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

9:06 a.m.

MS. MUKHERJEE: Hi everybody. Welcome. My name is Debjani Mukherjee. I am the senior director for the Medicaid Adult and Child Core Set Project, and welcome to our three day meeting. Of course, the Medicaid Adult Task Force will be here today and tomorrow, and with that, I will turn it over to Harold, to say a few welcoming remarks.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

both Adult and Child Task Forces.

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

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

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

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

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

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

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

employee I have some stock in CVS Health.

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

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

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

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

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

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

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

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

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

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

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

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

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

benefits through them.

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

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

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

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

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

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

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

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

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

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

important to have that kind of background to the advice.

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

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

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

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

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

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

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

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

(Off microphone comment.)

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

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

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

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

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

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

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

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

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

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

performance or a recognized disparity.

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

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

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

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

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

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

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

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

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

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

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

recommendations.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

has any questions.

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

(No response.)

CHAIR PINCUS: Okay, Karen.

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

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

meetings.

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

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

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

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

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

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

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

matter, as well as facilitate their quality improvement efforts.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Medicaid core sets are for state

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

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

We've also been at work developing

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

CHAIR PINCUS: Questions for Karen? Clarke.

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

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

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

opposed to a domain.

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

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

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

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

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

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

big ones, and smaller family-based organizations.

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

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

CHAIR PINCUS: Marissa.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. MATSUOKA: Sure.

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

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

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

CHAIR PINCUS: Deborah.

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

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

CHAIR PINCUS: Okay.

(Off mic comments.)

CHAIR PINCUS: Okay. Deirdra.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Moving on to the next slide, so first

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

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

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

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

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

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

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

So they've identified that as an opportunity, a low cost opportunity, an existing resource that they could make better use of, to hopefully improve care. We don't know yet. Well, I'll say we don't even quite know what the best strategies for increasing enrollment are. We've spent a lot of time reaching out to the national experts at the American Diabetes Association and the American Association of Diabetes Educators and the CDC to get intel on what are the best ways of getting people enrolled in these programs.

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

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

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

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

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

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

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

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

states on quality improvement.

So one, some process measures are more useful for quality improvement than others. I already alluded to the A1c measure. Process measures that indicate solely whether a test was done or whether something was documented in a chart, while important for the care of those individuals aren't ideal measures to pin quality improvement efforts to because they don't indicate whether or not the care that will improve health was delivered.

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

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

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

(Telephonic interference)

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

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

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

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

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

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

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

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

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

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

CHAIR PINCUS: Any questions for Deirdre?

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

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

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

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

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

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

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

you have?

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

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

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

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

DR. STOCKMANN: You're doing your job.

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

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

DR. STOCKMANN: Yep.

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

CHAIR PINCUS: Helen.

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

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

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

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

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

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

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

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

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

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

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

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

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

(Off mic comments.)

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

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

CHAIR PINCUS: Rachel and then Deborah.

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

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

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

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

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

CHAIR PINCUS: Deborah.

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

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

CHAIR PINCUS: Sure.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

for you here today.

CHAIR PINCUS: Any other questions?

(No response.)

CHAIR PINCUS: So with that, Judy.

MS. ZERZAN: Excellent, good morning. So I'm going to talk a bit about Colorado and what we're up to. I'm going to start with giving some lay of the land.

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

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

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

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

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

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

demand for health care in this population, that now has gone down. Since we spent a lot of time talking about diabetes, I'll say we have fewer than 30,000 diabetics in Colorado Medicaid. So for us, diabetes not so much of an issue. Smoking, 30 percent of our adults smoke. So every state, I think, has different needs. West Virginia has a super-high rate of diabetes, but in Colorado our diabetes rate is relatively low.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Next slide, and to get credit in this

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

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

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

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

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

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

The third column is the diabetes A1c measure that has been oft-talked about today, and you can see there's a fair bit of variation even in this one, which should be a pretty easy, basic

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

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

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

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

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

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

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

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

MS. ZERZAN: In the APM model?

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

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

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

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

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

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

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

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

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

definitely a bit of a tension there, yeah.

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

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

CHAIR PINCUS: Yes.

(Off mic comment.)

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

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

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

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

CHAIR PINCUS: So Deborah, then Clarke.

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

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

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

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

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

MEMBER KILSTEIN: And the adolescents I know --

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

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

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

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

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

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

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

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

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

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

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

CHAIR PINCUS: Sue and then Roanne.

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

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

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

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

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

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

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

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

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

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

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

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

CHAIR PINCUS: Lisa.

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

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

CHAIR PINCUS: Any other questions?

(No response.)

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

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

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

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

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

the table.

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

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

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

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

are just some reasons to highlight.

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

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

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

MAP can express the condition and we

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

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

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

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

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

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

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

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

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

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

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

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

That document gives you some of the reasons why states did not report the measure. Yes. And is everyone open - are you able to open your SharePoint pages? Is that a yes?

MEMBER SCHLAIFER: Yes.

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

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

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

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

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

MS. KUWAHARA: It was distributed as

an attachment as well.

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

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

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

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

Is everyone following me, before I go

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

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

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

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

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

The specs for the measure are located

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

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

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

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

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

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

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

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

for and actually pharmacologic interventions is one of the outcomes.

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

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

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

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

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

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

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

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

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

CHAIR PINCUS: Deborah?

MEMBER KILSTEIN: Just a comment. Generally, I think that in states where there is a heavy managed care penetration, I think the further you deviate from using HEDIS, which plans are generally reporting, the more difficult it is to collect the measure because the states have to kind of develop the measure independent of what plans have to do anyway generally.

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

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

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

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

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

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

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

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

depression in here.

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

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

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

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

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

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

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

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

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

CHAIR PINCUS: It's a G code.

MEMBER OSBORNE-GASKIN: Okay.

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

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

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

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

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

the effect over time.

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

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

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

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

then what the value is.

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

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

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

MS. GORHAM: So we will move on to 0476, which is the PCO3 antenatal steroid. I just want to say that this measure is part of a set of five nationally implemented measures that address perinatal care.

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

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

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

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

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

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

CHAIR PINCUS: Rachel?

MEMBER LA CROIX: We did try to have

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

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

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

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

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

some initiatives around this.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

standpoint.

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

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

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

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

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

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

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

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

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

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

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

CHAIR PINCUS: Other comments on this measure? Okay.

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

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

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

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

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

So I'll stop there and invite discussion.

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

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

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

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

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

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

CHAIR PINCUS: They're not giving you

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

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

CHAIR PINCUS: Rachel, what's your experience?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CHAIR PINCUS: Mary Kay?

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

It's all covered in the clinic. So we

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

CHAIR PINCUS: Deborah, did you have a comment? Any other comments on this measure?

Move on to the next one.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CHAIR PINCUS: Roanne?

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

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

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

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

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

MEMBER OSBORNE-GASKIN: Okay.

CHAIR PINCUS: -- steroid thing first -

MEMBER OSBORNE-GASKIN: Okay.

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

MEMBER OSBORNE-GASKIN: Okay. Sure.

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

MEMBER LA CROIX: I would second.

MEMBER JONES: I would, too.

CHAIR PINCUS: Huh?

MEMBER LA CROIX: I'll second.

MEMBER JONES: I would give it a third then.

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

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

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

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

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

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

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

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

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

waiting on three responses. Two more responses. Okay.

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

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

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

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

MEMBER OSBORNE-GASKIN: The

antidepressant medication management --

CHAIR PINCUS: Right.

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

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

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

MEMBER OSBORNE-GASKIN: It's 0105.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

service.

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

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

MEMBER SCHLAIFER: Oh, okay. Okay.

CHAIR PINCUS: Yeah. So that's --

MEMBER SCHLAIFER: Okay. Sorry. I apologize.

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

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

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

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

CHAIR PINCUS: Newly diagnosed and treated with medication.

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

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

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

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

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

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

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

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

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

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

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

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

for consideration that might be easier to collect and report.

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

CHAIR PINCUS: Lisa, and then Sue.

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

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

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

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

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

CHAIR PINCUS: Okay. Sue?

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

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

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

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

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

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

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

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

CHAIR PINCUS: Okay.

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

CHAIR PINCUS: Yeah.

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

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

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

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

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

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

So we don't consider that an addition

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

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

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

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

CHAIR PINCUS: Okay.

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

CHAIR PINCUS: Okay.

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

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

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

and follow-up plan measure?

Okay.

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

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

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

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

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

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

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

So Deborah? And Sue, do you -- is

your thing up there for comment?

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

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

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

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

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

There are currently no public comments at this time.

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

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

And still no public comments.

CHAIR PINCUS: Okay. Okay. Okay.

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

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

way. So Clarke, Lisa, Mary Kay.

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

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

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

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

CHAIR PINCUS: Okay. Lisa?

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

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

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

inclined to try to report on it.

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

PARTICIPANT: Lunch is not here yet.

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

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

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

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

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

CHAIR PINCUS: So we can move ahead on this?

So we're continuing to go through the

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

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

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

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

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

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

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

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

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

CHAIR PINCUS: Trying to find where that would be.

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

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

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

You can then click on measure

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

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

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

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

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

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

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

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

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

We know that outcome measures are the decided preference in the quality community. Does the measure address a quality challenge? Does the measure support efficient use of resources and alignment?

Can the measure be feasibly reported? Is it a NQF-endorsed measure? If the measure is in current use, no implementations issues have been identified with that measure.

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

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

implementation at the state level.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MS. GORHAM: So recommended by task

force members.

CHAIR PINCUS: Okay.

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

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

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

The next measure, 0541, Proportion of

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

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

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

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

some feedback from CMS about why they were not accepted?

MS. GORHAM: Sure.

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

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

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

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

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

DR. MATSUOKA: So maybe I'll start off

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

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

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

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

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

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

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

CHAIR PINCUS: So can I challenge your assumption?

DR. MATSUOKA: Mm-hm.

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

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

DR. MATSUOKA: Two things to that.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

And just push back on one other comment, which is the preventive care and screening for unhealthy alcohol use. I mean, one of the problems with the initiation or the identification and engagement measures for substance use is that they are highly variable depending upon whether people are being screened.

So that if you, basically if you screen, you're likely to get a worse outcome, I mean a worse measure result, on initiation and engagement, as compared to if you don't screen. So that this is kind of, you know, both a quality measure and also balancing measure.

DR. MATSUOKA: So I'll just say that parsimony is a driving force here, and we never make these decisions without consulting with our state partners. And ultimately what ends up shaking out of that whole process ends up being the 30 measures that to the best of our ability we think represent the spirit of what the core

measures are meant to be. But I'll turn it over to Gigi.

