NATIONAL QUALITY FORUM

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MEASURE APPLICATION PARTNERSHIP
MEDICAID ADULT TASK FORCE

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TUESDAY
MAY 24, 2016

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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
GEORGE ANDREWS, MD, MBA, CPE, FACP, FACC, FCCP, Humana, Inc.
DIANE CALMUS, JD, National Rural Health Association
KATHLEEN DUNN, RN, MPH, NH Department of Health and Human Services*
SUE KENDIG, JD, MSN, WHNP-BC, FAANP, American Association of Nurse Practitioners
CYNTHIA PELLEGRINI, March of Dimes

GRANT PICARILLO, America's Health Insurance Plans

MARISSA SCHLAIFER, RPh, MS, CVS Health

MICHAEL SHA, MD, FACP, Indiana University School of Medicine

SUBJECT MATTER EXPERTS PRESENT:

KIM ELLIOTT, PhD, Health Services Advisory Group
ANN MARIE SULLIVAN, MD, New York State Office of Mental Health

FEDERAL GOVERNMENT MEMBERS PRESENT (NON-VOTING):

DAVID HUNT, Office of the National Coordinator for Health Information Technology
LISA PATTON, PhD, Substance Abuse and Mental Health Services Administration

NQF STAFF:

MARCIA WILSON, PhD, MBA, Senior Vice President, Quality Management
SHACONNA GORHAM, MS, PMP, Senior Project Manager
DEBJANI MUKHERJEE, MPH, Senior Director
YETUNDE ALEXANDRA OGUNGBEMI, Project Analyst

ALSO PRESENT:

CHARLES GALLIA, PhD, Oregon Health Authority
MARSHA LILLIE-BLANTON, DrPH, Centers for Medicaid and Medicare Services
JUNQING LIU, PhD, MSW, National Committee for Quality Assurance
JULIA LOGAN, MD, PhD, California Department of Health Care Services
KAREN MATSUOKA, PhD, Centers for Medicaid and Medicare Services
GIGI RANEY, LCSW, Centers for Medicare and Medicaid

*** present by teleconference**

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Adjourn

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

9:03 a.m.

CHAIR PINCUS: So why don't we get started. Everybody's gotten their coffee. I'm Harold Pincus. I'm Professor and Vice Chair of Psychiatry at Columbia University Department of Psychiatry and also Director of Quality and Outcomes Research at New York Presbyterian Hospital, and I wanted to welcome everybody to the Adult Medicaid Task Force.

We have a fairly ambitious agenda, and we're going to sort of get right into it. Why don't we start off by doing introductions? So Shaconna, do we want to introduce the NQF staff that are going to be participating?

MS. GORHAM: Hi, my name is Shaconna Gorham and I'm the Senior Project Manager for the Medicaid Adult and Child Task Forces.

MS. MUKHERJEE: Hi, I'm Debjani Mukherjee. I'm the Senior Director for the Medicaid Adult and Child Task Force.

DR. WILSON: Hi, I'm Marcia Wilson.

I'm Senior Vice President for Quality Measurement, and are you ready for me to do the disclosures and the introductions of the rest of the -- or do you have any other remarks, Harold?

CHAIR PINCUS: No. I think, just as I mentioned, we have an ambitious agenda. We had, I think, a very good call in April where we went over some of the preliminary issues that we wanted people to do some homework beforehand in terms of thinking about some of the issues that we talked about that are sort of broader policy issues, including issues around alignment gaps, and also for people to identify potential measures that are potential candidates to be added to the Adult Core Set. And we had a number of people making suggestions and were pleased with that.

And so that's really it. Marsha, do you want to introduce yourself, also?

DR. WILSON: Microphone, please.

DR. LILLIE-BLANTON: I'm Marsha Lillie-Blanton, and I am Senior Advisor -- Senior

Policy Advisor with CMS now. Some of you may know me from my prior life where I served as the Director of the Division of Quality and Health Outcomes and the Chief Quality Officer.

Karen Matsuoka is coming. She's on the train trying to get here. So she is our new Chief Quality Officer.

I still have other roles. I'm largely working with our nationwide CAHPS survey data, as well as with the Medicaid Managed Care rollout. But I'll continue to support Karen and be a part of this effort to the extent I can.

So I want to thank all of you for joining us. I want to welcome you to today's meeting. And, you know, I'm looking forward to the discussion. Your input has been vital to our work, and we very much appreciate the guidance and direction you all provide to us.

CHAIR PINCUS: Great.

DR. LILLIE-BLANTON: Oh, can I say one more thing?

CHAIR PINCUS: Sure.

DR. LILLIE-BLANTON: I'm not sure -- we have an opportunity to introduce people? Okay.

MS. MUKHERJEE: And I was just going to say we also have some other CMS colleagues in the room, and we wanted them to have an opportunity to introduce themselves.

DR. FOX: Good morning. I'm Renee Fox. I'm the Medical and Health Policy Advisor for the Division of Quality and Health Outcomes, and I'm a pediatrician. I joined in September, and I'm the staff person primarily on this endeavor.

MS. RANEY: Good morning. I'm Gigi Raney, and I'm a Health Insurance Specialist and I was a Project Officer on the Adult Quality Grants.

MS. THOMAS: Hi, good morning. I'm Megan Thomas. I'm a Technical Director in the Division of Quality and Health Outcomes, and I'm the team lead for performance measurement work.

MS. PERAULT: I'm Kimberly Perault. I'm a Social Science Researcher within the

Division of Quality and Health Outcomes.

MS. CHAN: Hi, good morning. My name is Sophia Chan. I work on the IDIQ with NQF, and I'm also a Research Analyst working on quality improvement in payment programs.

DR. WILSON: Great, thank you, everyone. And now we'll turn back to the Committee. Again, my name is Marcia Wilson, and we're going to combine the Committee introductions with a few remaining disclosures. I think most of you did a disclosure of interest when you had your webinar, but there's a couple of people that still need to do their disclosure today.

So I'll read briefly the disclosure script for their benefit. I think you've heard this before, which is we're going to combine the introductions and the disclosures. The disclosures are actually from organizational representatives, and you do come representing your organization and those interests. And the only thing that you need to disclose is if you

have an interest of $10,000 or more in an entity that is related to the work of this Committee.

So let's go ahead and do our introductions, and, if you did not have a chance to disclose on the webinar, I'll ask you to do so today. And I think we have -- do we have one Committee person on the phone who's joined us? So we'll go around the room first, and then we'll turn to the person on the phone. And, Harold, if you'd like to start with the introductions.

