Before we actually do  
10                  that, can I just for a point of clarification?  
11                  So the personal outcome measures, this is a  
12                  survey, and they do not have actual measures in  
13                  this survey, so it's different from the HCBS-  
14                  CAHPS survey where we have endorsed measures.  
15                  NQF endorsed the measures and not the survey  
16                  itself. That is also the difference between the  
17                  NCI and the NCI-AD survey. That, again, is a  
18                  survey, and they do not yet have measures that  
19                  have been endorsed.

20                  So Clarke mentioned other projects,  
21                  and so we are - I'm also staffing the Medicaid  
22                  Innovation Accelerator Project with CMS, and we

1 discuss - April 18 and 19, where we had a  
2 representative from NASUAD, I think, is the  
3 developer for NCI, correct?

4 And so I know that they have or they  
5 are in the process of actually getting those  
6 measures developed, but they are about a year  
7 out, and so I'm not quite sure where the  
8 developer is in those measures, but that is the  
9 difference.

10 And so, again, we are not voting on  
11 this. It is just to hear your perspective and  
12 your thoughts on the relevance of this in  
13 relation to the Medicaid population, so if it is  
14 considered as a potential future recommendation,  
15 so again, we are not voting, but we welcome  
16 discussion.

17 CHAIR PINCUS: So questions, comments,  
18 thoughts? I had one just to kick things off.  
19 I'm trying to imagine how this would be converted  
20 into a measure. You know, I guess I'm more  
21 familiar with something like, for example, the  
22 PHQ-9 for depression.

1                   It's a measure of depression and it  
2 gets converted into a measure in terms of number  
3 one, whether it's administered, basically, and  
4 number two, you know, what the findings is for  
5 the population in terms of what proportion of  
6 people have achieved remission on the measure and  
7 what proportion of people have had a 50 percent  
8 improvement on the measure from time one to time  
9 two. So I'm trying to imagine how this would be  
10 converted to a measure.

11                   MS. YADAMEC: So to answer your  
12 question, I think that when we gather this  
13 information about how people are doing, so I  
14 might use an example of one of the measures is  
15 people have friends.

16                   So we could sit here and talk about  
17 how many friends are enough friends, and what's  
18 difficult with that one is that there are people  
19 in this room who have 5,000 friends because their  
20 definition of friend is anybody that they meet  
21 becomes their friend, and then there are other  
22 people who have friends that, you know, there's

1 two or three people that are really close  
2 friends.

3 And so what we're looking at in terms  
4 of measurement is for the outcome "people have  
5 friends" is whether or not that meets that  
6 person's personal definition of "people have  
7 friends," and so the measurement would be the  
8 number of people who have - for whom that outcome  
9 is met over the total number of people with whom  
10 we've asked that question.

11 CHAIR PINCUS: Sort of a change over  
12 time kind of basis for it because I'm trying to  
13 understand it? If you administer it once, then  
14 you're getting sort of the prevalence of all  
15 these sort of outcomes in the population, but  
16 would it be intended to be, "What happens at time  
17 one versus time two?" and what would be - you  
18 know, just sort of thinking about that in terms  
19 of its application.

20 MS. YADAMEC: So when we do this,  
21 certainly that is one of the things we're  
22 measuring is progress over time. For some

1 people, that outcome measure is met, and then  
2 later it's not met, or it changes and it is met  
3 because of the supports and services that are put  
4 into place, and so it does change over time.

5 So part of what happens with the  
6 personal outcome measures now is that in these  
7 individual organizations that we've talked about,  
8 and in some states who have it as part of their  
9 quality measurement system, they're looking at  
10 whether or not people have outcomes and supports  
11 in place, and then what are the things that need  
12 to happen in order to increase the likelihood  
13 that those outcomes and supports will be put in  
14 place?

15 So people are using them. So we use  
16 them in planning with people, and then we also  
17 then are able to evaluate the effectiveness of  
18 services and supports based on the measurement of  
19 the outcome.

20 CHAIR PINCUS: Other comments or  
21 questions? Lisa?

22 DR. PATTON: Yeah, I was just going to

1 mention that as of April of this year, SAMHSA  
2 began collecting data around the WHOQOL-8, so the  
3 quality of life, eight questions on home, health,  
4 community, and purpose, and so it gets its  
5 satisfaction with -

6 CHAIR PINCUS: Could you get a little  
7 bit closer to the mic?

8 DR. PATTON: Oh, I'm sorry. We're  
9 using the WHOQOL-8 with our grantees at SAMHSA.  
10 We just started the data collection. We piloted  
11 that instrument a couple of years ago, and it  
12 gets at home, health, community and purpose in an  
13 individual's life.

14 And it's eight questions asking about  
15 satisfaction with broad healthcare management,  
16 relationship satisfaction, housing, role in the  
17 community, those kinds of factors, and it can be  
18 administered repeatedly, so we'll have data on  
19 that within a year or so, but just commenting we  
20 are using that.

21 CHAIR PINCUS: Helen?

22 DR. BURSTIN: Since this is -

1 obviously there's a fair amount of work from  
2 where you are now to this being a performance  
3 measure, and we recognize that, and I think  
4 really the purpose of these discussions when  
5 there isn't really a vote is I think to get a  
6 read, my sense, for this group, correct me if I'm  
7 wrong, Karen, of your interest in seeing a  
8 measure like this around quality of life.

9           Again, it's a very different domain  
10 than we've talked about before, coming forward as  
11 being something that would be helpful for the  
12 Medicaid population, so I wouldn't get too  
13 fixated on the specifics here.

14           I mean, whether that becomes a process  
15 measure or an outcome measure, however you need  
16 help with that, we're happy to help along the  
17 path, but, you know, the key question is would  
18 this concept, would this overall idea of  
19 something around quality of life be something  
20 important for Medicaid to consider in the future  
21 since this is a future consideration?

22           CHAIR PINCUS: Diane?

1                   MEMBER CALMUS: I think I like the  
2                   idea of this sort of measure item, but my  
3                   concerns would be the same as I expressed with  
4                   the last one that we discussed in making sure  
5                   that this was something that was clear and  
6                   actionable moving forward.