MS. RANEY: I just wanted to speak to Harold's comment about the segmentation of the measures being more specific.

Because as Karen just said, we do have a lot of stakeholder feedback after we get the MAP recommendations, with both internal and external stakeholders, to see what they think is actually going to apply in real life, like whether on not they think they're going to be able to collect and report on measures that are proposed by the MAP.

And one of the things that we heard about those measures, like the controlling high blood pressure for people with serious mental illness, and the other, and the diabetes screen for individuals with schizophrenia, or however that one's shaked down, is that they actually thought those measures were going to be difficult for them to report sometimes.

We actually got mixed feedback from

the stakeholders about their ability to collect and report on those measures. Because they don't always get the additional diagnostic codes that would tell them about those different groups. And so it wasn't as easy as we thought it would be when we were talking about that, for people to collect and report on those.

So for us it was like, oh, we're already doing this, they've already got this. It's just a matter of them breaking the information a different way. But not all states have the ability to do that, and it took a lot more work from some of them in trying to negotiate that.

So, you know, I think it speaks to it's still a separate measure, even though it's a lot the same. We have to consider that there was a lot of additional resources for that. So behavioral health is my background, and as most people here probably know if they know me at all, like I'm always pushing for the behavioral health part.

But we do have to remember there are other groups in here. So as we're trying to grow that, you know, we added three measures last year, and two of those are behavioral health, with a focus on that to the adult core set, so.

DR. PATTON: So Gigi, I wanted to ask you and Karen, because 1932, the diabetes screen, was really developed as sort of a companion measure with the cardiovascular. So I was just curious, I mean, we saw the rates on the diabetes measures earlier and, you know, obviously they're quite high.

But I was curious about, you know, the discussion why the cardiovascular wasn't included although the diabetes screen for people with SMI was. I mean, you may not recall.

MS. RANEY: I think part of it had, again, to do with parsimony, which was like our word of the day last year, was trying to figure out where we could get the most bang for our buck in terms of state reporting and the population we serve.

DR. MATSUOKA: And the only thing I'd just add, so yes, everything Gigi said. But also, in some ways these measures are also signals for us for broader things. And so for us, what we really liked about this kind of measure was it kind of got to the issue of behavioral health integration.

DR. PATTON: Absolutely, co-physical health co-morbidities, that's the intent.

DR. MATSUOKA: Exactly. And so apart from measuring the subset of individuals with SMI who also had diabetes, we had sort of a broader kind of like monitoring interest in seeing the extent to which that's happening.

And so I don't think it was so much is it going to be diabetes or cardiovascular. I think it was sort of, given parsimony, let's go with one, so.

DR. PATTON: Yeah, and just one other point. 2152 has moved into hiatus, so just to make you aware that, so.

MEMBER ROSS: So Karen, you mentioned,

after discussions with your state partners, some state mental health authorities are the Medicaid-administering agent in their state for that defined population, and some state IDDD agencies are the state-administering agency.

Did you consult with the state alcohol and drug abuse directors, the state mental health authority commissioners, in making your decision?

DR. MATSUOKA: We -- I want to say we had three main groups of state stakeholder outreach efforts. One was to our CHIPRA grantees for the child core set, one was to our adult Medicaid quality grantees for the adult core set. We had our quality tag, which are also state representatives from each of the ten regions.

And I think we also consulted internally with the Medicaid organizational lead on these substance use disorder kinds of things, which are the Disabled and Elderly Health Programs Group, as well as the Medicaid Innovation Accelerators Program Group.

And I think our hope was that by

canvassing those broad channels for input, that either the states themselves or through our CMS partners internally that their feedback will have to some extent represented those individuals that you've talked about.

But I don't know that we've kept track of exactly who from what states were on these calls. But we can definitely start to do that moving forward? No, okay. I'm looking at Gigi. We do the best that we can for sure. Yes, that's right.

CHAIR PINCUS: Other comments?

MS. GORHAM: Okay, before we actually continue our discussion with the task force member recommendations, I think we should break for lunch. Okay, agreed? So we will see you back at the table at 1:30, all right.

(Whereupon, the above-entitled matter went off the record at 12:54 p.m. and resumed at 1:36 p.m.)

MS. GORHAM: Okay, as task force members come back to the table, we are going to

start with the task force recommendations for strengthening the adult core sets. So again, the task force members who recommended the measures will be the lead discussants, so we'll start with the lead discussant.

We have developers, either on the line or in the room, and it is always helpful to have the developers here to answer any type of technical questions about the measures that we are discussing.

We ask the developers to only respond to questions from the task force members. And with that, our first measure is the concurrent use of opioids and benzodiazepines. That is a PQA measure and Marissa is our lead discussant.

MEMBER SCHLAIFER: So this measure was, when we looked at the gaps determined in the last couple of years' discussions we've had, there were two gaps that were identified, one being polypharmacy, and one that was opioid use, and it was identified as early opioid use, 45 days, which I'm not sure we can squeeze that into

45 days, but as close as possible.

So this measure was - so I selected this measure for recommendation because it hits two gaps in one, so for that, you know, I felt that since trying to use the word "parsimony," in a sentence, we're looking at this from that point of view by trying to address two gaps with one.

So this measure is a PQA measure that was endorsed by PQA in December 2016. It has not yet been submitted for NQF endorsement. It's waiting for the next go around of patient safety measures, and will be submitted for NQF endorsement at that time, so I just thought I'd hit those questions before they get asked.

So this measure examines the percentage of individuals 18 years and older with concurrent use of prescription opioids and benzos, benzodiazepines. Most of the information, or all of the information is on the slide as far as the numerator and denominator.

The denominator, the group of patients are those with two or more prescription claims

for any opioid filled on two or more separate days for which the days supply is 15 or more a day, so you're looking at more chronic use, more than acute use during the measurement period, and then the numerator is the number of individuals from the denominator with two or more prescription claims for any benzodiazepine filled on two or more separate days, and concurrent use of opioids and benzodiazepines for 30 or more cumulative days.

So, you know, while benzos and - benzodiazepines and opioids are used together often, that's not necessarily a good thing, but approximately half of the patients receive both opioids and benzodiazepines from the same prescriber on the same day, and that's not necessarily something we want to see.

And in addition, when you look at fatal use of opioids, there's this concurrent benzodiazepine use in 31 to 61 percent of those fatalities with opioids, so that's kind of the trigger that this is an area that we should be

looking at.

Is there any other information you want to share?

MS. GORHAM: Well, I just wanted to point out I neglected to say that Marissa provided handouts for those of us who -

MEMBER SCHLAIFER: Oh, sorry.

MS. GORHAM: - like the feel of paper in our hand.

MEMBER SCHLAIFER: Yes.

MS. GORHAM: You do have handouts.

MEMBER SCHLAIFER: The complete specifications with the drug lists and everything, sorry, I meant to say that too, is on the table, and it's got all of the drugs, and all of the exclusions, and anything else you may want.

And we do have Lisa Hines from PQA is on the phone and Woody Eisenberg's in the room, so between the two of them, we should be able to answer any questions.

CHAIR PINCUS: Questions or comments

from the task force?

MEMBER KILSTEIN: I have a question. So you are including buprenorphine in as an opioid because I know some of the other measures, it's been excluded, so?

MS. HINES: I'd be happy to answer that question. This is Lisa Hines with PQA. Only buprenorphine that is indicated for pain is included in the measure. If it is indicated for opioid use disorder, it is not included.

CHAIR PINCUS: So I had two questions. One is what actually is the current prevalence of opioid and benzodiazepine use simultaneously?

MEMBER SCHLAIFER: Okay, Lisa, Woody's taking that one.

MS. HINES: Okay, it's 17 percent in 2013.

CHAIR PINCUS: 17 percent of what?

MS. HINES: So there's a recent publication by Sun and colleagues, so this isn't our measure benchmarking, looking at the association between opioids and benzodiazepines

prescribing in overdose, and this is out of privately insured individuals, over 300,000 individuals.

PARTICIPANT: But in addition to that, we did testing in some Medicaid populations and came up with almost 20 percent consistently.

CHAIR PINCUS: But 20 percent of what?

PARTICIPANT: Patients on opioids also having -

PARTICIPANT: That's right, patients who were on opioids who also had a prescription for a benzodiazepine.

CHAIR PINCUS: And I guess the question, the second question is among the range of sort of opioid-related quality measures, why this and not one of the others?

MEMBER SCHLAIFER: The reason, when we looked at the opioid - and I'll answer my reasons and then - at least my reason for putting this one forward rather than other things.

Last year, we looked at several opioid measures that really target people misusing

opioids that when you look at those measures that are multiple prescribers and multiple pharmacies, I think that's where you identify some of the true, for lack of a better word, abusers.

When looking at the gap areas, the gap was opioid use in the first 45 days which is - there aren't a lot of measures that identify potential misuse in the first 45 days, and this is -

So that was why this rather than some of the other things that do look at chronic opioid misuse, and also because this measure also hit the polypharmacy measure, so that was my reasoning. I don't know if Woody or Lisa, you want to -

PARTICIPANT: I would add that this combination of opioids and a benzodiazepine has been targeted by CDC as a particularly deadly combination, and that recently, the FDA has also come out with new box warnings on both benzos and opioids warning strongly against the use of both together.

And there have also been recent studies, some of them that have been carried out by the FDA, that have shown increased prescribing of opioids and benzos independently increased prescribing together, and correlating that with increased emergency room, hospitalization, and death.

CHAIR PINCUS: Other comments or questions? One thing maybe, Judy, if I could address something to you, is you had mentioned this Minnesota measure, and, you know, as a potential user of this, you know, these measures, how would you say this measure as compared to the Minnesota measure in terms of, you know, relative value?

MEMBER RHYS JONES: Yes, so for Colorado, this is on our radar, and we were on a bit of a pause as we implemented our new billing system, but this is one of the things that we're going to prior-authorize or not allow, and I think before the CDC came up with their report, we had also run some things about the risk of

death, and this is on that list.

So I don't know. I think it's a good question about how, like, what's the most important measure? And so as we were sort of discussing offline preventing people to get addicted as one of our pieces, and so that's why we've looked at the Minnesota measure and also the Washington Labor and Industry does it too as, "How do we promote good opiate use at the beginning so we don't get all the way down this path?"