CHAIR PINCUS: So, well, I introduced myself. I'm from Columbia. I don't have any additional disclosures since April.

DR. WILSON: Great, thank you. And, Marissa, if -- and we might ask you -- and I will tell you this is a little bit we're covering this housekeeping. You'll hear this all day long. Microphones, push the button on the -- you should get a red circle. Only three mikes can be on. The tendency is to leave the mike back here and sit back in your chair. You can move the mikes, and, because we do a transcript and a recording

and we do have people on the phone, we encourage you to speak out, use your outside voice and use the microphones.

So Marissa?

MEMBER SCHLAIFER: Hi, I'm Marissa Schlaifer. I represent the Academy of Managed Care Pharmacy but am employed by CVS Health, and I have nothing to disclose.

MEMBER PICARILLO: Good morning, everybody. I'm Grant Picarillo, representing America's Health Insurance Plan, sitting in for Aparna Higgins today. I have nothing further to disclose.

DR. WILSON: Thank you. And at the end of this table?

DR. SULLIVAN: Ann Sullivan, Commission of New York State Office of Mental Health. I'm here as a mental health expert.

MEMBER SHA: Michael Sha representing the American College of Physicians. I'm an internist geriatrician at Indiana University, Indianapolis VA.

DR. ELLIOT: Kim Elliot, and I have nothing to disclose. I work for Health Services Advisory Group, an external quality review organization working with Medicaid programs. And prior to that, I worked for about 15 years for the Medicaid program in Arizona.

MEMBER ANDREWS: Good morning. George Andrews. I'm a cardiologist, and I represent Humana. I'm Humana's Corporate Chief of Quality, and I have nothing to disclose.

MEMBER PELLEGRINI: Good morning. I'm Cindy Pellegrini. I'm with the March of Dimes, and I have no further disclosures.

DR. LOGAN: Good morning. My name is Julia Logan. I am not on a task force. I'll be presenting on behalf of the California Department of Healthcare Services.

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

DR. WILSON: Thank you. And I think that is all for the disclosures, except for we

have one Committee person on the phone. Could you please introduce yourself and let us know which organization you're with? Kathleen, are you on the phone?

OPERATOR: Kathleen has not joined yet.

DR. WILSON: Okay, thank you, operator. And so we'll have Kathleen make an introduction just as soon as she joins us by phone. Thank you so much. And, Debjani, back to you.

MS. MUKHERJEE: Thank you. I'm just going to go over a quick few housekeeping items. Please keep your cell phones on vibrate or silent. We know you're very busy and you have obligations. If you do need to take a call, you can take it in the area where you checked in. There's some chairs out there.

Please use your tent cards if you want to speak. Also, microphones, please turn on your microphone and make sure the microphone is red or we'll replace your microphone. We do get

transcripts and recordings, and we use that to accurately reflect the deliberations of the Committee when we write the report, so that's very important.

Throughout the day, we'll have public commenting periods. We'll go around the room first, then we'll ask the audience, then people on the phone, and, finally, we'll look at the web chat to see if anybody has commented using the web chat.

As you know, breakfast and lunch are provided for workgroup members and participating NQF staff. Members of the public are welcome to beverages, and we can help them find restaurants in the area.

We will be using voting tools throughout the day. When you vote, please point and click in the direction of the voting -- in Sheila's direction. Thank you.

And just as a reminder, organizational and subject matter experts are asked to vote and federal representatives are encouraged to

participate throughout the day in all our discussions but are requested to abstain from voting. And that is all the housekeeping. And any questions?

And the restrooms, very important, if you walk down where you came in past the elevators, it's the hallway to the right.

CHAIR PINCUS: So let's just go over a little bit of what we hope to get done today, and tomorrow for that matter. So one of the things we want to do is we want to hear from states about their experiences in participating in the reporting program for the Adult Core Set. And this is a very important component of the meeting today because we really want to see where there are problems, where there are issues, in terms of the ability to report, how states make use of the information, what areas they perceive as gaps in terms of their own priorities.

And then based on this information and some of the other information that NQF staff will be going over, we want to think about where are

the gaps and how might those gaps be filled in terms of considering other recommendations for either adding or deleting measures. And then think about then on a longer-term basis how we might inform CMS about strengthening the measure set, both in terms of the process of proceeding with adding measures but also in terms of thinking about issues such as alignment and other kind of overarching policy issues that might be considered. And, you know, we want people to feel completely free to, you know, bring up any issues that they want during the process.

Next slide. Yes, who controls the slides? Well, anyway, you know, basically, the next slide talks about the overall charge, which actually conforms very closely to what we just said our meeting objectives are. You know, as I said before, the kind of things that -- the overall charge to our task force, you know, for those of you that are newly participating, is that we're supposed to be reviewing states' experiences to refine the measure gaps that we

have identified before based upon what we've learned about states' experiences and also the sort of evolution of measure development over time, as well as the needs of the Medicaid program as a whole, to consider what might be done going forward and to actually give specific recommendations for which we'll be voting with regard to removal of measures from the set, as well as the addition of measures.

And as many of you know, the members of the task force represent a broad array of stakeholders in the process, as well as specific sources of expertise on particular areas that are relevant to the Medicaid program.

Next slide, please. So this is a little bit about the time frame. So today is just us, the Adult Task Force. Tomorrow we'll be joined with members of the Child Task Force, and Foster Gesten and I will be co-chairing that. And then on Thursday is going to be a meeting of the Child Task Force. And tomorrow we're going to be talking about both general policy issues

but also issues that kind of cross both adult and child, particularly maternal and child health kinds of issues.

This also gives a picture of the time frame in terms of how we operate. So once we finish our meetings, staff will put together a report and we'll have an opportunity to review that report. And then that needs to be submitted by August in a final version. And then CMS will review that report and make their decision -- because they don't have to do what we say -- and will make their decisions and put that out by the end of the year.

Okay. Next slide. So just to say a little bit about, I thought we had a very productive meeting by phone. And what we did at the last meeting by phone in August was we sort of went through what's the latest version of the Adult and Child Core Sets, looked at what had been suggested before in terms of gap areas. And we also wanted to inform our discussions by looking at what else is going on sort of in the

quality measure field, in particular pointing out the recent report from the Institute -- now the National Academy of Medicine, their report called Vital Signs, in which they tried to get at the issue that I think has been plaguing many people in the field around the tremendous proliferation of measures and how do we try to get at the most important and parsimonious set of measures that can be most useful and instructive without spending, you know, as much money doing the measurement as doing the care.