7                   You know, I haven't seen all of the  
8                   questions that are asked, but I think making it  
9                   something that really could be utilized by the  
10                  agency to make improvement would be, I think,  
11                  pretty welcome, and I like the kind of open-ended  
12                  idea of what you view as quality of life as being  
13                  a part of it.

14                 I think that's really important,  
15                 particularly with that community, but just to  
16                 make sure that it's something that provides  
17                 something useful to the Medicaid, and something  
18                 that would be actionable so that we're not just  
19                 asking them to spend a lot of money to collect  
20                 data that they don't view as actionable. That is  
21                 my concern.

22                 MS. YADAMEC: So in South Dakota, for

1 example, CQL and South Dakota have held a long-  
2 standing relationship in terms of the use of the  
3 personal outcome measures and our accreditation  
4 processes as well.

5 But one of the things that we would  
6 say over time is that when we first began working  
7 with South Dakota many years ago, there were many  
8 people who were in sheltered workshops who  
9 attended segregated day programs, lived in group  
10 homes, and now we're seeing much more, based on  
11 the use of the personal outcome measures, a  
12 change in how people live their lives, and that  
13 their quality of life is different, that they're  
14 not necessarily in congregate settings all the  
15 time.

16 So I think there are - we can show you  
17 that path and how that's happened over time, and  
18 how, for example, that state has used the  
19 personal outcome measures to change peoples'  
20 lives and change their systems.

21 CHAIR PINCUS: Deborah, did you -  
22 Roanne?

1                   MEMBER OSBORNE-GASKIN: So I think  
2                   this is, you know, something that definitely has  
3                   to be considered because I find that, you know,  
4                   kind of looking a little bit at how quality is  
5                   kind of developed, you know, there is a lot of  
6                   focus on making sure that we have certain, you  
7                   know, checked boxes.

8                   And so this kind of broadens the view  
9                   of not just, "Okay, we're going to try to hit  
10                  these targets because this is part of our  
11                  quality, what we have to do," but just broadening  
12                  it out to the patients' experience, but going  
13                  back to that point.

14                  So it may actually help to redirect  
15                  our focus on quality, especially for patients or  
16                  persons with disabilities, but then, you know,  
17                  kind of what is at the end of that, so, you know,  
18                  how would we use that to, you know, look at or  
19                  improve quality for persons with disability in a  
20                  real way? So, I mean, I like the idea, I just,  
21                  you know, just wanted to add that.

22                  MS. YADAMEC: So again, thinking

1 about, you know, some of the things that have  
2 happened in the state of Tennessee for example,  
3 they have embraced the personal outcome measures  
4 and they use that as a way to evaluate provider  
5 performance, but also to look at their state  
6 systems.

7 And so, you know, around the whole  
8 issue of, "Are people really living in the  
9 community?" which is, you know, a major emphasis  
10 in the change in the HCBS waiver rules is, you  
11 know, are people really living in the community  
12 and what's that person's experience?

13 And so they use the personal outcome  
14 measures as a tool to help look at what are those  
15 other supports or services that need to be put  
16 into place in order for people to have outcomes?  
17 Does that answer that?

18 CHAIR PINCUS: Other comments or  
19 questions? I guess just from my perspective, I  
20 think this could be an extraordinarily useful  
21 clinical instrument to use in the context of  
22 providing clinical services.

1 I still have a problem sort of  
2 understanding how this could be converted to a  
3 performance measure, and some of the challenges I  
4 would imagine is, you know, thinking about how  
5 one would look at this in terms of change over  
6 time?

7 How would we deal with risk  
8 adjustment, you know, as an outcome measure? And  
9 also, how would one sort of, you know, deal with  
10 sort of the breadth and complexity across 21  
11 areas? You know, so those would be, I think, the  
12 challenges in converting this to a performance  
13 measure. Other comments, questions?

14 MS. YADAMEC: I think we have other  
15 partners. We're working with some of the MCOs in  
16 North Carolina. We're working with New York  
17 around some of those very same issues, and I  
18 think that will be helpful in helping to map this  
19 out for everyone.

20 CHAIR PINCUS: Well, thank you. This  
21 has been, you know, very helpful.

22 MEMBER ROSS: Thank you all. Thank

1       you, Cathy.

2                   CHAIR PINCUS:   So we have voted, so,  
3       and we've voted, I think, for one measure to be  
4       included conditionally, and one measure to be -  
5       well, actually, for both measures to be  
6       conditionally recommended, and provided input to  
7       the personal outcome measures for further  
8       development.   So are there any other measures  
9       that task force members would like to propose for  
10      consideration in terms of recommending to be  
11      supported?

12                  MEMBER SCHLAIFER:   We're also  
13      discussing asthma, the asthma measure tomorrow  
14      with the - okay.

15                  CHAIR PINCUS:   Right, yeah, the ones  
16      that go along with - potentially apply to kids as  
17      well, we're going to consider tomorrow, but are  
18      there any other, you know, adult measures that  
19      people feel would warrant consideration for  
20      voting with regard to adults?

21                  So we have two measures.   Do we need  
22      to prioritize them?

1 MS. GORHAM: So yeah, what I would  
2 say, just as a matter of process so we won't  
3 duplicate efforts, if we wait until - as you  
4 know, and I'll just reiterate for the new members  
5 of the table, so we like to first vote, recommend  
6 the measures to CMS, but we also like to  
7 recommend just a ranking of the measures so we  
8 know that resources are tight.

9 And when we place recommendations to  
10 CMS, we like to rank them in order one, two,  
11 three, however many measures we have in order of  
12 importance, and so I think what we will do is we  
13 have two measures that we have voted on thus far.

14 We are also talking about asthma and  
15 MIH tomorrow, in which we will continue to vote  
16 on measures that would apply to the core set, so  
17 I think we will actually rank after we've voted  
18 on all of the measures. That will one, kind of  
19 save us time, and then also just be more  
20 efficient.

21 CHAIR PINCUS: So now we have the  
22 opportunity for public comment. Can we open the

1 lines for public comment?