And if I can take the pleasure of the mic, I think in general, if I were to say, "Are there new measures that should be added?" I'd want them to be measures that are in CPC, or MACRA, or like things that go towards the maximum overlap of things that are happening.

And I also think parsimony at this level isn't a problem. This is a claims measure that's pretty easy to do, but parsimony in terms of how many things can a practice realistically address and how many things realistically can we

even drive quality improvement projects on is a much more narrow spectrum.

Probably somewhere in the range of six to 10, I think, is a practice's bandwidth, and it takes a couple of years of working at something for a practice to make a difference, and so while ease of collecting measures is pretty easy, I think figuring out what to focus on or what to change is something to think about also.

CHAIR PINCUS: Other comments or questions? Oh, Diane?

MEMBER CALMUS: Is there any information looking at kind of the regionality of this? Is this something that's more common in certain areas versus others as a prescribing practice?

MS. HINES: Indeed, there's wide geographic variation, and we have a manuscript pending, but I could share some preliminary information on that.

CHAIR PINCUS: Okay, so do we have a second for considering this to be a

recommendation to be added? Okay, any other comments before we vote? Lisa?

DR. PATTON: Yes, I was just going to say, so some of my staff have published in this area in the past year, and looking at market scan data, and, you know, so there is some good literature out there, and, you know, when - because we're so interested in reducing opioid deaths, you know, I think this measure is one way to really get at that.

You know, we've had a lot of discussions about, you know, some very straightforward ways to get at that kind of issue, so I think this measure does help with that or could potentially help with that.

And, you know, we do see - I mean, in terms of guidelines around good care for these issues, you know, there just aren't a lot of strong guidelines that, you know, measures have been developed around or could be developed around.

So, you know, this one seems, again,

to kind of hit the mark in terms of clear guidelines for providers, you know, with the concurrent prescribing issues.

DR. BURSTIN: Wasn't this discussed at MAP? Was this the same measure that was discussed at MAP? There was a measure on concurrent administration of opioids and benzos. I'll find it.

PARTICIPANT: It's not ringing a bell.

PARTICIPANT: Could I add one other comment? This isn't a measure of addiction. This is a measure of overlapping use because even short term use can be deadly.

CHAIR PINCUS: Yes, I mean, it seems this is more of a measure, you know, to prevent mortality.

PARTICIPANT: Right.

CHAIR PINCUS: Okay, I think we're ready to vote.

MS. KUWAHARA: All right, the same routine as last time. For measure concurrent use of opioids and benzodiazepines - oh, I'm sorry,

one more question.

MEMBER SCHLAIFER: Sorry, I'm assuming that because this is not yet NQF endorsed, that full support isn't on the table?

MS. GORHAM: So as Marissa said - I think my computer's about to do something crazy. You will be voting to conditionally support this measure because it is not NQF endorsed yet.

MEMBER SCHLAIFER: And then once it's -

MS. GORHAM: Right, so again, conditional support signals to CMS kind of, again, if we use my - is a yellow light. CMS can choose to add the measure before endorsement. That is their prerogative. However, we're conditionally supporting.

Once the measure is fully supported, if it has not already been adopted by CMS, then it will be on the list next year with the actual NQF number, and in the event that it is not endorsed, then of course, it will not have one. So for the purposes of voting today, you are

using two or three, so two for conditional support and three for do not support.

MS. KUWAHARA: All right, please feel free to cast your votes. All seven members selected number two, conditional support, to add this measure to the adult core set.

CHAIR PINCUS: Okay.

MS. GORHAM: Okay.

CHAIR PINCUS: Move onto the next one.

MS. GORHAM: So we can move onto the next measure recommended, and that measure is an NQF endorsed measure. That is the 2967. It is the CAHPS home and community-based services experience measure.

Again, that is NQF endorsed. You have a few supplementary presentations on this measure that can be found in your committee's SharePoint page. Clarke is our lead discussant on that measure, and so I will turn it over to Clarke.

MEMBER ROSS: Thank you very much. What you have in the PowerShare is the March 30 CMS presentation to the work group on persons

dually eligible for Medicare and Medicaid, going through the evolution and the details of this CAHPS trademark, already National Quality Forum endorsed, home and community-based service experience survey.

This was a request of the work group on persons dually eligible for Medicare and Medicaid and a request of the National Quality Forum committee on home and community-based services to develop an experience survey, and CMS and AHRQ, the Agency for Healthcare Research and Quality, collaborated. CMS financed, and the consulting partners were Truven Health Analytics and the American Institutes for Research.

This first came through the Person and Family-Centered Care Committee and was endorsed by that committee. Then it was endorsed by the full National Quality Forum, and subsequently in March, was endorsed by the work group on persons dually eligible for Medicare and Medicaid, so we're hoping that this task force can fully support this survey which is already endorsed by

the National Quality Forum and two of its component organizations.

This meets the April 2017 MAP report, the CMS that identified six high-value needed measures, two of which are patient reported outcomes and measures addressing patient experience.

This is a CAHPS endorsed patient experience survey. Another unmet need gap area of the MAP in addition to patient experience is home and community-based services, so it addresses those areas.

This survey instrument was pilot tested in 10 states, Colorado being one, Arizona, Colorado, Connecticut, Georgia, Kentucky, Louisiana, Maryland, Minnesota, New Hampshire, and Tennessee, and the eligible persons to participate are recipients enrolled in a Medicaid-funded home and community-based service program, and the individuals - there's a chart in the PowerShare slides.

The individuals who were interviewed

had labels of intellectual or developmental disability, serious mental illness, brain injury, frail, elderly, and physically disabled, so each state had a different cluster and arrangement of the target population that was served.

There are eight domains in the survey. Those domains are staff reliable and helpful, staff listen and communicate well, case manager is helpful, choosing the services that matter to you, transportation to medical appointments, unmet needs, personal safety, and planning your time and activities, and I think - I can't remember precisely, but I think there are 21 questions that address these eight domains.

So that's an overview, and my motion is that we fully support this National Quality Forum endorsed survey measure.

CHAIR PINCUS: Is there a second?

MEMBER LA CROIX: I second.

MEMBER RHYS JONES: Could I ask a question? First, why this one? So we may have done this in the past, although I don't know. We

now do the National Core Indicator Survey from NASUAD, the National Association of State something -

MEMBER ROSS: State Directors of Directors of Developmental Disability Services.

MEMBER RHYS JONES: Yes, and they have an aging and disabled one, and also an IDD one, so, and it may not be NQF endorsed. I'm not sure.

MEMBER ROSS: It's being presented.

(Simultaneous speaking)

MEMBER ROSS: After this topic, I'm presenting on the personal outcome measures which is a survey instrument that's been around for two-and-a-half decades. June 6 and 7, the Accelerating Medicaid Innovation group of the National Quality Forum is meeting.

MEMBER RHYS JONES: I'm on that.

MEMBER ROSS: And the national core indicators are being presented at the June 6 and 7 meeting. So both the national core indicators and the personal outcome measures have been

presented to the Home and Community-Based Service Committee and the work group on persons dually eligible. We're more formally presenting them today, the personal outcome measures, and June 6 and 7, the national core indicators.

Both national core indicators and personal outcome measures have been in operation for two-and-a-half decades, so there's a track record. We'll talk about the populations when we get to the personal outcome measures.

MEMBER KILSTEIN: I have a question, well, actually two questions. One is how many states are currently doing this CAHPS survey for home and community-based services? Do we know that?

And then two, are we getting ahead of the other - I know there's a number of other panels that are recommending measures specific to the dual eligibles and disabled population, and are we getting ahead of that?

MEMBER ROSS: No, we're not getting ahead. I'm on the duals work group. I've been

on it since 2012, and this is already a National Quality Forum endorsed survey, and the duals work group and the person and family centered care committee both endorsed it, but it's also by the parent body endorsed, and it's a -

It fills the gap of how do we measure home and community-based services for people with a variety of disabilities and the label some of us don't like of frail elderly, but the vulnerable elderly that need home and community-based services?

So we're not getting ahead. We're asking you to endorse what three other entities of the National Quality Forum have already endorsed, and it's endorsed by the parent body, oh, and a number of states.

So CMS, the people who work on this at CMS aren't here. Ten states that I read the list from were engaged in the piloting of it, but I can't answer, personally I can't answer the question, "How many states are actually going to use it today or next week?"

CHAIR PINCUS: Rachel?

MEMBER LA CROIX: As I understand it, it only got its CAHPS designation last summer, and then was just endorsed by NQF in the fall, so I'm not sure if many states have had the opportunity to use it yet, but I know we're planning to start using it in Florida now that there is a standardized survey available.

CHAIR PINCUS: So I had a question. So there are no other CAHPS surveys that are part of the Medicaid core set?

DR. MATSUOKA: There is.

CHAIR PINCUS: Oh, there is?

DR. MATSUOKA: The health plan CAHPS is on the core set.

CHAIR PINCUS: That would be -

DR. MATSUOKA: CAHPS 5.0, yes.

CHAIR PINCUS: Health plan CAHPS, and so is that - what's been the experience with that?

DR. MATSUOKA: It's funny you ask. It's one of those things that I think has had a

history. So it's been on our core set, I want to say, from almost the beginning, but I'm going to look to - yes, so almost from the beginning, but because it's a health plan CAHPS, I think state reporting and who is reporting what to whom has varied over time.

So we don't actually report out the same kinds of data information we do for these other measures like the MAPS and how states are performing in different parts of the survey instrument because of that, because, you know, some states are having the data flow to AHRQ, and we started work, I want say, multiple years back, even before I started working at CMS, on how can we leverage AHRQ to do some data analysis of the information that they have?

There's also, of course, the information that NCQA sits on to the extent that plans are required to do CAHPS as part of accreditation, but there doesn't seem to be - you know, if the CAHPS measure is meant to be an experience of care measure for the Medicaid

population served in a state, I don't know that there are many states who have reporting on their full state beneficiary sample in the way that we would want.

So we have it as part of our core set because we think patient experience of core measures, to the earlier speaker's point, is very important. We know that states, multiple states, are measuring it to some extent, but not in an even enough way that we've been able to really analyze the data. So we do have the health plan CAHPS, but of course, you know, to that point, if you're a mostly fee for service state, you're not necessarily fielding the health plan CAHPS. So, anyway, it's been a mixed, a storied past.

CHAIR PINCUS: So I also want to get a sense. That made me think about what are the issues or barriers in getting the survey out to the appropriate denominator?

MEMBER RHYS JONES: Money.

CHAIR PINCUS: Expand on that maybe a little bit.