And so that's part of what we wanted to do is to get at really key areas and to think about how we harmonize measures so that there's not a lot of duplication of effort in gathering the data and also align them so that there's some clear understanding of like why things are done -- are measured for which purposes. So we aligned the measurement with the purposes and the use of the measures.

And we also get into some discussions around how we define alignment and what we mean

by alignment. It doesn't necessarily mean that we use the same measure in every program, but it means that there's some rationale for the selection of measures. And all things being equal, if we're trying to measure the same concept, to do it in the same way.

And then we discuss some of the sort of operational road blocks in trying to achieve alignment, some of the little bitty details that sometimes bedevil us in terms of being able to use similar concepts in similar settings -- in different settings.

So, Shaconna, you're going to go over some of the key points. So in the interim, since April, staff have gone over the current Core Set, looked at measures that have been placed, that have come up for endorsement as part of the NQF Consensus Development Process, looked at some of the gaps that have been previously identified, and have begun to think about and make suggestions around how we might consider some refinement of the Core Set.

MS. GORHAM: Thank you, Harold. So just as an overview -- you can go to the next slide, please, Alexandra -- just to reiterate CMS's three-part goal for the Adult Core Set, one is to increase the number of states reporting Core Set measures. Two, increase the number of measures reported by each state; and, three, increase number of states using Core Set measures to drive quality improvement.

Next slide, please. CMS uses the Core Set data to obtain a snapshot of the quality across Medicaid. The Core Set data are presented in several populations, including the annual adult health quality reports, the annual child health quality reports, the chart pack and other analysis. Lastly, the Core Set data is used to inform policy and program decisions.

The Medicaid adult population -- as we went over in the April web meeting and that you're very familiar with, I won't go over all of these bullets -- but just to say that Medicaid provides coverage for approximately 44 million

adults, and two out of three adult women on Medicaid are in their reproductive years.

Next slide. So in the 20 states that have not expanded Medicaid, eligibility levels are 42 percent for parents and zero for other adults, leaving many poor adults in a coverage gap since they earn too much to qualify for Medicaid but not enough for tax credit subsidies to purchase marketplace coverage, which begins at 100 percent. And our sources are located at the bottom of the screen, but -- although they're like really small, you can't really see that.

But next slide, please. So ACA required the Secretary of Health and Human Services to establish an adult healthcare quality measurement program to standardize the measurement of healthcare quality across state Medicaid programs and facilitate the use of the measures for quality improvement. This year will be MAP's fourth set of annual recommendations to HHS, and, again, the states are voluntarily submitting data to CMS and they do so on an

annual basis.

Next slide. Before you you have the measures recommended in 2015. There were nine measures recommended to CMS in 2015, and they are listed on your screen.

Next slide. In front of you, you have the two measures that were actually added to the Core Set. So in 2016, the Adult Core Set was updated with the two measures that MAP recommended. One, Measure 1932, diabetes screening for people with schizophrenia or bipolar disorder who are using anti-psychotic medications. The other is the use of opioids with multiple providers or at high dosage in persons with cancer, opioid high dosage. That is not NQF endorsed; however, that measure will be submitted to a project coming up soon. So these updates correspond well to MAP's suggested course of action.

CHAIR PINCUS: Shaconna, could you go back one just to see which ones weren't added.

MS. GORHAM: So the contraceptive

measures -- there were two contraceptive measures, and those were not added. There were two other opioid measures that were not added. The medication management for people with asthma was not added, and then there was one more. The cardiovascular health screening for people with schizophrenia or bipolar disorder was not added and the controlling high blood pressure for people with serious mental illness.

And so we knew that when we recommended nine measures that was a bit ambitious. CMS tends to make incremental changes to the Core Sets to kind of reduce the burden for the states, so two measures, historically, have been about how many they add, if they add any.

CHAIR PINCUS: And it's worth pointing out that there's -- oh.

MEMBER SHA: And I think also just to clarify my understanding -- since I'm new to the task force -- I believe the last report recommended removing the timely transmission of records, but that was not -- that removal was not

implemented with the current measures. Is that correct?

DR. LILLIE-BLANTON: So, first, it probably would be helpful to let you know the process we used as we reviewed the recommendations. We actually got input from multiple stakeholders. We got input from stakeholders within CMS, we got input from our Quality Technical Advisory Group, and we also got input from our Adult Quality Grantees. So across that different spectrum of stakeholders, we tried to assess their view of changes in the recommendations.

In terms of the transmission -- the timely transmission, we are sensitive to the fact and we're sensitive to the fact that very few states can report on that measure. But there were several factors that weighed into our decision not to retire it at this point. It doesn't mean that at some point we won't, particularly if you all choose to make that recommendation to us again. But the factors that

we considered were the fact that, one, it is now a part of the Inpatient Psychiatric Reporting Program for Medicare, so it is a required measure for Medicare reporting just for inpatient psych patients. And though I'm not as familiar with all the details, I think there will be some financial incentives or at least some payment penalties ultimately. I think the first couple of years -- it's a new measure, but the first couple of years it's just kind of a reporting requirement and then, ultimately, it will be subject to some penalties if it's not reported. So in the spirit of alignment and because there is some recognition in the Medicare program of the importance of that measure, we thought it would be premature for us to retire it at this point.

The other factor that weighed heavily was we heard at least from two states -- we heard from one state that had lots of problems with it but two states which were actively, actively working, and I can tell you -- I'm willing to say

the two states. It was Pennsylvania and Georgia who felt that they were very close to reporting on that measure. So they are both Adult Quality Grantees, so they are states that had some financial resources to support trying to collect and report that data. And we do know that states that don't have that infrastructure or resources are challenged.

But we heard from those states that they thought it was important. But we also heard -- there was at least one other state, Washington, that felt very strongly that this was a problem measure. So we were trying to balance what we knew was going into the reporting program for Medicare with what we heard from our states and decided not to retire it, though we are still seriously looking at this measure. I mean, for us to have -- you know, we know the measure has value and is important in terms of continuity of care, in terms of information and transition from one care setting to another. Oh, and one more thing that we know is happening is that our

Medicare rule, which has added requirements for care coordination. And one of it is trying to make sure that there is better care coordination from different settings of care, whether it's from a managed care organization to a hospital or a hospital to a skilled nursing facility or other long-term care facility. So we thought that, between all those different avenues trying to improve care coordination, and that being our only measure currently in the data set -- though we do think there are other measures in the data set that kind of help us understand care coordination, so that's something else I think this body can help us with. But we do know this measure is problematic, and there was a lot of discussion last time about this measure and I presume there will be discussion this time again.