2 OPERATOR: In order to ask a public  
3 comment, please press star, then the number one.  
4 Again, that's star, one. At this time, there are  
5 no public comments.

6 CHAIR PINCUS: Could we hold it open  
7 a little bit longer?

8 OPERATOR: Yes.

9 CHAIR PINCUS: Okay, thank you. So we  
10 have an opportunity for a break. Can we take a  
11 10-minute break and reconvene at five of? Okay.

12 (Whereupon, the above-entitled matter  
13 went off the record at 2:45 p.m. and resumed at  
14 3:12 p.m.)

15 CHAIR PINCUS: I guess the last part  
16 of today's meeting, in which we are going to be  
17 going over the priorities that we put forward to  
18 CMS for the further development of measures for  
19 the core set.

20 And what's been done is that we have  
21 a long list of domains. Actually it's sort of a  
22 mixture of domains and categories and -- that

1 varies, as Helen said, in altitude, or levels of  
2 abstraction.

3 And what we want people to do is to go  
4 through an exercise that we're going to put the  
5 little dots on these things so people can express  
6 their views about what should be the largest  
7 priorities, and also to think about how we can  
8 consolidate some of these categories, to make it  
9 more clear and give better direction to CMS.

10 And so -- but first we wanted Helen to  
11 sort of go through what NQF is about in terms of  
12 criteria for prioritization.

13 DR. BURSTIN: So we just thought it'd  
14 be helpful for those of you who were at our  
15 annual meeting. We just put this forward  
16 actually as part of our annual meeting in April.  
17 So these are a set of criteria that we are  
18 putting forward as a way for us to use across all  
19 of our efforts.

20 We think this sort of crosses domains,  
21 crosses settings, types of programs, just a way  
22 for us all to wrap our head around, what do we

1 want in terms of the future of measurement. What  
2 kinds of measures we want.

3 We thought it might just be helpful to  
4 put these up here for you, just so you know the  
5 exercise we went through as we looked at all of  
6 the prioritization criteria used nationally and  
7 internationally -- about 25 different sets of  
8 criteria -- and distill them down initially to  
9 about a dozen that seemed to come up most often.

10 And then through feedback from groups  
11 like yours and others, we whittled it down to  
12 these four. And we think these are helpful ways  
13 to think about everything we've heard about where  
14 we think healthcare is going, where we think  
15 measurement should go, as the tool with which to  
16 really accomplish some transformation.

17 So the first is, not surprisingly,  
18 outcome focus. It doesn't just say outcomes. It  
19 says outcome focus. We very much have a  
20 preference for outcome measures, and measures  
21 that may not be outcome measures, that have a  
22 strong link to improved outcomes and quality.

1                   So sometimes -- and perhaps the best  
2                   example would be the discussion we had this  
3                   morning about the measure that assessed, did you  
4                   do an A1C, as opposed to, what's the actual  
5                   performance on the A1C.

6                   Did you do the A1C, is pretty far away  
7                   from the actual outcome of glycemic control, as  
8                   an example.

9                   The second one is one that comes up a  
10                  lot, and the interest in the other comments we've  
11                  just had for much of this afternoon, all come  
12                  back to this question of, would this measure  
13                  provide actionable and improvable information?

14                 So no, another lens through which to  
15                 look at it. If you had measures that would --  
16                 for which there's a demonstrated need for  
17                 improvement -- and there's actually some  
18                 evidence-based strategies for which to do so. Or  
19                 at least the data would be useful in a way that,  
20                 if you had this information in hand, you could  
21                 drive improvement.

22                 The third one is that the results --

1 not just the measure itself, but the results --  
2 would actually be meaningful to patients and  
3 caregivers, if they got the results back to them,  
4 and understandable as a third one.

5 And then finally, and not  
6 surprisingly, given a lot of the discussions  
7 we've had today, a measure that would support  
8 more of a systemic or integrated view of care.  
9 So rather than measures that are always so  
10 focused in on a single setting of care or a  
11 single provider of care, really more measures  
12 that reflect care that spans settings, providers,  
13 and time, so you can get more of a holistic view  
14 of care for patients.

15 So we think these four criteria might  
16 be useful, as you begin putting your dots up, to  
17 think about if this is the future for Medicaid.  
18 And broadly, what kinds of measures would help  
19 drive towards that?

20 Was that helpful Karen? Anything you  
21 want to add?

22 DR. MATSUOKA: No. I love these

1 criteria.

2 DR. BURSTIN: Good. Very good.  
3 Questions? Thoughts? Helpful? Whatever you've  
4 got. Okay. You get to stand up.

5 CHAIR PINCUS: So do people have any  
6 other thoughts about how they might think about  
7 prioritizing criteria that are not sort of on  
8 this list? If they just get a sense of what  
9 people would feel to be particularly important  
10 from their point of view, that's not quite  
11 captured here? Deborah?

12 MEMBER KILSTEIN: There is an issue  
13 that I don't see addressed, unless I'm just  
14 missing it, that I would like to see on the list,  
15 and that's identifying the impact of social  
16 determinants of health. I don't see that --  
17 anything about screening for social determinants  
18 of health, or -- I just don't see any of those in  
19 terms of the gaps -- identified as a gap.

20 CHAIR PINCUS: Well are you talking  
21 about in terms of this list of gaps, or are you  
22 talking about the prioritization criteria?

1                   MEMBER KILSTEIN: Oh I'm sorry.  
2       You're just talking about the criteria, and not  
3       the -- never mind. Sorry.

4                   CHAIR PINCUS: Yes. I mean, yes, I  
5       mean we can come back to that actually. I mean  
6       we probably have another category that people can  
7       write in. Okay?

8                   MEMBER KILSTEIN: Okay, very good.  
9       Let's put a blank there.

10                  CHAIR PINCUS: Yes, maybe put a blank  
11       piece of paper up.

12                  (Off mic comment.)