MEMBER RHYS JONES: It's really expensive and you have to pay your EQRO or someone else to do it, and so, yeah, it's just, it's more expensive. I don't know how much this one is, but it's money.

MEMBER ROSS: This addresses the gap of if one wants to have an experience measure of people participating in home and community-based services, is there a standardized National Quality Forum endorsed gap?

Several of the CMS-funded demonstrations for persons dually eligible for Medicare and Medicaid have used, starting with Massachusetts, have used the experience survey, and according to the Medicare and Medicaid Coordination Office of CMS, they're hopeful to expand the use of the HCBS experience survey and the dual demos program because a vast something - I can't remember the exact number, but something like 68 percent of dually eligible people in the demos are HCBS participants also.

CHAIR PINCUS: So Marissa, Mary Kay,

Rachel, did you - or any - and Deborah, oh, and then Roanne.

MEMBER MARY KAY JONES: I was going to ask, there is a great need, I think, for home and community-based measurements and metrics. There's not much that is out there for us and it's becoming more and more of a larger population that really needs to be measured and make sure that it's being taken care of properly, so I'm all for having a standard measurement.

From the managed care perspective, what we find frustrating with the CAHPS is that it's not very actionable. It gives you a very high level result, but as far as being able then to drill down or do more work with the information you have, you have to do additional focus groups or surveys, etcetera.

So is this one more actionable? Will it give you enough information that you can then go forward to do improvements? Has that been looked at?

MEMBER ROSS: If you look at the eight

domains, this is a very helpful instrument. One of the eight domains is unmet needs, so what do individual recipients of current home and community-based services say are unmet needs?

That's a helpful tool to the state and hopefully to the health plan in figuring out, "Oh, these are gaps that a significant proportion of our recipients have identified, and how can we develop or modify programs to meet those needs?" as one example.

And I probably shouldn't say this, but the 17 representatives of the duals committee voted to endorse this, right, so, and thought this, again, incrementally addressed a big gap as you have said.

MEMBER KILSTEIN: Just one more question. You mentioned in MMP, the Medicare and Medicaid demos, that they're using CAHPS. Are they using this CAHPS or are they using the adult CAHPS or the existing CAHPS?

MEMBER ROSS: My understanding is that the Massachusetts demo has used this survey -

MEMBER KILSTEIN: Massachusetts has?

MEMBER ROSS: Massachusetts demo, and because of that experience and the endorsement of the National Quality Forum, the MMCO hopes that other demo programs will use this survey for home and community-based services.

The challenge is the demos do a lot more than home and community-based services, and so I think they're having - CMS is having the discussion on, "How far do we push this and in what component ways?" and I'm not an advocate. I don't know any of that.

MEMBER KILSTEIN: Okay, thank you.

MEMBER OSBORNE-GASKIN: So I agree with Mary Kay that we definitely need standardization of, you know, these community and home-based services, but CAHPS, I think, has previously had not that great a response when we sent it out to, you know, in terms of like actual responses we got back.

So is it that - and I don't know if there has been a projected response from these

patients, you know, because I don't know what, you know, the rates are, but we've seen rates as low as, you know, 15, 20 percent sometimes, really not a lot of people responding to the survey.

MEMBER ROSS: Well, again, the people who ran the pilot should be the ones to answer the question. The 10 participating states had a very high participation rate.

Now, pilots usually have a higher participation rate than mainstreamed programs over time, so I can't answer your question other than there was a high participation rate in 10 state Medicaid programs by recipients of home and community-based services.

MS. GORHAM: If I could just read a comment to your question about how many states are using the measure, I can't answer all of the states, but someone just chatted that Arizona currently uses the instrument as its de facto instrument. I'm sorry.

So I can't answer how many states in

total, but someone just chatted that Arizona currently uses the instrument as its de facto instrument.

MEMBER SCHLAIFER: As Judy leaves the room, I wanted to make sure - I had two parts of the question, but what the second part is, Judy had asked the question why this measure instead of another measure?

And I know there was a reference to the following measure which I don't think is related at all, so I think it may just be my lack of knowledge. I'm confused about did we get an answer of why this measure rather than the measure you were asking about?

So the next measure I'm looking at - and I know we probably shouldn't jump ahead. Does the next measure have - they seem like two very different measures to me, but on this -

Oh.

MEMBER ROSS: No.

MEMBER SCHLAIFER: Okay.

MEMBER ROSS: I'm presenting as an

introductory - what's the phrase -

MEMBER SCHLAIFER: Okay.

MEMBER ROSS: - future consideration -

MEMBER SCHLAIFER: Okay.

MEMBER ROSS: - for personal outcome measures. The personal outcome measures and the national core indicators that are each two-and-a-half decades old were predominantly developed for people with intellectual and developmental disabilities, and that's the population served until recent years.

And in recent years, because of the absence of home and community-based service measures, both the national core indicators and the personal outcome measures have expanded to other populations.

Something like 40 percent of people served by state intellectual and developmental disability agencies have a co-occurring mental illness, so both national core indicators and personal outcome measures have developed an expertise and experience with mental illness.

Under a grant from the Administration on Community Living, the National Association of States United for Aging and Disability piloted, modified and then piloted the national core indicators for physically disabled and "frail elderly" folks.

So these are long-standing instruments that are expanding in settings and populations, and again, June 6 and 7 at the Medicaid Innovation Committee meeting, the national core indicators will be presented.

MEMBER SCHLAIFER: Okay, and just the other comment I just wanted to make that may or may not apply to this, I think as I'm trying to understand that this may be a really good measure, but I'm trying to understand if it's a really good measure for the Medicaid core measure set.

I know it was mentioned that it's been NQF endorsed, and I think that's one of the things we keep coming back to is NQF endorsement means it's a good measure, and that what we're

trying to get today is, "Is it a good measure for this purpose?" and I'm still trying to get my head around that, so anyone who's in the Medicaid world, I'd love to learn more.

MEMBER ROSS: Well, if you looked at Judy's slide, 6.6 percent of the Colorado Medicaid population are people with disabilities, but they account for almost 30 percent of the expenditures, so this is what we're talking about, the most vulnerable severely engaged population who spends a lot of money. That would be a partial response to why should home and community-based services be part of a core Medicaid measure set?

MEMBER SCHLAIFER: And I was not questioning whether there is a need for a measure at all. I think you have explained, and I think from Judy's presentation, I totally recognize the need. I guess my question is is this CAHPS measure the right measure?

MEMBER ROSS: The right measure for?

MEMBER SCHLAIFER: Just this program,

just this measure. From some of the comments I've heard earlier, I guess I'm still trying to figure out just from what I've heard from people in the room whether this measure is usable in their setting, in the - yeah.

CHAIR PINCUS: Well, let me say, Rachel, do you want to say something to that issue?

MEMBER LA CROIX: Sure, I actually was just talking to Karen about this during our lunch break. We've had Medicaid managed care for long-term care for several years now, and there has been a dearth of measures or surveys available. So as a state, we've had to create some of our own measures, our own surveys, and so having this survey available now and be able to be used, and knowing that CMS is also working with Mathematica on some measures that can be used for HCBS waiver programs and managed long-term care, I know I'm personally very glad these standardized and tested measures are available to use.

In Florida, I think we have at least

80,000 people in our managed long-term care program, and so this would go ahead and provide some measures as part of the core set that would cover that population, whereas all of these other measures in the adult core set don't really address the services provided through our long-term care program.

Okay, glad I could help.

CHAIR PINCUS: Diane?

MEMBER CALMUS: Well, that actually, I think it went a long way in answering my question as well. So I guess my concern, and I was kind of in the same place as Marissa, as not sure if this is the best measure. You know, my concern is taking what Mary Kay said about concern about response rates and adding that to how actionable is what comes out of this?

And then saying, okay, so we have - you know, if we have a low response rate, you know, and the data is or is not actionable, does that, you know, provide useful enough feedback to the agency to really know what improvements that

we're making?

I mean, I know Judy brought up the concern of, you know, kind of limited bandwidth to be able to respond and kind of make improvements, and so making sure that if we're going to add something to the data set, that it really is providing something actionable that really does represent this population, which I absolutely agree we need a measure for.

They're a particularly vulnerable population and it is concerning that we don't have anything, but does this provide something that's actionable and useful in the end is, I guess, my question?

MEMBER LA CROIX: I believe it will, at least more than what we've had, and I think especially being able to go ahead and start gauging responses to these items, and track progress over time, and also being able to see how your state is doing or how your plans might be doing relative to other states or at a national level as more folks start using some of

these measures, I think that will definitely be useful.

Up to this point, we have been using a state-created survey, so we're able to look at our plans compared to each other using that survey, but not really know how that fits in, if it's good or bad compared to things at a national level or in other programs.

Also just one comment, and Clarke, I don't think you had mentioned, the administration methods for this survey are a little different than for health plan CAHPS. For health plan CAHPS, the NCQA protocol is to do the mail out with a telephone follow up for it, but this survey is actually intended to be done either in person or as a telephonic interview where someone is interacting with the respondent, and so I think that also should improve the quality of responses for this population.

MEMBER ROSS: Thank you, Rachel. I'm glad you're here to answer this. You haven't studied the eight domains, but one of the

domains, "Are staff reliable and helpful?" If 62 percent of the beneficiaries say, "no," that is a clue to the health plan that's managing the population and to the state Medicaid agency. You know, we have some staffing challenges in home and community-based service programs, and we should take some action to do it.

Now, you don't have to act as either the plan or the funder, but there is data here that will reinforce that we're doing a sort of okay job, or we'll red flag three or four areas that require, the advocates would say require additional action.

CHAIR PINCUS: So do we have - oh, Helen?

DR. BURSTIN: I just want to make one point. I think this is a common conversation for any new measure that comes forward. We don't have that much experience. The beauty of this is it is new entering in a space where, frankly, there have not been very many measures. I just want to also point out though that it is

specifically only for beneficiaries who receive these services for three months or longer, right, Clarke?

I mean, I'm looking and I pulled up the specs, so it is not everyone, so it is already just the subsection of those persons who receive these services. So again, it's not universal, but I think it would be potentially just for that subset of persons for whom these services are received.

MEMBER ROSS: But as Rachel said, I think it was Rachel who said, it's the managed long-term services and supports program. Well, by definition, one would think at least three months, if not for a lifetime, in an area of intellectual disability and serious mental illness. So, but you're right. There are boundaries in all of these measures, and there's a boundary in this one.

CHAIR PINCUS: So do we have a second?

MEMBER LA CROIX: I seconded it earlier.