So I just wanted to give you that history so you understand why we didn't retire it. I think the others are pretty obvious, so, I mean, if you want more information I can give you but that's the only one I think --

CHAIR PINCUS: Well, I think one of the things that came up is just that it's -- you know, it's not a claims-based measure, it's difficult to collect the data in a systematic and consistent way, so that was one of the reasons it came up in the discussion we had last time.

The other thing that's worth pointing out is that, you know, sometimes we will make recommendations of several measures within a kind of particular domain, and it's understandable that not all of them will be picked up, that CMS has to be quite selective, you know, in terms of the burden of reporting and so forth. So that, you know, choosing one -- for example, one of the sort of segmentation measures of looking at the care of chronic diseases in the severely mentally ill population, there were several of them that were there and they chose one, and there were several measures for opioid use and they chose one.

DR. LILLIE-BLANTON: Right.

MS. GORHAM: Okay. So we went over

the two measures that were added there. The addition of these two measures allows CMS and states to expand the measurement of quality of care and Medicaid for two population groups: adults with substance use disorders and/or mental health disorders.

Next slide. So before you you have the 2016 Core Set measures.

DR. SULLIVAN: Question. What happens with the recommendation, the list of recommendations that CMS doesn't pick up? Do they kind of -- do they have to be re-recommended or do they stay somewhere? I'm just curious. When they took two out of the ones we recommended. What happens with the others in terms of CMS's view?

DR. LILLIE-BLANTON: I can tell you the past is that -- well, this has only happened two years, right? So, for the past two years. I think what would be advisable, if MAP feels we need to reconsider a past recommendation, is that you would need to re-make that recommendation. I

mean, I think the climate changes, the issues change, the clinical evidence changes -- so our pattern has not been to reach back to, let's say, the first year's set of recommendations and look at them. So it's not as if we keep a whole set of recommendations in a store and kind of go back and pick them up and look at them again. So I think our --

MS. GORHAM: And so from NQF's perspective, what we've done -- we're doing voting a little different this year. We've upgraded. So last year we raised our hands when we wanted to vote. This year we actually have electronic voting. And what we've done, you all will discuss measures that were recommended either by task force members or staff picked, but we've also given you the options, we've listed the recommendations from last year that were not picked up, and so you all can place a motion if you want to vote on those again.

So you have the -- this is the updated Core Set for 2016 and it includes the measures

that were added to the Core Set by CMS. And you will see those measures, they have an asterisk on them. Alexandra, can you advance the slide? Yes. So probably my old eyes can't see, but there are two measures up there, one at the bottom and there's one midway. Thank you.

Next slide. Okay. So what we did was kind of look at the 2014 reporting to give you an overview of just what the states did, the uptake for the states. And CMS provided us with one pagers, as well as snapshots. The snapshots were provided for those states who've reported 26 measures or more. And the one pagers were one pagers with information for measures that did not receive at least 26 states reporting on that measure. And they allowed us to see the states' uptake, kind of the patterns for technical assistance where the states asked for assistance, and so forth.

Next slide. Okay. So there is room for improvement, but, overall, the Adult Core Set participation is strong. You'll see over the

next couple of slides that the most frequently reported measures were focused on postpartum care visits, diabetes care management, women's preventive healthcare, and the detailed TA requests that came in from CMS.

And you also -- I know you all receive a slew of information and files from us, and so in that -- all of the files and information you sent -- was a handout with all of the TA requests and the states that asked for the request and so forth. Okay.

So this chart compares the number of states reporting in 2013 and 2014. The bold red line divides the measures that were reported on by 26 or more states. And, there, for the purposes for illustration, we kind of bucketed the measures in high, medium, and low, and you'll see that over the next couple of slides.

CHAIR PINCUS: Maybe say something about why the red line is there because there's --

MS. GORHAM: So the red line divides

the measures that were reported on by at least 26 states or more, and those are publicly-reported measures. Twenty-five or more. Thank you.

Okay. Next slide. So I have it on the slide correctly, that's good. So those with at least 25 states reporting are the ten measures that are listed on this slide.

And just to draw your attention to four of the measures that showed the most growth, at least six or more states reported these measures in 2014 than in 2013. And that would be the Adult Body Mass Index. Ten more states reported it in 2014 than in 2013. The chlamydia screening for women, seven more states reported it in 2014. The initiation and engagement of alcohol and other drug dependencies, seven more states reported it in 2014 versus 2013. And then the antidepressant medication management, six more states reported that measure in 2014 than in 2013.

Next slide. This chart represents measures with 12 to 24 states reporting. The

number of states reporting these measures increased or held steady from 2013 to 2014 with the exception of PC-01. The number of states reporting PC-01 decreased from 13 states in 2013 to 11 states in 2014.

Next slide. So the measures showed on this slide had the least amount of uptake and the fewest states reporting. HIV viral load suppression, it's important to note that this measure was collected for the first time in FY 2014. The PC-03, five fewer states reported in 2014 compared to 2013. And the care transition, timely transmission of transition records, which Marsha just spoke on, remained the same. The screening for clinical depression and follow-up remained the same, as well.

Next slide. Okay. So, again, I spoke about the handout in your file deck, if you will. For the reasons given for technical assistance, measures with the most TA requests ranged from five to eight requests for various reasons. Reasons are included in the handout submitted, so

non-measure-specific requests were also high. The measures receiving the most TA requests are listed on the screen, but non-measure-specific requests included reasons such as reporting of age stratification, requests from CARTS templates, clarification on reporting period and population for inclusion in Core Set measures, questions about time line for release of Core Set specifications, reporting the deadline, and availability of public benchmarks. Again, they were -- all of these reasons and all of the measures with the states were in that handout that you received.

Next slide. Any questions?

MEMBER ANDREWS: I do have one question. The fact that a state is not reporting on certain measures, is that an indication of the fact that that measure has not been applied or acted upon or is it because of other reasons?

DR. LILLIE-BLANTON: So I would say that there are many reasons a state doesn't report on a measure, but it doesn't mean that the

state is not collecting that data and using it internally. It just could be that it's using it for one care delivery setting, so it could be it's using it only in its managed care setting. But it is conceivable that if a state is not reporting the data that they are not collecting it, particularly measures which are hybrid measures. We find that those are measures that -- you know, measures that require medical record review are really problematic for states. And so if they're not a primarily managed care state and they have access to an entity to help them with the medical records review, they often will not collect and report on that data.