13                  CHAIR PINCUS: And you could use one  
14       of your dots for something you might write in.  
15       But in terms of prioritization criteria, one  
16       thing that is missing here, at least it seems to  
17       me, are things specific to the Medicaid program.  
18       Because it seems that's -- because we are --

19                  MEMBER KILSTEIN: Well that's the kind  
20       of spread.

21                  CHAIR PINCUS: Yes, in the service of  
22       that. So I think that that -- so that one should

1 think about, in addition to these four  
2 prioritization criteria, to add the criteria that  
3 there's special relevance to the Medicaid  
4 population. Anything else Karen, that you think  
5 that we should -- to elaborate on that point?

6 DR. MATSUOKA: No. No, I think it's  
7 a well-taken point. I kind of assumed that it  
8 was -- to your point, that it sort of, these are  
9 the prioritization criteria that we would use in  
10 the context of thinking about Medicaid measures.  
11 But it deserves to be said and made explicit, I  
12 think.

13 Only other thing I'll just add, and  
14 maybe it gets to some of the conversation we had  
15 this morning about patient reporting outcome  
16 measures, is things that are -- and we're finding  
17 this through our work with the QRS as well -- the  
18 Medicaid managed care QRS.

19 It really depends on who you're  
20 asking, what the value of the measure is. And so  
21 there are things that are very meaningful from  
22 the point of view of patients and caregivers,

1       that may not always map to what a clinical  
2       provider might think is important.

3               I think most of the time they do  
4       overlap. But it's just -- I think that a  
5       different dimension to also keep in mind, that  
6       they're not always the same. So the meaningful  
7       to patients and caregivers may not always  
8       necessarily be the same things that are important  
9       for clinical quality improvement. So --

10              CHAIR PINCUS: And I think also, to  
11       some degree in doing this prioritization, we're  
12       kind of -- I don't know if explicitly or  
13       implicitly -- saying that we want to be a bit  
14       more on the aspirational side than on the  
15       practicality and feasibility side. Clarke?

16              MEMBER ROSS: So one partial response  
17       to Karen, in the CMS home community-based service  
18       experience survey and the two other measures,  
19       there's an area of proxy responses by family  
20       members. Because the res- -- I have a 26-year-  
21       old son with co-occurring developmental  
22       disabilities.

1                   His view on life, his life, and my  
2                   view on his life, differ in some ways. It's an  
3                   important cord know what his preferences are, but  
4                   he depends on his family. So it's important to  
5                   know what my preferences are, but not mix them.

6                   So segmenting the different kinds of  
7                   audiences is a solution that technically can be  
8                   easily done, and is done in these other  
9                   approaches that I talked about. And it's  
10                  important to know the different segments, and  
11                  what their predominant views are.

12                 CHAIR PINCUS: So why don't we go  
13                  around and distribute your dots. Five dots.  
14                  Five dots.

15                 MS. GORHAM: Your colors don't mean  
16                  anything?

17                 CHAIR PINCUS: Yes. Colors don't  
18                  mean --

19                 MS. GORHAM: You can put your dots  
20                  anywhere? You can put all five in one --

21                 CHAIR PINCUS: Yes.

22                 MS. GORHAM: -- spot? Or you can

1 mix -- also put a blank sheet on the wall, so if  
2 you want to write in a gap area, you can do that,  
3 so we have one list here --

4 CHAIR PINCUS: But if you write in,  
5 you got to use a dot.

6 MS. GORHAM: You have to use a dot if  
7 you write it in? There's a -- to your left there  
8 is a --

9 CHAIR PINCUS: It's in the threshold.

10 MS. GORHAM: -- partial list. Behind  
11 me there's another list. And then to my right  
12 there's a list. Go for it.

13 DR. MATSUOKA: Maybe you should -- we  
14 have people who have write-ins, write in first,  
15 so that other people can vote on it too?

16 MS. GORHAM: That's a good idea.

17 (Off mic comment.)

18 CHAIR PINCUS: Mm hmm.

19 PARTICIPANT: Oh we'll give you a dot.

20 CHAIR PINCUS: Okay.

21 (Pause.)

22 CHAIR PINCUS: Okay. The outcome of

1       this prioritization project -- process -- seems  
2       to be the ones that are -- number one, it  
3       suggests that there's some potential areas for  
4       consolidation.

5               That, for example, there's a number of  
6       parts where behavioral health is sort of saying  
7       the same thing, said in different ways. So  
8       there's behavioral health and integration with  
9       primary care, and then there's a care  
10      coordination that's -- with specifics around  
11      integration, medical and psychosocial services.

12             And there's also a section talking  
13      about treatment outcomes through behavioral  
14      health. So in some ways, the kind of larger  
15      categorization of behavioral health in terms of  
16      both integration coordination and outcomes, seems  
17      like a major area.

18             Number two, again in looking at areas  
19      that received a lot of dots, is the assessment of  
20      social determinants of health. I would make a  
21      friendly amendment to that. I think assessment  
22      and -- what was the term I used? Assessing and

1       addressing.

2               Because assessment may not go far  
3       enough, social determinants of health being sort  
4       of a second sort of high priority area.

5               A third high-priority area is, looking  
6       the five dots, long-term supports and services.  
7       Then the other ones that come up with multiple  
8       ones is maternal and reproductive health, with  
9       some subsets of categories there in terms of  
10      maternal reproductive health, new chronic opioid  
11      use, efficiency, and I would say sort of  
12      beneficiary reported outcomes.

13              And then, sort of somewhat lower down,  
14      were -- was workforce and polypharmacy. And that  
15      some items did not get any dots, which were  
16      cultural competency, trauma-informed care, and  
17      engagement in activation in healthcare.

18              So do people feel this an adequate  
19      representation of the priorities? Are there any  
20      items -- okay, are there any items that people  
21      think didn't get the right amount of votes you  
22      feel strongly about, that were left off? And any

1 other further ideas also for sort of other  
2 categories that were left off. So Sue?

3 MEMBER KENDIG: Two. First, on the  
4 behavioral health front. There were a lot of us  
5 for behavioral health and integration with  
6 primary care, which I feel is important whenever  
7 they were looking at treatment outcomes.

8 But I would also invite us to consider  
9 that, particularly those patients with complex  
10 behavioral health needs when they are  
11 hospitalized.

12 Integration with medical services in  
13 the acute care setting is equally as important,  
14 because that could potentially affect the  
15 treatment outcomes portion over there, and I  
16 would suggest that's across all populations.