CHAIR PINCUS: Okay, that's fine. So are we ready to vote?

MS. KUWAHARA: All right, for NQF number 2967, CAHPS at home and community-based services experience measures, to select support, please press one, conditional support, press two, and three, do not support.

MS. GORHAM: Just to clarify, so this is an NQF endorsed measure, so you would either be supporting or not supporting the measure.

There are, there are other reasons. So with that said, we usually choose, but if you are voting support, then one, and then conditional support, two.

DR. BURSTIN: Although usually we would ask groups to vote on conditional support when you have a condition before the committee. So you would ask somebody if you want to have people potentially have the ability to use the conditional option, you need to actually state what you'd like people to view that conditional on.

CHAIR PINCUS: So maybe just to make that point, I mean, is there anybody that would put forward conditions that they would want to be considered in the voting?

MEMBER KILSTEIN: I would love to hear CMS actually, you know, the condition in terms of CMS looking at feasibility and, you know, in terms of using a measure that they want to use consistently that's going to align across all of their programs, not just the adult core set measure, but the MMP measures, and the dual set, and, you know, to make sure that there is alignment across all of the measures. So for me, that's a condition.

Without CMS, you know, weighing in on that alignment, I would be a little bit hesitant in terms of the support, not that I don't think a measure is absolutely necessary, but in terms of ensuring that there's an alignment across the different measure sets.

CHAIR PINCUS: Okay, so people can choose to vote support, conditional support with

that consideration, or do not support. Okay, we're ready to vote.

MS. KUWAHARA: So it looks like we're still waiting on one response, okay, great. 38 percent of our eight respondents supported it. 50 percent of our eight respondents selected conditional support, and 13 percent chose not to support this measure.

CHAIR PINCUS: Conditional support?

DR. BURSTIN: Yes, because anything in MAP world, and this is MAP world, rolls up, rolls down to the lowest one, so that it would be 50 plus. Its support plus conditional support is over the 60 percent, and then it rolls down to conditional.

CHAIR PINCUS: Okay, so let's move on to the next item, Clarke.

MEMBER ROSS: Thank you. So the developer, Cathy Yadamec, is coming to the mic in the back of the room. She's the director of training and certification for the Council for Quality and Leadership, which is the organization

that has developed and implements the personal outcome measures.

So I already tried - we have the national core indicators, which is two-and-a-half decades old, developed by the National Association of State Directors of Developmental Disability Services, which looks at the entire statewide system of services and supports, predominantly for individuals with intellectual and developmental disability, but evolving into other populations.

We also have the personal outcome measures, two-and-a-half decades of experience, focused on community-based organizations, so more like an accrediting body, and this topic is not - I'm not seeking anybody's vote.

This is the introductory presentation to this group of the personal outcome measures, and indirectly, the relationship to national core indicators, and the CMS, HCBS experience survey.

Personal outcome measures are used in over 700 community-based agencies, and Medicaid

is the primary financier of these community-based agencies, and the vast majority of beneficiaries in these community-based agencies, again, predominantly intellectual and developmental disabilities, but evolving into other disabled population groups, are Medicaid beneficiaries, and so that's why we're bringing this to you, and personal outcome measures have been used in over 30 states.

There are five domains and 21 indicators for the personal outcome measure, so Cathy can answer questions you have on those. The categories are similar to both the national core indicators and the CMS home and community-based service indicators.

The five factors are my human security, my community, my relationships, my choices, and my goals, and then there are 21 indicators for these five factors. This is a person to person interview process.

I won't take the time to laundry list the 21 indicators, but they're in the PowerPoint

presentation and the PowerShare that you have previously been downloaded.

Also, someone asked in this morning's discussion about personal stories. Personal stories would enhance. The former president and executive director of the Council for Quality and Leadership has published a book. It's a brief book that I downloaded to the SharePower site, and it's called A Sample of One.

And it basically is a series of personal stories to explain the personal dynamic of individuals who are served in community agencies and who have gone through the personal outcome measures process, so this is a nice additional piece to have.

I guess that's all I want, given the previous discussion. We want all of the appropriate entities of the National Quality Forum to be aware that the national core indicators have a two-and-a-half decade experience. The personal outcomes have a two-and-a-half decade experience.

They're evolving, and the national core indicators and personal outcome measures actually complement one another because NCI is focused on statewide systems, and personal outcome measures are focused on individual community agencies, and they both have a personal interview process. So please ask lots of questions and Cathy can answer them.

MS. GORHAM: Before we actually do that, can I just for a point of clarification? So the personal outcome measures, this is a survey, and they do not have actual measures in this survey, so it's different from the HCBS-CAHPS survey where we have endorsed measures. NQF endorsed the measures and not the survey itself. That is also the difference between the NCI and the NCI-AD survey. That, again, is a survey, and they do not yet have measures that have been endorsed.

So Clarke mentioned other projects, and so we are - I'm also staffing the Medicaid Innovation Accelerator Project with CMS, and we

discuss - April 18 and 19, where we had a representative from NASUAD, I think, is the developer for NCI, correct?

And so I know that they have or they are in the process of actually getting those measures developed, but they are about a year out, and so I'm not quite sure where the developer is in those measures, but that is the difference.

And so, again, we are not voting on this. It is just to hear your perspective and your thoughts on the relevance of this in relation to the Medicaid population, so if it is considered as a potential future recommendation, so again, we are not voting, but we welcome discussion.

CHAIR PINCUS: So questions, comments, thoughts? I had one just to kick things off. I'm trying to imagine how this would be converted into a measure. You know, I guess I'm more familiar with something like, for example, the PHQ-9 for depression.

It's a measure of depression and it gets converted into a measure in terms of number one, whether it's administered, basically, and number two, you know, what the findings is for the population in terms of what proportion of people have achieved remission on the measure and what proportion of people have had a 50 percent improvement on the measure from time one to time two. So I'm trying to imagine how this would be converted to a measure.

MS. YADAMEC: So to answer your question, I think that when we gather this information about how people are doing, so I might use an example of one of the measures is people have friends.

So we could sit here and talk about how many friends are enough friends, and what's difficult with that one is that there are people in this room who have 5,000 friends because their definition of friend is anybody that they meet becomes their friend, and then there are other people who have friends that, you know, there's

two or three people that are really close friends.

And so what we're looking at in terms of measurement is for the outcome "people have friends" is whether or not that meets that person's personal definition of "people have friends," and so the measurement would be the number of people who have - for whom that outcome is met over the total number of people with whom we've asked that question.

CHAIR PINCUS: Sort of a change over time kind of basis for it because I'm trying to understand it? If you administer it once, then you're getting sort of the prevalence of all these sort of outcomes in the population, but would it be intended to be, "What happens at time one versus time two?" and what would be - you know, just sort of thinking about that in terms of its application.

MS. YADAMEC: So when we do this, certainly that is one of the things we're measuring is progress over time. For some

people, that outcome measure is met, and then later it's not met, or it changes and it is met because of the supports and services that are put into place, and so it does change over time.

So part of what happens with the personal outcome measures now is that in these individual organizations that we've talked about, and in some states who have it as part of their quality measurement system, they're looking at whether or not people have outcomes and supports in place, and then what are the things that need to happen in order to increase the likelihood that those outcomes and supports will be put in place?

So people are using them. So we use them in planning with people, and then we also then are able to evaluate the effectiveness of services and supports based on the measurement of the outcome.

CHAIR PINCUS: Other comments or questions? Lisa?

DR. PATTON: Yeah, I was just going to

mention that as of April of this year, SAMHSA began collecting data around the WHOQOL-8, so the quality of life, eight questions on home, health, community, and purpose, and so it gets its satisfaction with -

CHAIR PINCUS: Could you get a little bit closer to the mic?

DR. PATTON: Oh, I'm sorry. We're using the WHOQOL-8 with our grantees at SAMHSA. We just started the data collection. We piloted that instrument a couple of years ago, and it gets at home, health, community and purpose in an individual's life.

And it's eight questions asking about satisfaction with broad healthcare management, relationship satisfaction, housing, role in the community, those kinds of factors, and it can be administered repeatedly, so we'll have data on that within a year or so, but just commenting we are using that.

CHAIR PINCUS: Helen?

DR. BURSTIN: Since this is -

obviously there's a fair amount of work from where you are now to this being a performance measure, and we recognize that, and I think really the purpose of these discussions when there isn't really a vote is I think to get a read, my sense, for this group, correct me if I'm wrong, Karen, of your interest in seeing a measure like this around quality of life.

Again, it's a very different domain than we've talked about before, coming forward as being something that would be helpful for the Medicaid population, so I wouldn't get too fixated on the specifics here.

I mean, whether that becomes a process measure or an outcome measure, however you need help with that, we're happy to help along the path, but, you know, the key question is would this concept, would this overall idea of something around quality of life be something important for Medicaid to consider in the future since this is a future consideration?

CHAIR PINCUS: Diane?

MEMBER CALMUS: I think I like the idea of this sort of measure item, but my concerns would be the same as I expressed with the last one that we discussed in making sure that this was something that was clear and actionable moving forward.

You know, I haven't seen all of the questions that are asked, but I think making it something that really could be utilized by the agency to make improvement would be, I think, pretty welcome, and I like the kind of open-ended idea of what you view as quality of life as being a part of it.

I think that's really important, particularly with that community, but just to make sure that it's something that provides something useful to the Medicaid, and something that would be actionable so that we're not just asking them to spend a lot of money to collect data that they don't view as actionable. That is my concern.

MS. YADAMEC: So in South Dakota, for

example, CQL and South Dakota have held a long-standing relationship in terms of the use of the personal outcome measures and our accreditation processes as well.

But one of the things that we would say over time is that when we first began working with South Dakota many years ago, there were many people who were in sheltered workshops who attended segregated day programs, lived in group homes, and now we're seeing much more, based on the use of the personal outcome measures, a change in how people live their lives, and that their quality of life is different, that they're not necessarily in congregate settings all the time.

So I think there are - we can show you that path and how that's happened over time, and how, for example, that state has used the personal outcome measures to change peoples' lives and change their systems.

CHAIR PINCUS: Deborah, did you - Roanne?

MEMBER OSBORNE-GASKIN: So I think this is, you know, something that definitely has to be considered because I find that, you know, kind of looking a little bit at how quality is kind of developed, you know, there is a lot of focus on making sure that we have certain, you know, checked boxes.

And so this kind of broadens the view of not just, "Okay, we're going to try to hit these targets because this is part of our quality, what we have to do," but just broadening it out to the patients' experience, but going back to that point.