So I think there are various reasons, but I just don't think we'd want to assume that it's not being collected and reported on. And I don't know, we have a few states here, too, so I don't know if any of the states want to add to that, either California or Oregon or --

DR. LOGAN: Yes. So Marsha is exactly right. There are so many different reasons why

states don't report. A lot of times it's capacity. You know, obtaining the measures and running the measures takes a lot of time and manpower, and we just don't have the capacity to run all the measures. As Marsha said, we're not able to get into the chart review process, so for those measures that include fee-for-service and managed care populations, we can't do that.

Another reason would probably be because the data is not available in our data warehouse, it's available in the Department of Public Health or some other data repository that we don't have access to.

MEMBER ANDREWS: I do have another question. I'm sorry.

CHAIR PINCUS: Let's hear from Oregon.

DR. GALLIA: Oh, yes. So my name is Charles Gallia, and I'm from Oregon. And I'm actually going to spend some time talking about some of the reasons for -- from not just Oregon's perspective but from Alaska and West Virginia. And I'll provide some detailed explanations about

what precipitates reporting or not.

CHAIR PINCUS: George?

MEMBER ANDREWS: Yes. The other question I have relates to the added measure of diabetes for schizophrenia and bipolar disorder. And my question relates to the fact that we do have a problem in terms of care coordination between behavioral and medical. So for a state to be reporting on a measure that is very important, somebody has to do that diabetes evaluation.

And so my question is do we have an expectation as to whether behavioral or medical is supposed to be doing that; and, if so, how is the information on the expectation related to the medical or the behavioral?

DR. MATSUOKA: Well, I think your question points to a very important issue, which is, you know, at a very high level, what is the purpose of these core measures and what are we trying to get out of it? I would just say, speaking for myself, you know, being somewhat new

still to CMS, one of the interesting things that I'm hoping to get out of the core measures is comparative information across states on these very kinds of issues.

So, for example, in our Health Homes Initiative, many states are looking at this very issue of behavioral health integration within primary care settings. So we know that many states are looking at the issue. They all might be measuring it in very different ways. They might be enacting the delivery reforms in many different ways, but I think the hope is that, over time, that activity will bubble up and roll up to improvement on a state level measure. Regardless -- you know, we can talk about whether it's behavioral health providers that should be reporting the measure or the primary care provider reporting the measure, but, either way, over time we should see improvement on that measure. And I think the hope is that we can start to see, comparatively, which states are doing better than others and then dive deeper

into what it is that the states that are doing well are doing and then start to spread those lessons learned.

And so I think it points to and it gets back to a very high-level issue, which I think we should all try to keep in mind as we're thinking about measures and voting on measures for the next year is, you know, how are these measures actually being used? What does it mean by it's the states that are really the life blood of this program? It's a voluntary program. It takes a lot of effort and resources for them to report the measures. How do we make sure that the measures that we're selecting really tie back into the very important initiatives, the many of them that are already happening at the state level, and how do we make sure that the measures that we select help us to help them with quality improvement for those initiatives?

So I don't know that that necessarily directly addresses your question. It's just all of which to say you're raising very important

issues that I think we should all just keep in mind as the day progresses.

CHAIR PINCUS: Cindy, is this on this issue or a different one? Okay. Because I want to make a comment on it after you.

MEMBER PELLEGRINI: Sure. So I'm hoping that perhaps our colleagues from the states who are here, our guests -- thank you for being here -- can talk a little bit in your presentations about this idea of claims data versus other types of data and how do we, over time, move away from using claims data which is really the most basic, the most fundamental, the least granular kind of data.

About three weeks ago, I participated in the perinatal measures panel meeting here and what we saw on a number of things -- first of all, you see that a lot of the perinatal measures are the ones least reported because they are most challenging. Or you end up with measures like postpartum visit or prenatal care visits, which actually don't tell you anything about the

quality of care, they only tell you about the quantity of care and the fact that an opportunity was presented for delivering quality care but you don't know if it actually happened. And we're never going to get that kind of granular data about what kinds of issues, for example, were covered in a preventive care visit from claims data.

So what do we need to do, what do we need to do to help the states and other users move in the direction of being able to use EHRs or somehow making chart review more efficient or easier or less expensive?

CHAIR PINCUS: I think what people are talking about are some of the limitations in process measures and most of which is derived from claims, which give you some information about, as you said, quantity of care. And even here, it's a little bit about quality, at least whether or not, for this important sub-population, there was, in fact, some kind of assessment of a critical potential side effect.

Whether something was done about that, once identified, is a whole other issue. And how that actually gets done in terms of who's responsible for it -- whether it's behavioral health or primary care -- is not specified in the measure, simply that it happened.

We actually have a grant from the Commonwealth Fund to develop an agenda for measurement at the interface of behavioral health and general medical care, and we're actually in the process of doing that. We've done -- we've, you know, published a couple of articles reviewing all the measures that are out there. We're in the process of convening a Delphi panel to come up with some recommendations about priorities in that area.

But I think it's one of the challenges is to come up with something that gets beyond process but still is not so ambitious in terms of the expectations of data availability that it just isn't going to get done. So that's one of the kind of sort of windows of ambitiousness to

kind of get in there.

I do want to say that one of the strategies, though, that we've looked at has been this whole sort of notion of segmentation or thinking of people with severe mental illness as kind of a disparities population. You know, they obviously have disparities in terms of outcomes. They die, you know, almost two decades sooner than people in the general population, oftentimes from a variety of a general medical co-morbidities. And in fact, actually, despite having severe mental illness, the direct healthcare costs are actually greater on the general healthcare side than they are on the behavioral healthcare side so that there's a lot of reasons to kind of look at this and to think about are there ways by which we can kind of segment that population and compare the performance on existing measures that are relevant to the general population. That's one thing that we're looking at, and this is an example of that.

But as you point out, it doesn't say how it actually gets done and who's responsible for it and what do they do about it once it's found. And I think that that's, you know, getting at other -- you know, getting at that, one of the measures that was suggested last time was for the same population segment to look at people with co-morbidities of severe mental illness and hypertension, looking at control of hypertension. Again, that's a more complicated thing because it requires that you actually have access to data about whether -- you know, whether people actually have, you know, a reduced blood pressure and, you know, how do you get that and how do you time it so that it's relevant to the assessment of change over time. So that adds to a much more complicated way of doing it.

As we move towards a more integrated data systems, in terms of electronic data systems, that may become something that can be done. But right now we're not there yet, certainly across all the states.

I had a question I just wanted to ask our colleagues from CMS. And just to clarify -- so for states that have both fee-for-service and managed care, are they expected to report a combined result or separate or one or the other? How does that work?