17 CHAIR PINCUS: I would say I think --  
18 we think it's sort of the larger category of sort  
19 of behavioral health. And then sort of subset it  
20 in terms of, in particular, with primary care and  
21 other general medical services, including  
22 inpatient, and all seven incorporating sort of

1 outcomes-related or outcomes focused.

2 MEMBER KENDIG: Yes. I wanted to  
3 assure that we were really thinking about that  
4 across the continuum of care.

5 CHAIR PINCUS: Mm hmm.

6 MEMBER KENDIG: Because so many times  
7 it does hit that primary care piece, and then  
8 it's like, well this is happening elsewhere.

9 And then regarding the maternal and  
10 reproductive health piece, I just wanted to point  
11 out the inter-conception care piece and the poor-  
12 birth-outcomes piece. Really is a nice segue to  
13 well woman care.

14 And so I think as we are framing that  
15 as a priority area, that is really the transition  
16 to well woman care as well, because during that  
17 inter-pregnancy component, which quite honestly  
18 can be 30 years, it's really important that we  
19 are focusing on things that help to keep women  
20 healthy.

21 CHAIR PINCUS: Roanne?

22 MEMBER OSBORNE-GASKIN: So I just

1 wanted to just put two things. The workforce  
2 question, and the efficiency question. There's  
3 been a lot of talk in the primary care provider  
4 community about physician burnout, and so that,  
5 and the way to use efficiency in practice to  
6 reduce that.

7           So we know that we're going to have a  
8 workforce shortage for primary care in the  
9 upcoming years. And so I just kind of wanted to  
10 highlight that, and that's why I kind of put  
11 those to the fact that we do have a shortage.

12           We have people who are burning  
13 out -- of primary care physicians who are burning  
14 out. How to address that. And I'm not sure -- I  
15 kind of looked at it from the point of view of  
16 meaningful to patients and caregivers I guess,  
17 because we're just finding primary care having  
18 less and less time to spend with patients.

19           So just kind of, how would be -- I  
20 don't know how that would translate into, say, a  
21 measure, but just kind of looking at that.  
22 That's why I just wanted to focus on that a

1       little bit.

2                   CHAIR PINCUS:   Okay.   Diane?

3                   MEMBER CALMUS:   And I may have  
4       misplaced my dot on this button, but one of the  
5       issues that is really coming up a lot in rural  
6       America -- and I don't know if it's kind of  
7       spreading out into any other areas -- is there's  
8       a huge difficulty, especially for the Medicaid  
9       population, for access to OB care.

10                   So somewhere to deliver a baby.   And  
11       there are rural areas where you may have to  
12       travel three hours in order to get someplace to  
13       deliver a baby.   And frankly, it's a problem  
14       that's getting worse, and has been getting worse  
15       kind of under the radar.

16                   And unfortunately, we're starting --  
17       or fortunately, we're now starting to get some  
18       research on this.   But there's not a whole lot of  
19       research on where these women are having their  
20       babies.   We know that rural women haven't stopped  
21       reproducing.

22                   But what we don't know is where

1       they're having their babies, and kind of what  
2       those outcomes are. So I know in rural areas  
3       that's a huge concern. And so I don't -- and I  
4       know a lot of the larger hospitals also complain  
5       about Medicaid payment rates for births, and  
6       there are populations where there are larger  
7       percentages of the births that are Medicaid-  
8       supported.

9               It's the majority in rural America.  
10       It's in the 60 percentile range that are paid for  
11       by Medicaid. So I think that's a huge issue that  
12       I would throw out there that's specific to the  
13       rural population, but I'm sure is also something  
14       being experienced elsewhere too.

15              CHAIR PINCUS: Other comments? Sue,  
16       you had another comment?

17              MEMBER KENDIG: Yes. I'm just  
18       thinking on -- about building on what Diane said,  
19       because in my head I'm going to the sort of --

20              CHAIR PINCUS: Oh, put your mike on.  
21       Okay.

22              MEMBER KENDIG: Yes. I'm just not

1        talking into it. Sorry. Yes, building on what  
2        Diane said, I think that goes in also to the  
3        birth outcomes piece -- delivery at an  
4        appropriate facility access to prenatal care, all  
5        of those things that would be particularly  
6        salient to our rural populations, in a different  
7        way.

8                    CHAIR PINCUS: If you feel you might  
9        have been sort of left out, or not supported  
10       sufficiently, or that would be an expansion of  
11       the comments here -- of the categories I mean.  
12       Debbie?

13                   MEMBER KILSTEIN: Something that was  
14       on the slide that I didn't see up there, which  
15       was postpartum complications, and maternal  
16       outcomes.

17                   CHAIR PINCUS: Okay. That would go  
18       within the sort of maternal reproductive area.  
19       So just -- I'm trying to sort of summarize, but  
20       it seems to me if I was trying to sort of  
21       categorize them in terms of -- it sort of falls  
22       into, now we've narrowed it down to I think

1 pretty much eight categories that got sufficient,  
2 so with -- for the in order for behavioral  
3 health, and both in terms of integration and  
4 outcomes, and integration across the range of  
5 services and care.

6 Number two, assessment, and assessing  
7 and addressing social determinants of health.

8 Number three, long-term services and  
9 supports, and home and community-based services.

10 Number four, maternal and reproductive  
11 health, and well woman health, with multiple  
12 categories within that.

13 Number five seemed to be efficiency.

14 Number six was new chronic opioid use.

15 And then workforce, including  
16 physician burnout.

17 And then eight is sort of  
18 polypharmacy. In turn, if I was to look at the  
19 voting, that's where things seemed to turn out.

20 Does that all seem to make sense --  
21 ring true -- to fit in with people's views? I  
22 think it also pulls them together in a way where

1       it's more similar categories. So what do we do  
2       next?

3               PARTICIPANT: Invite comments --

4               PARTICIPANT: Staff. Yes.

5               CHAIR PINCUS: Okay. Any public  
6       comments that -- could we open up the line for  
7       public comments with regard to discussion of  
8       priorities?