So it may actually help to redirect our focus on quality, especially for patients or persons with disabilities, but then, you know, kind of what is at the end of that, so, you know, how would we use that to, you know, look at or improve quality for persons with disability in a real way? So, I mean, I like the idea, I just, you know, just wanted to add that.

MS. YADAMEC: So again, thinking

about, you know, some of the things that have happened in the state of Tennessee for example, they have embraced the personal outcome measures and they use that as a way to evaluate provider performance, but also to look at their state systems.

And so, you know, around the whole issue of, "Are people really living in the community?" which is, you know, a major emphasis in the change in the HCBS waiver rules is, you know, are people really living in the community and what's that person's experience?

And so they use the personal outcome measures as a tool to help look at what are those other supports or services that need to be put into place in order for people to have outcomes? Does that answer that?

CHAIR PINCUS: Other comments or questions? I guess just from my perspective, I think this could be an extraordinarily useful clinical instrument to use in the context of providing clinical services.

I still have a problem sort of understanding how this could be converted to a performance measure, and some of the challenges I would imagine is, you know, thinking about how one would look at this in terms of change over time?

How would we deal with risk adjustment, you know, as an outcome measure? And also, how would one sort of, you know, deal with sort of the breadth and complexity across 21 areas? You know, so those would be, I think, the challenges in converting this to a performance measure. Other comments, questions?

MS. YADAMEC: I think we have other partners. We're working with some of the MCOs in North Carolina. We're working with New York around some of those very same issues, and I think that will be helpful in helping to map this out for everyone.

CHAIR PINCUS: Well, thank you. This has been, you know, very helpful.

MEMBER ROSS: Thank you all. Thank

you, Cathy.

CHAIR PINCUS: So we have voted, so, and we've voted, I think, for one measure to be included conditionally, and one measure to be - well, actually, for both measures to be conditionally recommended, and provided input to the personal outcome measures for further development. So are there any other measures that task force members would like to propose for consideration in terms of recommending to be supported?

MEMBER SCHLAIFER: We're also discussing asthma, the asthma measure tomorrow with the - okay.

CHAIR PINCUS: Right, yeah, the ones that go along with - potentially apply to kids as well, we're going to consider tomorrow, but are there any other, you know, adult measures that people feel would warrant consideration for voting with regard to adults?

So we have two measures. Do we need to prioritize them?

MS. GORHAM: So yeah, what I would say, just as a matter of process so we won't duplicate efforts, if we wait until - as you know, and I'll just reiterate for the new members of the table, so we like to first vote, recommend the measures to CMS, but we also like to recommend just a ranking of the measures so we know that resources are tight.

And when we place recommendations to CMS, we like to rank them in order one, two, three, however many measures we have in order of importance, and so I think what we will do is we have two measures that we have voted on thus far.

We are also talking about asthma and MIH tomorrow, in which we will continue to vote on measures that would apply to the core set, so I think we will actually rank after we've voted on all of the measures. That will one, kind of save us time, and then also just be more efficient.

CHAIR PINCUS: So now we have the opportunity for public comment. Can we open the

lines for public comment?

OPERATOR: In order to ask a public comment, please press star, then the number one. Again, that's star, one. At this time, there are no public comments.

CHAIR PINCUS: Could we hold it open a little bit longer?

OPERATOR: Yes.

CHAIR PINCUS: Okay, thank you. So we have an opportunity for a break. Can we take a 10-minute break and reconvene at five of? Okay.

(Whereupon, the above-entitled matter went off the record at 2:45 p.m. and resumed at 3:12 p.m.)

CHAIR PINCUS: I guess the last part of today's meeting, in which we are going to be going over the priorities that we put forward to CMS for the further development of measures for the core set.

And what's been done is that we have a long list of domains. Actually it's sort of a mixture of domains and categories and -- that

varies, as Helen said, in altitude, or levels of abstraction.

And what we want people to do is to go through an exercise that we're going to put the little dots on these things so people can express their views about what should be the largest priorities, and also to think about how we can consolidate some of these categories, to make it more clear and give better direction to CMS.

And so -- but first we wanted Helen to sort of go through what NQF is about in terms of criteria for prioritization.

DR. BURSTIN: So we just thought it'd be helpful for those of you who were at our annual meeting. We just put this forward actually as part of our annual meeting in April. So these are a set of criteria that we are putting forward as a way for us to use across all of our efforts.

We think this sort of crosses domains, crosses settings, types of programs, just a way for us all to wrap our head around, what do we

want in terms of the future of measurement. What kinds of measures we want.

We thought it might just be helpful to put these up here for you, just so you know the exercise we went through as we looked at all of the prioritization criteria used nationally and internationally -- about 25 different sets of criteria -- and distill them down initially to about a dozen that seemed to come up most often.

And then through feedback from groups like yours and others, we whittled it down to these four. And we think these are helpful ways to think about everything we've heard about where we think healthcare is going, where we think measurement should go, as the tool with which to really accomplish some transformation.

So the first is, not surprisingly, outcome focus. It doesn't just say outcomes. It says outcome focus. We very much have a preference for outcome measures, and measures that may not be outcome measures, that have a strong link to improved outcomes and quality.

So sometimes -- and perhaps the best example would be the discussion we had this morning about the measure that assessed, did you do an A1C, as opposed to, what's the actual performance on the A1C.

Did you do the A1C, is pretty far away from the actual outcome of glycemic control, as an example.

The second one is one that comes up a lot, and the interest in the other comments we've just had for much of this afternoon, all come back to this question of, would this measure provide actionable and improvable information?

So no, another lens through which to look at it. If you had measures that would -- for which there's a demonstrated need for improvement -- and there's actually some evidence-based strategies for which to do so. Or at least the data would be useful in a way that, if you had this information in hand, you could drive improvement.

The third one is that the results --

not just the measure itself, but the results -- would actually be meaningful to patients and caregivers, if they got the results back to them, and understandable as a third one.

And then finally, and not surprisingly, given a lot of the discussions we've had today, a measure that would support more of a systemic or integrated view of care. So rather than measures that are always so focused in on a single setting of care or a single provider of care, really more measures that reflect care that spans settings, providers, and time, so you can get more of a holistic view of care for patients.

So we think these four criteria might be useful, as you begin putting your dots up, to think about if this is the future for Medicaid. And broadly, what kinds of measures would help drive towards that?

Was that helpful Karen? Anything you want to add?

DR. MATSUOKA: No. I love these

criteria.

DR. BURSTIN: Good. Very good. Questions? Thoughts? Helpful? Whatever you've got. Okay. You get to stand up.

CHAIR PINCUS: So do people have any other thoughts about how they might think about prioritizing criteria that are not sort of on this list? If they just get a sense of what people would feel to be particularly important from their point of view, that's not quite captured here? Deborah?

MEMBER KILSTEIN: There is an issue that I don't see addressed, unless I'm just missing it, that I would like to see on the list, and that's identifying the impact of social determinants of health. I don't see that -- anything about screening for social determinants of health, or -- I just don't see any of those in terms of the gaps -- identified as a gap.

CHAIR PINCUS: Well are you talking about in terms of this list of gaps, or are you talking about the prioritization criteria?

MEMBER KILSTEIN: Oh I'm sorry. You're just talking about the criteria, and not the -- never mind. Sorry.

CHAIR PINCUS: Yes. I mean, yes, I mean we can come back to that actually. I mean we probably have another category that people can write in. Okay?

MEMBER KILSTEIN: Okay, very good. Let's put a blank there.

CHAIR PINCUS: Yes, maybe put a blank piece of paper up.

(Off mic comment.)

CHAIR PINCUS: And you could use one of your dots for something you might write in. But in terms of prioritization criteria, one thing that is missing here, at least it seems to me, are things specific to the Medicaid program. Because it seems that's -- because we are --

MEMBER KILSTEIN: Well that's the kind of spread.

CHAIR PINCUS: Yes, in the service of that. So I think that that -- so that one should

think about, in addition to these four prioritization criteria, to add the criteria that there's special relevance to the Medicaid population. Anything else Karen, that you think that we should -- to elaborate on that point?

DR. MATSUOKA: No. No, I think it's a well-taken point. I kind of assumed that it was -- to your point, that it sort of, these are the prioritization criteria that we would use in the context of thinking about Medicaid measures. But it deserves to be said and made explicit, I think.

Only other thing I'll just add, and maybe it gets to some of the conversation we had this morning about patient reporting outcome measures, is things that are -- and we're finding this through our work with the QRS as well -- the Medicaid managed care QRS.

It really depends on who you're asking, what the value of the measure is. And so there are things that are very meaningful from the point of view of patients and caregivers,

that may not always map to what a clinical provider might think is important.

I think most of the time they do overlap. But it's just -- I think that a different dimension to also keep in mind, that they're not always the same. So the meaningful to patients and caregivers may not always necessarily be the same things that are important for clinical quality improvement. So --

CHAIR PINCUS: And I think also, to some degree in doing this prioritization, we're kind of -- I don't know if explicitly or implicitly -- saying that we want to be a bit more on the aspirational side than on the practicality and feasibility side. Clarke?

MEMBER ROSS: So one partial response to Karen, in the CMS home community-based service experience survey and the two other measures, there's an area of proxy responses by family members. Because the res- -- I have a 26-year-old son with co-occurring developmental disabilities.

His view on life, his life, and my view on his life, differ in some ways. It's an important cord know what his preferences are, but he depends on his family. So it's important to know what my preferences are, but not mix them.

So segmenting the different kinds of audiences is a solution that technically can be easily done, and is done in these other approaches that I talked about. And it's important to know the different segments, and what their predominant views are.

CHAIR PINCUS: So why don't we go around and distribute your dots. Five dots. Five dots.

MS. GORHAM: Your colors don't mean anything?

CHAIR PINCUS: Yes. Colors don't mean --

MS. GORHAM: You can put your dots anywhere? You can put all five in one --

CHAIR PINCUS: Yes.

MS. GORHAM: -- spot? Or you can

mix -- also put a blank sheet on the wall, so if you want to write in a gap area, you can do that, so we have one list here --

CHAIR PINCUS: But if you write in, you got to use a dot.

MS. GORHAM: You have to use a dot if you write it in? There's a -- to your left there is a --

CHAIR PINCUS: It's in the threshold.

MS. GORHAM: -- partial list. Behind me there's another list. And then to my right there's a list. Go for it.

DR. MATSUOKA: Maybe you should -- we have people who have write-ins, write in first, so that other people can vote on it too?