DR. LILLIE-BLANTON: They're asked to report combined data. Now, what we get from them varies. But, usually, in our tables -- the detailed tables in the report -- it will say whether or not the state did report a combined, whether they reported only for their managed care, whether they reported a combined rate. So we ask, but we get --

CHAIR PINCUS: Do they also provide information about the proportion of the population that's represented?

DR. LILLIE-BLANTON: It varies, but we certainly ask them to. And in our new system, one of the things we haven't talked about is that this year we transitioned to Macro, which is a new system for collecting and reporting --

collecting the data which has the capacity to provide -- or we ask additional detail from states and we ask it with specific questions. So we are now specifically asking in the report that comes out next year, we will have information on the proportion of the population that they reported on for that measure. But still, in the past, in some cases we got that information because we would ask, but, you know, if it wasn't a specific question sometimes you wouldn't get that information, a state wouldn't respond to that question.

CHAIR PINCUS: Other questions? Oh, Ann?

DR. SULLIVAN: Just to echo what you were saying, Harold, I think that the value of this kind of measure in terms of when you look at it, if you do have a low rate of this for schizophrenia, then whose responsibility is it? And that forces your system to kind of start thinking about whether or not behavioral health should be following it or primary care and how do

they work together, and I think that's one of the beauties of some of these measures is they push down into the way your systems are actually designed to do things.

And I think the other beauty of it is it can point out the disparity, which is I think what you said, that this could -- you could do a broad measure on diabetes and you'd look pretty good because you wouldn't be capturing that small group of some of the disparities, one of which could be schizophrenia. So that's why it's important, I think, to push these up so that you can see it because, you know, you could look very good but not be touching this population really at all very much.

So I think it's a very valuable measure, but it does point out the weaknesses, I think, in a big way, in our systems. And that's one of the values of these kinds of measures.

CHAIR PINCUS: Other questions? So, Karen, you're going to be presenting from CMS's point of view?

DR. MATSUOKA: Sure. So really -- and I apologize for my delay. I had some transportation issues this morning. And really, you know, you're going to get a much more --

CHAIR PINCUS: That seems to be the norm in Washington nowadays.

DR. MATSUOKA: Is it? Okay. You're going to get a much more full-blown CMS update. There's a lot of activity underway, as you all know. And you're going to get that full-blown update tomorrow when we have the Adult and the Child Task Forces together.

So I'm just going to have a very abbreviated update today for this particular session because I wanted to flag a couple of things that I think might be pertinent for you or that we would hope that you take into consideration as you're voting on measures for the Adult Core Set for this year.

So we've touched a little bit already on the resource and capacity issues at the state level. We've talked a little bit about how this

is a voluntary program. Given where we are in the funding streams that have supported this program to date, that becomes all the more important this year moving forward.

As you all know, we had a $100 million investment through CHIPRA to support -- through the child's demonstration grants -- supporting states on developing infrastructure to be able to report the measures in the Child Core Set. We also had a $58 million investment over two years to states to help them report on the Adult Core Set measures. As of fiscal year '15, that funding has ended.

So I know that one of the things that we've asked you to consider all along has been the value of the measure given the burden of the measure it is to report from the state's point of view. This is just a quick update to let you know that, now more than ever, that becomes a much bigger consideration moving forward, given that a lot of this kind of comparative analysis is not possible if we don't have enough states

reporting on particular measures so that we can start to compare across at least 25 states. So just something to keep in mind as you're thinking ahead.

And I think also we've started to touch on this a little bit. You know, data infrastructure at the state level is always continually developing, and I think we are trying to keep that in mind as we think through what the best appropriate measures might be for our Core Set measures. But given the state of infrastructure as it is now -- and I think you're going to hear a lot more about the issue of alignment throughout the day -- I think thinking through that alignment piece is going to be very critical. But also not just in terms of not duplicating reporting burden for the states but also in thinking through this very question of what is it that we want these measures to do at the state level?

If they're not necessarily meant to replace what's happening at the clinic level, at

the plan level, with the Medicaid managed care rule, we're going to have a quality reporting system. And within the next few years, states will have a lot more information at the plan level for Medicaid managed care.

So we have the CMS core measures. So separate from the Medicaid core measures, there's the CCSQ core measures that have been developed in conjunction with AHIP and on the child side with AAP. If all of those are feeding into measurement at the provider level and then the Medicaid managed care rule is feeding into measurement at the plan level, what does that mean for what we want to know at the state level? Is it necessarily the same measures but rolled up to the state level, or is it something else to get to the kinds of things that Ann mentioned?

So just a couple of -- you know, given where we are in the landscape of things, funding considerations, new regulations, new programs that are being implemented all the time at the state level, what really is it that we want the

state-level measures to do. And how do we make sure that the ones that we pick are going to be the ones that have the biggest value add to our state partners and also at the federal level as we're trying to look across the states to provide quality improvement assistance.

So more to come tomorrow but, for today, those are just some of the considerations that we thought might be helpful as you're thinking through measures for next year.

CHAIR PINCUS: I think it's a really good point because one of the things we think about as we go through this day is, you know, to my mind, one of the prime criteria that we want to use -- at least what I think about when I vote about adding more measures -- is what is going to drive change? What will sort of push, you know, how -- sort of the whole fit-for-use, fit-for-purpose kind of thing, how does a measure sort of start a ball rolling that can actually result in improved outcomes in care, particularly for the Medicaid populations that are, you know,

generally so needy.

So that's the way at least I think about it. And even though it's not a perfect measure, if it sort of gets the ball rolling, sort of helps to identify where there's problems and the states can then look, okay, we're finding big variation here, let's try to understand what's going on for the high performers, what's going on with the low performers, how do we sort of make use of that information. To my mind, that can be of great value, you know, as an initial step. Thank you.

Any comments, questions?

DR. ELLIOT: When I think about it a lot from the Medicaid perspective -- I've probably been away too long -- but one of the challenges and I think something that really is an inhibitor, I guess, is that when we do everything by aggregator, by the state-level population, it's really --

CHAIR PINCUS: Speak up a little bit. Get a little bit closer.

DR. ELLIOT: -- it's really not focusing us on the sub-populations or the stratifications. And we're talking here a lot about behavioral health measures, and simple things like access to care for behavioral health -- and when I say access to care it's not necessarily to the physical health side, it's just as much to a behavioral health provider and how we measure that. And there aren't equal and related measures on the behavioral health side as there are on the physical health side, so I don't know that, even with the measure sets we're looking at today, we're getting to that level where it really is going to make a huge difference in the quality of care provided. When we're looking at access to care and including the behavioral health numbers into a PCP visit, that's wonderful, but if you're not getting access on the behavioral health side through a behavioral health professional you may still not see that quality improvement in care.