9               OPERATOR: At this time if you'd like  
10      to make a public comment, please press star, then  
11      the number one, on your telephone keypad. We'll  
12      pause for just a moment.

13              And you do have a public comment from  
14      Junqing Liu, from NCQA.

15              DR. LIU: Hi. This is Junqing Liu.  
16      Could folks hear me?

17              CHAIR PINCUS: Yes we can.

18              DR. LIU: Thanks. I'd like to make a  
19      comment about recommending a measure for the  
20      Medicaid adult core set. That's the depression  
21      remission at six months measure, that's NQF-  
22      endorsed. The NQF number is 0711. That's a

1 Minnesota community measurement measure.

2 I heard the discussion about  
3 behavioral health is one priority for the  
4 Medicaid population. There's a need for patient-  
5 reported outcome measure. So I would like to  
6 recommend the task force to consider the  
7 depression remission at six-month measure.

8 So this measure is also now in a HEDIS  
9 Health Plan measure set for health plan  
10 reporting. The performance has shown that the  
11 gap for improvement, there's also evidence-based  
12 collaborative care model, to improve depression  
13 outcomes.

14 I'm sure depression is especially  
15 relevant for the Medicaid population. This  
16 measure, in my mind, meets all the prioritization  
17 criteria that Helen just mentioned. So I'd like  
18 to recommend this measure for consideration for  
19 the core set.

20 CHAIR PINCUS: Yes. We had some  
21 discussion about this earlier, although it wasn't  
22 specifically brought up as a consideration. But

1       there was, I think, an important focus on  
2       thinking about going beyond the screening, to  
3       actually look at sort of the implementation of  
4       coordinated care models.

5               DR. PATTON:   Yes.   And Harold, I was  
6       just going to say, when we had that original  
7       discussion this morning, that was the one I  
8       raised as a potential add to the set.   So --

9               OPERATOR:   And there are no further  
10       comments at this time.

11              CHAIR PINCUS:   Are there other public  
12       comments.

13              OPERATOR:   There are no further  
14       comments at this time.

15              CHAIR PINCUS:   Okay.   So with regard  
16       to the last public comment, does anybody want to  
17       formally make a motion to consider adding the --

18              DR. BURSTIN:   0711.

19              CHAIR PINCUS:   -- 0711?

20              DR. BURSTIN:   Mm hmm.

21              CHAIR PINCUS:   Depression remission at  
22       six months?

1 MS. MUKHERJEE: Is 0711 depression  
2 remission at six months? And the measure -- oh  
3 I'm sorry.

4 DR. BURSTIN: Maybe Miranda could pull  
5 it up on QPS and just display it, see if  
6 everybody could see it. Is it one we mentioned  
7 this morning, so it requires the collection of  
8 the PHQ-9, which, back to your point this  
9 morning, is the standardized tool.

10 And then it looks at two points in  
11 time, to see whether there has been a 50 percent  
12 improvement in the score or remission. I think  
13 the one they're suggesting is the 50 percent --  
14 is the remission of the -- were they suggesting -  
15 -- what is the one --

16 CHAIR PINCUS: Yes. Well there's --

17 DR. BURSTIN: -- or the other one?

18 CHAIR PINCUS: Junqing you -- I think  
19 you mentioned remission. Is there a reason why  
20 you specifically mentioned remission? Because  
21 some people have raised questions about it being  
22 remission or clinically significant improvement.

1 DR. LIU: Yes, I'm recommending the  
2 remission that's measured as the PHQ-9 score  
3 less than five. So what Harold mentioned is  
4 another measure that's a valid response. That's  
5 a 50 percent --

6 CHAIR PINCUS: Right.

7 DR. LIU: -- reduction. That's 0710.  
8 That's a different measure. So I'm recommending  
9 the remission measure, because I think that's the  
10 ultimate outcome measure that will be very  
11 important for this population, for us to strive  
12 for that.

13 CHAIR PINCUS: Yes. Although I do  
14 know that people at the last MAP meeting, there  
15 was concern expressed that that might drive --  
16 that may not be sufficiently responsive to the  
17 patient perceptions and desires, because it  
18 might -- some people might be happy going from a  
19 score of 23, to a score of seven, and it would  
20 push clinicians to sort of add additional  
21 medications that might not be ideal, to get them  
22 below remission.

1                   So the thought was that there are  
2                   advantages for it to be clinically significant  
3                   improvement, or remission.

4                   So does anybody want to make a motion  
5                   to add this to -- for us to consider and vote on  
6                   recommending this to CMS?

7                   CHAIR PINCUS:   So nobody seems to be  
8                   jumping at it.   Rachel?

9                   MEMBER LA CROIX:   I have to admit I'm  
10                  not overly familiar with this measure.   But if  
11                  you're only looking at folks who have the  
12                  diagnosis -- which you could get through  
13                  claims -- but you're also looking at whether they  
14                  had a PHQ-9, would you need to do some kind of  
15                  medical record review, or at least electronic  
16                  health record review, to establish even your  
17                  denominator for the measure?

18                  PARTICIPANT: Just have to have a  
19                  diagnosis --

20                  MEMBER LA CROIX:   and --

21                  CHAIR PINCUS:   And you have to have an  
22                  initial indexed PHQ-9 score.

1 MEMBER LA CROIX: -- a PHQ-9 score.

2 DR. BURSTIN: Right right. I'm just  
3 saying, it has to be greater than those.

4 MEMBER LA CROIX: Yes.

5 CHAIR PINCUS: Yes. I --

6 DR. LIU: Yes. It was a required  
7 information from medical record, or electronic  
8 health record, because it requires you have a  
9 depression diagnosis, and an elevated PHQ-9 score  
10 for the denominator.

11 Then you look out for six months, to  
12 see if you achieve remission, meaning that your  
13 second PHQ-9 score is less than five. So that --  
14 we recognize that's one of the challenge for  
15 outcome measures.

16 Oftentimes you need to have two data  
17 points, and you need the medical record data.  
18 But we have talked to states and the plans, and  
19 NCQA has implemented a remission measure at six  
20 months, and HEDIS for two years.