MS. GORHAM: That's a good idea.

(Off mic comment.)

CHAIR PINCUS: Mm hmm.

PARTICIPANT: Oh we'll give you a dot.

CHAIR PINCUS: Okay.

(Pause.)

CHAIR PINCUS: Okay. The outcome of

this prioritization project -- process -- seems to be the ones that are -- number one, it suggests that there's some potential areas for consolidation.

That, for example, there's a number of parts where behavioral health is sort of saying the same thing, said in different ways. So there's behavioral health and integration with primary care, and then there's a care coordination that's -- with specifics around integration, medical and psychosocial services.

And there's also a section talking about treatment outcomes through behavioral health. So in some ways, the kind of larger categorization of behavioral health in terms of both integration coordination and outcomes, seems like a major area.

Number two, again in looking at areas that received a lot of dots, is the assessment of social determinants of health. I would make a friendly amendment to that. I think assessment and -- what was the term I used? Assessing and

addressing.

Because assessment may not go far enough, social determinants of health being sort of a second sort of high priority area.

A third high-priority area is, looking the five dots, long-term supports and services. Then the other ones that come up with multiple ones is maternal and reproductive health, with some subsets of categories there in terms of maternal reproductive health, new chronic opioid use, efficiency, and I would say sort of beneficiary reported outcomes.

And then, sort of somewhat lower down, were -- was workforce and polypharmacy. And that some items did not get any dots, which were cultural competency, trauma-informed care, and engagement in activation in healthcare.

So do people feel this an adequate representation of the priorities? Are there any items -- okay, are there any items that people think didn't get the right amount of votes you feel strongly about, that were left off? And any

other further ideas also for sort of other categories that were left off. So Sue?

MEMBER KENDIG: Two. First, on the behavioral health front. There were a lot of us for behavioral health and integration with primary care, which I feel is important whenever they were looking at treatment outcomes.

But I would also invite us to consider that, particularly those patients with complex behavioral health needs when they are hospitalized.

Integration with medical services in the acute care setting is equally as important, because that could potentially affect the treatment outcomes portion over there, and I would suggest that's across all populations.

CHAIR PINCUS: I would say I think -- we think it's sort of the larger category of sort of behavioral health. And then sort of subset it in terms of, in particular, with primary care and other general medical services, including inpatient, and all seven incorporating sort of

outcomes-related or outcomes focused.

MEMBER KENDIG: Yes. I wanted to assure that we were really thinking about that across the continuum of care.

CHAIR PINCUS: Mm hmm.

MEMBER KENDIG: Because so many times it does hit that primary care piece, and then it's like, well this is happening elsewhere.

And then regarding the maternal and reproductive health piece, I just wanted to point out the inter-conception care piece and the poor-birth-outcomes piece. Really is a nice segue to well woman care.

And so I think as we are framing that as a priority area, that is really the transition to well woman care as well, because during that inter-pregnancy component, which quite honestly can be 30 years, it's really important that we are focusing on things that help to keep women healthy.

CHAIR PINCUS: Roanne?

MEMBER OSBORNE-GASKIN: So I just

wanted to just put two things. The workforce question, and the efficiency question. There's been a lot of talk in the primary care provider community about physician burnout, and so that, and the way to use efficiency in practice to reduce that.

So we know that we're going to have a workforce shortage for primary care in the upcoming years. And so I just kind of wanted to highlight that, and that's why I kind of put those to the fact that we do have a shortage.

We have people who are burning out -- of primary care physicians who are burning out. How to address that. And I'm not sure -- I kind of looked at it from the point of view of meaningful to patients and caregivers I guess, because we're just finding primary care having less and less time to spend with patients.

So just kind of, how would be -- I don't know how that would translate into, say, a measure, but just kind of looking at that. That's why I just wanted to focus on that a

little bit.

CHAIR PINCUS: Okay. Diane?

MEMBER CALMUS: And I may have misplaced my dot on this button, but one of the issues that is really coming up a lot in rural America -- and I don't know if it's kind of spreading out into any other areas -- is there's a huge difficulty, especially for the Medicaid population, for access to OB care.

So somewhere to deliver a baby. And there are rural areas where you may have to travel three hours in order to get someplace to deliver a baby. And frankly, it's a problem that's getting worse, and has been getting worse kind of under the radar.

And unfortunately, we're starting -- or fortunately, we're now starting to get some research on this. But there's not a whole lot of research on where these women are having their babies. We know that rural women haven't stopped reproducing.

But what we don't know is where

they're having their babies, and kind of what those outcomes are. So I know in rural areas that's a huge concern. And so I don't -- and I know a lot of the larger hospitals also complain about Medicaid payment rates for births, and there are populations where there are larger percentages of the births that are Medicaid-supported.

It's the majority in rural America. It's in the 60 percentile range that are paid for by Medicaid. So I think that's a huge issue that I would throw out there that's specific to the rural population, but I'm sure is also something being experienced elsewhere too.

CHAIR PINCUS: Other comments? Sue, you had another comment?

MEMBER KENDIG: Yes. I'm just thinking on -- about building on what Diane said, because in my head I'm going to the sort of --

CHAIR PINCUS: Oh, put your mike on. Okay.

MEMBER KENDIG: Yes. I'm just not

talking into it. Sorry. Yes, building on what Diane said, I think that goes in also to the birth outcomes piece -- delivery at an appropriate facility access to prenatal care, all of those things that would be particularly salient to our rural populations, in a different way.

CHAIR PINCUS: If you feel you might have been sort of left out, or not supported sufficiently, or that would be an expansion of the comments here -- of the categories I mean. Debbie?

MEMBER KILSTEIN: Something that was on the slide that I didn't see up there, which was postpartum complications, and maternal outcomes.

CHAIR PINCUS: Okay. That would go within the sort of maternal reproductive area. So just -- I'm trying to sort of summarize, but it seems to me if I was trying to sort of categorize them in terms of -- it sort of falls into, now we've narrowed it down to I think

pretty much eight categories that got sufficient, so with -- for the in order for behavioral health, and both in terms of integration and outcomes, and integration across the range of services and care.

Number two, assessment, and assessing and addressing social determinants of health.

Number three, long-term services and supports, and home and community-based services.

Number four, maternal and reproductive health, and well woman health, with multiple categories within that.

Number five seemed to be efficiency.

Number six was new chronic opioid use.

And then workforce, including physician burnout.

And then eight is sort of polypharmacy. In turn, if I was to look at the voting, that's where things seemed to turn out.

Does that all seem to make sense -- ring true -- to fit in with people's views? I think it also pulls them together in a way where

it's more similar categories. So what do we do next?

PARTICIPANT: Invite comments --

PARTICIPANT: Staff. Yes.

CHAIR PINCUS: Okay. Any public comments that -- could we open up the line for public comments with regard to discussion of priorities?

OPERATOR: At this time if you'd like to make a public comment, please press star, then the number one, on your telephone keypad. We'll pause for just a moment.

And you do have a public comment from Junqing Liu, from NCQA.

DR. LIU: Hi. This is Junqing Liu. Could folks hear me?

CHAIR PINCUS: Yes we can.

DR. LIU: Thanks. I'd like to make a comment about recommending a measure for the Medicaid adult core set. That's the depression remission at six months measure, that's NQF-endorsed. The NQF number is 0711. That's a

Minnesota community measurement measure.

I heard the discussion about behavioral health is one priority for the Medicaid population. There's a need for patient-reported outcome measure. So I would like to recommend the task force to consider the depression remission at six-month measure.

So this measure is also now in a HEDIS Health Plan measure set for health plan reporting. The performance has shown that the gap for improvement, there's also evidence-based collaborative care model, to improve depression outcomes.

I'm sure depression is especially relevant for the Medicaid population. This measure, in my mind, meets all the prioritization criteria that Helen just mentioned. So I'd like to recommend this measure for consideration for the core set.

CHAIR PINCUS: Yes. We had some discussion about this earlier, although it wasn't specifically brought up as a consideration. But

there was, I think, an important focus on thinking about going beyond the screening, to actually look at sort of the implementation of coordinated care models.

DR. PATTON: Yes. And Harold, I was just going to say, when we had that original discussion this morning, that was the one I raised as a potential add to the set. So --

OPERATOR: And there are no further comments at this time.

CHAIR PINCUS: Are there other public comments.

OPERATOR: There are no further comments at this time.

CHAIR PINCUS: Okay. So with regard to the last public comment, does anybody want to formally make a motion to consider adding the --

DR. BURSTIN: 0711.

CHAIR PINCUS: -- 0711?

DR. BURSTIN: Mm hmm.

CHAIR PINCUS: Depression remission at six months?

MS. MUKHERJEE: Is 0711 depression remission at six months? And the measure -- oh I'm sorry.

DR. BURSTIN: Maybe Miranda could pull it up on QPS and just display it, see if everybody could see it. Is it one we mentioned this morning, so it requires the collection of the PHQ-9, which, back to your point this morning, is the standardized tool.

And then it looks at two points in time, to see whether there has been a 50 percent improvement in the score or remission. I think the one they're suggesting is the 50 percent -- is the remission of the -- were they suggesting -- what is the one --

CHAIR PINCUS: Yes. Well there's --

DR. BURSTIN: -- or the other one?

CHAIR PINCUS: Junqing you -- I think you mentioned remission. Is there a reason why you specifically mentioned remission? Because some people have raised questions about it being remission or clinically significant improvement.

DR. LIU: Yes, I'm recommending the remission that's measured as the PHQ-9 score less than five. So what Harold mentioned is another measure that's a valid response. That's a 50 percent --

CHAIR PINCUS: Right.

DR. LIU: -- reduction. That's 0710. That's a different measure. So I'm recommending the remission measure, because I think that's the ultimate outcome measure that will be very important for this population, for us to strive for that.

CHAIR PINCUS: Yes. Although I do know that people at the last MAP meeting, there was concern expressed that that might drive -- that may not be sufficiently responsive to the patient perceptions and desires, because it might -- some people might be happy going from a score of 23, to a score of seven, and it would push clinicians to sort of add additional medications that might not be ideal, to get them below remission.

So the thought was that there are advantages for it to be clinically significant improvement, or remission.

So does anybody want to make a motion to add this to -- for us to consider and vote on recommending this to CMS?

CHAIR PINCUS: So nobody seems to be jumping at it. Rachel?