CHAIR PINCUS: I think you've

identified an important gap that we can talk about more, yes. In terms of access, you know, about a year ago, we published a paper in JAMA Psychiatry showing that 40 percent of psychiatrists nationwide take no insurance, and a majority do not accept Medicaid.

Diane?

MEMBER CALMUS: I just would kind of bring up two related issues. I think, you know, looking at how these measures align is really important, particularly as we move more towards the population health side of things and making sure that we're kind of looking forward and saying, as we move to a system that is more population health-based, are these the measures that we need to be looking at to kind of make that transition and not only help in reporting whether it's happening but also in helping realign the providers that are providing the care to say is this what we need to be looking at for population health.

And, similarly, I think aligning with

other systems that are trying to make that change is really important, so looking at what the ACOs are doing and how these can align with an ACO. So an ACO that's working with the Medicare population, can we utilize that same infrastructure that's already in place and make it very simple for them to say, you know, we also want to work with this managed care population as they move towards population health. And so really just making sure that we're not continually reinventing the wheel with all of the metrics and making it harder for those who are already kind of one step ahead on looking towards population health, to say we also want to work on this different population.

CHAIR PINCUS: Other comments, questions? What Debjani is going to be talking about is issues around the homework that all of you had and some of the broader sort of policy issues that we talked about earlier in April on the conference call and some of the work that's been done since then in terms of integrating that

information.

MS. MUKHERJEE: Thank you, Harold. So next slide, please. So where all this discussion started was we did some work around the IOM Vital Signs report and looking at some of the themes and then looking across our Core Sets, both adult and child. But today I'll speak to the adult, and then tomorrow I'll do a more in-depth presentation of these policy themes, and then we'll combine both adult and child themes together.

Some of the issues that resonated across not only the IOM report but our Core Sets was alignment coordination, community linkage. So they all kind of tie into each other without appropriate care coordination, you might not have alignment. And then once you do a community, especially for behavioral health, if you don't have community linkages of clinical services with supports in other community-related social service supports, you still won't get the outcome that you hope to.

Next slide, please. So we had done a SWOT analysis, and in the next slide I'll provide a quick overview of some of the strengths and weaknesses. Some of the strengths were that there were a lot of measures in the quality domain covering screening, immunization, diabetes, asthma, behavioral health, perinatal. And some of the weaknesses are things that we always hear: not enough outcome measures, not enough granularity of data.

Some opportunities, such as the meeting today, to revisit gaps and to talk about where we can go from here, also to look at some of the AHRQ CMS PQMP measures. And some of the threats are the usual suspects of burden, resource, data infrastructure, just the capacity to do all this work and bring it together.

Next slide, please. So some of the resonant themes were healthy people, engaged people, and patient and family-centered care, and that gets to some of the linkage issues across healthcare services and supports. Care

coordination was a big one. Access to care was something that we saw, as well as resource, data collection and reporting, having the infrastructure resource to do that, as well as measurement, alignment, and data burden, and how can we lower the data burden by aligning across different programs and things.

Next slide. So that gets us to one of our first big topics today: alignment. And when we're talking about alignment, we're talking about the concept of alignment; alignment of measurement, which necessarily does not mean aligning the exact measure; aligning across multiple programs; standardizing definitions so that you can align easily; and then aligning across different pairs also.

Next slide. So this is just a very quick recap of the definition of alignment, and this first one was taken from the MAP Coordinating Committee report. They defined it as same or related measures, and the goal is to reduce duplicative data collection, enhance

comparability and transparency of healthcare information. However, there is a caveat that when alignment is not possible and there's a compelling reason, multiple and/or similarly narrowly-focused measures should be allowed.

And next slide, please. The next definition is a more technical definition of alignment, but, at the same time, it talks about the use of similar standardized performance measures across and within public and private sector efforts. So it seems like the same words are used in every definition, except you don't know if they're talking about the concept, the exact measure across programs, points of implementation.

So we had some questions -- next slide, please. So we had some questions for homework, and they were around what do we mean by alignment, how do we operationalize the concept of alignment, is it the same concept being measured the same way, same concept being measured across different programs.

And next slide, please. Over the next couple of slides, what I will do is present some of the themes, and these were all collated from the responses that we received.

CHAIR PINCUS: Debjani, just one question. In an earlier slide, it said alignment is not the same as harmonization. Can you say something about the difference?

MS. MUKHERJEE: Sure. So one is a more conceptual concept, and the other is more specificity. So you can align conceptually and say we're both looking at HBA1C levels. But to harmonize means you have to have the same value ranges. It's like we always talk -- at least from my experience in the guideline world -- you could align easily conceptually saying I want to look at blood pressure control, but, then once you get to the harmonization, that's when nuances of the patient population, exclusions come in, the ranges become important as far as considerations go.

So I think they're terms that are used

frequently together, except there's that fine definition of how exactly are you implementing these measures. And I think, for our discussion today, alignment is what we're looking at, and the three things that the IOM report talked about was parsimony, alignment, and harmonization, so there were like three separate buckets. And for today, we picked up alignment and, hopefully, parsimony as part of the discussion, as well.

So some of the themes -- the way the responses themed out was benefits and challenges of alignment. Some of the alignment benefits was comparability across states, across pairs, just looking at the quality arena, simplifying reporting and reporting burden, lowering that, facilitating any kind of comparison, and also aligning across levels of measurement to make sure people are measuring what they think and they say they are measuring, as well as across programs and payment models. And especially if you're looking at a more population health perspective and you want to aggregate the data,

alignment becomes a bigger issue.

Some of the challenges were voluntary nature of reporting, aligning with commercial and private pairs, as well as innovation and variation. And that's something that no matter how much we want to prevent changes, if it's for innovation, if it's evidence-based then it's just necessary. And in some areas there's a lot of evidence and evidence evolution, and, because of that, there's a lot of variation, and that causes a challenge.

Next slide, please. So the next set of slides, couple of slides, talks about how to operationalize this concept of alignment. And, interestingly, mandate came up: measure mandate, methodology mandate, as a way to standardize how it's being implemented. Now, this was a wish list, and I'm just reporting what I saw, but I thought that was very interesting, given that it's a voluntary program.