21 We actually also convened in a  
22 depression learning collaborative with plans and

1 providers who could use electronic health records  
2 registry, and the health plan case management  
3 data systems, to get information for the measure,  
4 so that they could leverage the health IT to  
5 report a measure efficiently.

6 So we received feedback that this is  
7 very important, and places are building the  
8 systems to report a measure using the electronic  
9 health records. It is recommended as a measure  
10 in HEDIS for using electronic data systems.

11 CHAIR PINCUS: Roanne?

12 MEMBER OSBORNE-GASKIN: So I guess my  
13 only issue with this type of measure would be the  
14 remission. So we're kind of moving depression  
15 from being a chronic disease. I think that's  
16 kind of how it will figure -- that's kind of how  
17 I'm seeing it from a clinician's perspective.

18 Because remission means that -- I  
19 don't want to say will give us a false sense of  
20 security, but so what do we -- we kind of, if  
21 somebody's been diagnosed with depression, we  
22 tend to leave that diagnosis there, just to kind

1 of keep us aware that even if they have  
2 improvement in symptoms, whether or not that is  
3 demonstrated by a reduction in the PHQ-9, that  
4 this person still may be at risk.

5 And so remission is kind of a term  
6 that the medical community may just have issues  
7 with dealing with a chronic disease. We don't  
8 necessarily talk about remission with, like say  
9 diabetes or heart failure, or something like  
10 that.

11 So that's kind of my only sort of --  
12 I would prefer if we were going to have a  
13 measure, it would demonstrate some sort of  
14 reduction as an improvement in symptoms, but not  
15 necessarily remission of depression.

16 CHAIR PINCUS: Other comments. I  
17 think one of the issues, if -- my concern is that  
18 this may be a bridge too far as -- in terms of a  
19 state Medicaid program, in terms of being able to  
20 collect this data.

21 It may be something that could be  
22 aspirational as we move forward. And remember

1       that the Minnesota Community Measurement really  
2       put this together as kind of a basket of measures  
3       that included process -- both structural  
4       measures -- in terms of the capacity to collect  
5       this information -- as well as process measures,  
6       showing -- which -- I can't remember off the top  
7       of my head which NQF-endorsed measure it is.

8               But there's -- whether or not the --  
9       but there's, number one is the short-term measure  
10      of having essentially a registry that allows you  
11      to collect this information.

12             Number two, a process measure  
13      indicating that there's the actual collection of  
14      data -- PHQ-9 data -- at 6 and 12 months.

15             And number three, outcomes, which  
16      include both -- Roanne -- both clinically  
17      significant improvement, which is basically 50  
18      percent improvement in 6 or 12 months, or this  
19      measure of remission at 6 or 12 months.

20             So that's something that I think would  
21      be aspirational for states to develop that  
22      capacity. I think right now, it's -- I think few

1 states are there yet.

2 DR. BURSTIN: It's going to be worth  
3 further discussion with Jeff Schiff in Minnesota,  
4 to understand. I believe they are collecting it  
5 for the sake of being part of Minnesota. So it  
6 might be an interesting discussion --

7 CHAIR PINCUS: Yes, to see how they're  
8 doing it.

9 DR. BURSTIN: -- to find out where  
10 they are so far.

11 CHAIR PINCUS: Yes, so I think that's  
12 something that we may want to explore going  
13 forward, in terms of getting more information  
14 about what is the capacity of states to collect  
15 this kind of information and apply it. And it  
16 may be worth talking to people in Minnesota.

17 And I would also add probably in  
18 Washington State also. I know there's a number  
19 of Washington State programs that have been using  
20 this as well.

21 DR. BURSTIN: And it's now a part of  
22 the ACO program. So just -- this has now been

1 put into federal programs. It is now part of the  
2 ACO MSSP program. So there is now some federal  
3 experience as well with using it.

4 Again, more at a system level, and the  
5 question of how that then becomes the state level  
6 measure is an interesting one further to explore.  
7 But it sounds like there's interest overall in  
8 this concept of patient-reported outcomes. I  
9 think the question is, more so, how to make that  
10 happen at this level of analysis. Thank you for  
11 the suggestion.

12 DR. LIU: Sure. Thanks for the  
13 consideration.

14 CHAIR PINCUS: Okay. Next.

15 Okay, so we've now, we've elucidated,  
16 reorganized and prioritized the gaps. Now the  
17 question is, do people feel that any of the gaps  
18 that we've identified have been satisfied.  
19 Obviously not, because we just identified the  
20 gaps. So --

21 Number two, what do we think in terms  
22 of, are there particular areas that -- where

1       there's particularly promising opportunities  
2       going forward for filling those gaps?

3               MEMBER LA CROIX: For the HCBS -- the  
4       long-term services and supports measures -- I  
5       know federal CMS has been working with  
6       Mathematica, and put out some measures for public  
7       comment in August 2016. So I assume those are  
8       coming at some point in the near future.

9               CHAIR PINCUS: Marsha, is that  
10      something that's come out of your --

11              DR. SMITH: Pardon?

12              CHAIR PINCUS: That sound like that's  
13      to come out of your shop? Or your shop, Karen?

14              DR. MATSUOKA: It's a combination  
15      of -- there's actually a lot of great work  
16      happening in this space because I think there's  
17      been a longstanding recognition of just having no  
18      good measures really, for some of this stuff.

19              So it's coming out of both IAP -- the  
20      Innovation Accelerator Program -- as well as  
21      the -- there's a little working group that's come  
22      together with the Waiver Group, the Disabled and

1 Elderly Health Programs Group, and then our  
2 division of quality, to think through an LTSS  
3 measurement as well.

4 So actually, this would be really --  
5 it would be helpful, this exercise, to start to  
6 differentiate between -- are we talking about  
7 gaps in our current core set, gaps in the  
8 availability of measures at all?

9 And then, thinking through also, what  
10 is -- if it's an aspirational gap that we want to  
11 start to think to fill, that would be good to  
12 know, because I think if we have a good critical  
13 mass of states who agree that those are key gap  
14 areas, then we can start to put some concerted  
15 effort into thinking through how to fill them.