MEMBER LA CROIX: I have to admit I'm not overly familiar with this measure. But if you're only looking at folks who have the diagnosis -- which you could get through claims -- but you're also looking at whether they had a PHQ-9, would you need to do some kind of medical record review, or at least electronic health record review, to establish even your denominator for the measure?

PARTICIPANT: Just have to have a diagnosis --

MEMBER LA CROIX: and --

CHAIR PINCUS: And you have to have an initial indexed PHQ-9 score.

MEMBER LA CROIX: -- a PHQ-9 score.

DR. BURSTIN: Right right. I'm just saying, it has to be greater than those.

MEMBER LA CROIX: Yes.

CHAIR PINCUS: Yes. I --

DR. LIU: Yes. It was a required information from medical record, or electronic health record, because it requires you have a depression diagnosis, and an elevated PHQ-9 score for the denominator.

Then you look out for six months, to see if you achieve remission, meaning that your second PHQ-9 score is less than five. So that -- we recognize that's one of the challenge for outcome measures.

Oftentimes you need to have two data points, and you need the medical record data. But we have talked to states and the plans, and NCQA has implemented a remission measure at six months, and HEDIS for two years.

We actually also convened in a depression learning collaborative with plans and

providers who could use electronic health records registry, and the health plan case management data systems, to get information for the measure, so that they could leverage the health IT to report a measure efficiently.

So we received feedback that this is very important, and places are building the systems to report a measure using the electronic health records. It is recommended as a measure in HEDIS for using electronic data systems.

CHAIR PINCUS: Roanne?

MEMBER OSBORNE-GASKIN: So I guess my only issue with this type of measure would be the remission. So we're kind of moving depression from being a chronic disease. I think that's kind of how it will figure -- that's kind of how I'm seeing it from a clinician's perspective.

Because remission means that -- I don't want to say will give us a false sense of security, but so what do we -- we kind of, if somebody's been diagnosed with depression, we tend to leave that diagnosis there, just to kind

of keep us aware that even if they have improvement in symptoms, whether or not that is demonstrated by a reduction in the PHQ-9, that this person still may be at risk.

And so remission is kind of a term that the medical community may just have issues with dealing with a chronic disease. We don't necessarily talk about remission with, like say diabetes or heart failure, or something like that.

So that's kind of my only sort of -- I would prefer if we were going to have a measure, it would demonstrate some sort of reduction as an improvement in symptoms, but not necessarily remission of depression.

CHAIR PINCUS: Other comments. I think one of the issues, if -- my concern is that this may be a bridge too far as -- in terms of a state Medicaid program, in terms of being able to collect this data.

It may be something that could be aspirational as we move forward. And remember

that the Minnesota Community Measurement really put this together as kind of a basket of measures that included process -- both structural measures -- in terms of the capacity to collect this information -- as well as process measures, showing -- which -- I can't remember off the top of my head which NQF-endorsed measure it is.

But there's -- whether or not the -- but there's, number one is the short-term measure of having essentially a registry that allows you to collect this information.

Number two, a process measure indicating that there's the actual collection of data -- PHQ-9 data -- at 6 and 12 months.

And number three, outcomes, which include both -- Roanne -- both clinically significant improvement, which is basically 50 percent improvement in 6 or 12 months, or this measure of remission at 6 or 12 months.

So that's something that I think would be aspirational for states to develop that capacity. I think right now, it's -- I think few

states are there yet.

DR. BURSTIN: It's going to be worth further discussion with Jeff Schiff in Minnesota, to understand. I believe they are collecting it for the sake of being part of Minnesota. So it might be an interesting discussion --

CHAIR PINCUS: Yes, to see how they're doing it.

DR. BURSTIN: -- to find out where they are so far.

CHAIR PINCUS: Yes, so I think that's something that we may want to explore going forward, in terms of getting more information about what is the capacity of states to collect this kind of information and apply it. And it may be worth talking to people in Minnesota.

And I would also add probably in Washington State also. I know there's a number of Washington State programs that have been using this as well.

DR. BURSTIN: And it's now a part of the ACO program. So just -- this has now been

put into federal programs. It is now part of the ACO MSSP program. So there is now some federal experience as well with using it.

Again, more at a system level, and the question of how that then becomes the state level measure is an interesting one further to explore. But it sounds like there's interest overall in this concept of patient-reported outcomes. I think the question is, more so, how to make that happen at this level of analysis. Thank you for the suggestion.

DR. LIU: Sure. Thanks for the consideration.

CHAIR PINCUS: Okay. Next.

Okay, so we've now, we've elucidated, reorganized and prioritized the gaps. Now the question is, do people feel that any of the gaps that we've identified have been satisfied. Obviously not, because we just identified the gaps. So --

Number two, what do we think in terms of, are there particular areas that -- where

there's particularly promising opportunities going forward for filling those gaps?

MEMBER LA CROIX: For the HCBS -- the long-term services and supports measures -- I know federal CMS has been working with Mathematica, and put out some measures for public comment in August 2016. So I assume those are coming at some point in the near future.

CHAIR PINCUS: Marsha, is that something that's come out of your --

DR. SMITH: Pardon?

CHAIR PINCUS: That sound like that's to come out of your shop? Or your shop, Karen?

DR. MATSUOKA: It's a combination of -- there's actually a lot of great work happening in this space because I think there's been a longstanding recognition of just having no good measures really, for some of this stuff.

So it's coming out of both IAP -- the Innovation Accelerator Program -- as well as the -- there's a little working group that's come together with the Waiver Group, the Disabled and

Elderly Health Programs Group, and then our division of quality, to think through an LTSS measurement as well.

So actually, this would be really -- it would be helpful, this exercise, to start to differentiate between -- are we talking about gaps in our current core set, gaps in the availability of measures at all?

And then, thinking through also, what is -- if it's an aspirational gap that we want to start to think to fill, that would be good to know, because I think if we have a good critical mass of states who agree that those are key gap areas, then we can start to put some concerted effort into thinking through how to fill them.

So I want to differentiate between gaps for our current year-over-year core set recommendations, and then I want to welcome you all to put on the table some aspirational kinds of measures like these that we can think through, more than just, a year ahead.

CHAIR PINCUS: Another -- Clarke?

MEMBER ROSS: The Administration on Community Living has funded a five-university collaborative -- it's led by the University of Minnesota -- to look at every measure in existence, or the published literature on home- and community-based service measures.

And so ACL and the National Institute on Disability, Independent Living and Rehabilitation Research, are the co-funders. And we had a presentation at the March workgroup on persons dually eligible on the project itself, so there's a slide deck -- I've got a paper copy with me -- but we could post the slide deck on the shared PowerPoint site for this group, and then any of you could go and see who the lead researchers are, and contact points, and what they're looking at, and that sort of thing.

CHAIR PINCUS: Deborah?

MEMBER KILSTEIN: Maybe Clarke could talk about this a little bit too, but measures of frailty and -- is that something that should be addressed in the -- our core measure set?

CHAIR PINCUS: Say a little bit more about -- when you say measures of frailty.

MEMBER KILSTEIN: Well, or measures of improvement. I mean when you're talking about home- and community-based services, measures of improvement in terms of functional status.

MEMBER ROSS: So the World Health Organization is the lead in the world on functional outcomes in people with disabilities. And we're like decade- -- we as a country are like decades behind the World Health Organization in doing this.

And because it's the World Health Organization, a lot of prominent policymakers don't want to learn because it's the world, and we're the United States.

Gloria Krahn, who was the deputy director at CDC's National Center on Birth Defects and Developmental Disabilities, is at the University of Oregon, and she's published some work on how to measure function, and then translate it into some kind of standardized

quality measurement.

It's infant work, and what she's trying to do is use the World Health Organization work and -- but diminish the reference, because there's just this bias against what other countries and other entities are doing.

But it's a major gap in the entire disability world.

CHAIR PINCUS: Other comments or thoughts about what gap areas where there may be some near-term -- Lisa, I was wondering in terms of the behavioral health area, whether you have some thoughts.

DR. PATTON: Well, we are -- we're currently working on some measures around suicide, suicide prevention, and as I mentioned earlier, we are working on getting the screening of brief intervention for alcohol, and that just was recently -- well, will be moving into HEDIS.

So we're very interested in the opioid measures and gaps in that area -- polypharm in particular -- and so we're very pleased to see

the combination of the opioid and the benzo measure put forth today.

So we are obviously extremely interested in outcome measures, and like most of you, a bit frustrated by where we are with those, and how we might get to a better place.

And also patient experience of care is another priority area for us. But most of these have been addressed today. I don't think -- yes, I was trying to think if there were any kind of outliers that we hadn't discussed today, but I think we've covered the terrain. Yes.

CHAIR PINCUS: Yes, I would add to that, that no, we've had a -- my group at Columbia has had a grant from the Commonwealth Fund in which we've developed a series of papers coming out around sort of behavioral health, sort of measures at the interface between behavioral health and general healthcare. That'll be coming out, and we're talking with Commonwealth about it. Sort of a follow-up in terms of implementing that in the context of value-based payment

models.

Other areas where there are people aware of potential gap areas that are -- where there's some stuff going on that might be helpful?

So I think we've already asked about additional gap areas, and I think we've already done a kind of a prioritization process. So I think we've pretty much filled in the issues around the gaps that we can sort of lay out more.

But I also realized when I made my list, I had left out beneficiary reported outcome. Yes, so that just --

PARTICIPANT: That was in the study.

CHAIR PINCUS: Okay. Ah. Okay. Good. Okay, now we have a final opportunity for public comments. No. Oh, we already did it. Okay. Oh, now we adjourn for the day.

Any last -- Clarke?

MEMBER ROSS: Just a suggestion for a crosswalk. April 2017, the MAP -- the National Quality Forum MAP -- sent its report -- annual

report -- to CMS, and identified six high-value measure areas that aren't adequately addressed. It might be nice to crosswalk what the MAP already sent to CMS and what we've fooled around with today, and see where the overlap and consistency are, and where the inconsistency might be.

CHAIR PINCUS: Great. Well I want to thank the terrific NQF staff, which is always really incredibly systematic in its approach, and really very helpful in terms of setting this on course. Tomorrow we'll be meeting with the Child Task Force, and so we'll be going over areas of mutual interest.

We'll be going over some stuff that we've done a little bit today, but also some new stuff tomorrow. So we look forward to seeing you all tomorrow.

(Whereupon the above-entitled matter went off the record at 4:04 p.m.)

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C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Measure Application Partnership
Medicaid Adult Task Force

Before: NQF

Date: 05-23-17

Place: Washington, DC

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Neal R. Gross

Court Reporter