16 So I want to differentiate between  
17 gaps for our current year-over-year core set  
18 recommendations, and then I want to welcome you  
19 all to put on the table some aspirational kinds  
20 of measures like these that we can think through,  
21 more than just, a year ahead.

22 CHAIR PINCUS: Another -- Clarke?

1                   MEMBER ROSS: The Administration on  
2                   Community Living has funded a five-university  
3                   collaborative -- it's led by the University of  
4                   Minnesota -- to look at every measure in  
5                   existence, or the published literature on home-  
6                   and community-based service measures.

7                   And so ACL and the National Institute  
8                   on Disability, Independent Living and  
9                   Rehabilitation Research, are the co-funders. And  
10                  we had a presentation at the March workgroup on  
11                  persons dually eligible on the project itself, so  
12                  there's a slide deck -- I've got a paper copy  
13                  with me -- but we could post the slide deck on  
14                  the shared PowerPoint site for this group, and  
15                  then any of you could go and see who the lead  
16                  researchers are, and contact points, and what  
17                  they're looking at, and that sort of thing.

18                 CHAIR PINCUS: Deborah?

19                 MEMBER KILSTEIN: Maybe Clarke could  
20                 talk about this a little bit too, but measures of  
21                 frailty and -- is that something that should be  
22                 addressed in the -- our core measure set?

1 CHAIR PINCUS: Say a little bit more  
2 about -- when you say measures of frailty.

3 MEMBER KILSTEIN: Well, or measures of  
4 improvement. I mean when you're talking about  
5 home- and community-based services, measures of  
6 improvement in terms of functional status.

7 MEMBER ROSS: So the World Health  
8 Organization is the lead in the world on  
9 functional outcomes in people with disabilities.  
10 And we're like decade- -- we as a country are  
11 like decades behind the World Health Organization  
12 in doing this.

13 And because it's the World Health  
14 Organization, a lot of prominent policymakers  
15 don't want to learn because it's the world, and  
16 we're the United States.

17 Gloria Krahm, who was the deputy  
18 director at CDC's National Center on Birth  
19 Defects and Developmental Disabilities, is at the  
20 University of Oregon, and she's published some  
21 work on how to measure function, and then  
22 translate it into some kind of standardized

1       quality measurement.

2                   It's infant work, and what she's  
3       trying to do is use the World Health Organization  
4       work and -- but diminish the reference, because  
5       there's just this bias against what other  
6       countries and other entities are doing.

7                   But it's a major gap in the entire  
8       disability world.

9                   CHAIR PINCUS: Other comments or  
10       thoughts about what gap areas where there may be  
11       some near-term -- Lisa, I was wondering in terms  
12       of the behavioral health area, whether you have  
13       some thoughts.

14                  DR. PATTON: Well, we are -- we're  
15       currently working on some measures around  
16       suicide, suicide prevention, and as I mentioned  
17       earlier, we are working on getting the screening  
18       of brief intervention for alcohol, and that just  
19       was recently -- well, will be moving into HEDIS.

20                  So we're very interested in the opioid  
21       measures and gaps in that area -- polypharm in  
22       particular -- and so we're very pleased to see

1 the combination of the opioid and the benzo  
2 measure put forth today.

3 So we are obviously extremely  
4 interested in outcome measures, and like most of  
5 you, a bit frustrated by where we are with those,  
6 and how we might get to a better place.

7 And also patient experience of care is  
8 another priority area for us. But most of these  
9 have been addressed today. I don't think -- yes,  
10 I was trying to think if there were any kind of  
11 outliers that we hadn't discussed today, but I  
12 think we've covered the terrain. Yes.

13 CHAIR PINCUS: Yes, I would add to  
14 that, that no, we've had a -- my group at  
15 Columbia has had a grant from the Commonwealth  
16 Fund in which we've developed a series of papers  
17 coming out around sort of behavioral health, sort  
18 of measures at the interface between behavioral  
19 health and general healthcare. That'll be coming  
20 out, and we're talking with Commonwealth about  
21 it. Sort of a follow-up in terms of implementing  
22 that in the context of value-based payment

1 models.

2 Other areas where there are people  
3 aware of potential gap areas that are -- where  
4 there's some stuff going on that might be  
5 helpful?

6 So I think we've already asked about  
7 additional gap areas, and I think we've already  
8 done a kind of a prioritization process. So I  
9 think we've pretty much filled in the issues  
10 around the gaps that we can sort of lay out more.

11 But I also realized when I made my  
12 list, I had left out beneficiary reported  
13 outcome. Yes, so that just --

14 PARTICIPANT: That was in the study.

15 CHAIR PINCUS: Okay. Ah. Okay.  
16 Good. Okay, now we have a final opportunity for  
17 public comments. No. Oh, we already did it.  
18 Okay. Oh, now we adjourn for the day.

19 Any last -- Clarke?

20 MEMBER ROSS: Just a suggestion for a  
21 crosswalk. April 2017, the MAP -- the National  
22 Quality Forum MAP -- sent its report -- annual

1 report -- to CMS, and identified six high-value  
2 measure areas that aren't adequately addressed.  
3 It might be nice to crosswalk what the MAP  
4 already sent to CMS and what we've fooled around  
5 with today, and see where the overlap and  
6 consistency are, and where the inconsistency  
7 might be.

8 CHAIR PINCUS: Great. Well I want to  
9 thank the terrific NQF staff, which is always  
10 really incredibly systematic in its approach, and  
11 really very helpful in terms of setting this on  
12 course. Tomorrow we'll be meeting with the Child  
13 Task Force, and so we'll be going over areas of  
14 mutual interest.

15 We'll be going over some stuff that  
16 we've done a little bit today, but also some new  
17 stuff tomorrow. So we look forward to seeing you  
18 all tomorrow.

19 (Whereupon the above-entitled matter  
20 went off the record at 4:04 p.m.)  
21  
22

A			
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This is to certify that the foregoing transcript

In the matter of: Measure Application Partnership  
Medicaid Adult Task Force

Before: NQF

Date: 05-23-17

Place: Washington, DC

was duly recorded and accurately transcribed under  
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Court Reporter

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