Balancing goal of measurement and implementation flexibility. So at the same time

mandate was put forth, also the flexibility and having the flexibility to measure what is feasible and possible, given the resource, limitations was put forth.

Some of the temporal considerations, if you're looking across age ranges within a core set and/or if you're looking across the child through Adult Core Sets, that also gets to some of the care coordination issues. And then this example was given where comparability versus actual comparability. It's saying I'm measuring something yes/no versus I'm measuring and this is a range that I'm looking at, and that is an interesting fine distinction that might not be apparent when you're looking at data.

Next slide, please. And this is just one of --

CHAIR PINCUS: Let me just say the way I think about alignment and distinction from harmonization is that I think about alignment across programs. So basically that if a program is measuring something around a particular

domain, that it ought not -- unless there's a good reason, it ought to be doing it in the same way as another program. Whether it's Medicaid managed care or Medicaid fee-for-service or between Medicaid and Medicare, if the same concept is being approached in terms of performance in diabetes care, they ought to be measuring similar things so providers, payers, and so forth don't have to go through all kinds of gymnastics around trying to do something that's somewhat different.

On the other hand, there's a balance because the Medicare program may want to have more measures that address sort of elderly and frail people to be able to capture that. So it doesn't mean that every measure has to be used. It should be responsive to the population. But when they are looking at a similar concept, they ought to be doing it in a similar way.

Harmonization has to do with the harmonization, as you said, of the measure operationalization, that they're being

operationalized in the same way. But I think that that's an important point. There can be reasons why, for the Medicaid program, why there may be some areas where there may not be alignment because of our particular issues in Medicaid that need to be addressed in a particular way, and it may not be the same for a commercial program or for the Medicare program.

MS. MUKHERJEE: And at the end of the next couple of slides, we'll pause to get any other ideas and thoughts, anything that was missed or not submitted from the group here.

So one of the interesting quotes was measures are only as good as their design, and that gets to sort of the design issues that affect either operationalizing it, harmonizing it, aligning it across programs, whatever we're looking at. And some of the measure components that were addressed were exclusions, risk adjustment, the modeling used for risk adjustment, the transient nature of the Medicaid population, who's following it, who's falling

out, and how long are they in this program, resource issues, as well as data issues again.

And at this point, I was just going to pause to see if there are any others that were missed or should be added to this list for consideration. Okay. We'll also have some questions at the end.

Next slide, please. So the next set of questions got to the feasibility of data collection and maybe moving beyond claims data and what's feasible and what can be done as far as stratifying the data by different sub-populations.

Next slide, please. And we realize that claims data is rather basic and not as granular as sort of chart data, but one of the biggest themes was that claims data being the limit of feasibility, especially due to the voluntary nature of reporting, as well as some resource limitations. Also, alignment came up under feasibility and sort of the purpose of measurement, the comprehensiveness. Also as far

as alignment goes, full alignment versus partial alignment and maybe annotation of that, streamlining data acquisition and data collection. And analysis came up as something that would facilitate data collection and sort of make it more feasible, as well as identifying and developing outcomes measures, so including more outcomes and patient-reported outcomes in the data collection to get at more granularity of data.

Next slide, please. And some other themes that came up was the ability to track system and population-level health improvements and get data at the patient level but be able to make some assumptions about population-level improvements, interoperability of EHRs, EMRs, measure design and exclusions, and the quote was to simplify measure constructs, which is interesting given that we have more complex measures coming up, more composites and such. Survey data was another one, looking at functional status, HCVS-type surveys, patient-

reported outcomes.

Also, it was noted that we should try to maximize provider-reporting systems, such as MDS Nursing Home Compare, to get as much data as we can from them. And then, finally, for data stratification, the NQF SDS project trial period, to follow the data stratification results from that, was another suggestion.

Next slide, please. And there was a special section which was for factors influencing state participation in reporting, and some of the themes was clarity of measure specifications, the feasibility of data collection, and with that, it's also data completeness and sort of being able to follow the data longitudinally. The budgetary environment, the perceived importance of a measure, as well as the political will.

And at this point, we are pausing for just a little bit of discussion and sort of the question is which barriers of the ones mentioned can be reduced by HHS and/or this MAP through recommendations, and sort of what is the gestalt

of the thought of this group in means and ways to go about doing that.

CHAIR PINCUS: Comments, questions?

MEMBER DUNN: Good morning. This is Katie Dunn.

CHAIR PINCUS: Katie. Okay.

MEMBER DUNN: Yes, good morning. My apologies for my technical issues, but I'm all set now. To the question that was just asked around feasibility --

CHAIR PINCUS: Katie, can you also introduce yourself?

MEMBER DUNN: Oh, I'm sorry. Yes, of course. Good morning, everyone. My name is Katie Dunn. I am the Associate Commissioner and Medicaid Director for the State of New Hampshire. And for the purposes of this meeting, I'm representing the National Association of Medicaid Directors.

CHAIR PINCUS: Thanks. So your question?

MEMBER DUNN: And I'm sorry that I'm

not able to be with you all. It's a long story, but I'm happy to be with you at least through technology. What I was going to offer for a comment on the feasibility of data collection is that most of the Medicaid directors have found that, from a fee-for-service perspective, we seem to be able to do a better job at the data collections establishing the methodology, the population, the numerator, the denominator. So alignment, harmonization, isn't an issue.

Where we're running into trouble, though, is through the managed care organizations. There seems to be still this idea of one-size-fits-all and that Medicaid so far has not risen to the front of the pack in terms of who's driving how an MCO sets up their data collection systems and what they view as important versus what we view as important.

CHAIR PINCUS: Okay. George?

MEMBER ANDREWS: Yes. In reference to this slide, I was wondering to what degree, I don't know if we do know or don't know, to what

degree is a state's reporting based on the performance on the particular measure? If I'm doing so well, do I report it, versus if I'm willing struggling, do I not report it? In which case, it puts us in a situation where the information we're trying to identify to help other states in terms of what's working for them and why, you don't really get to see that information or be able to ask the questions.

DR. LILLIE-BLANTON: So, actually, that's the issue that we have found in a few states. I can't say it generally, but I think it's an issue that occurs more in managed care than in fee-for-service, to follow-up on Kathy's comment. We have found in some states the tracking of the information is occurring more routinely in managed care than in fee-for-service. And part of it is, I mean, fee-for-service providers tend not to focus on the findings because they can't really identify and attribute a finding to them. But in the managed care setting, oftentimes the data are reported in

what we call external quality review reports by managed care plans, and there is the ability to look and track performance.

And so, certainly, some managed care plans will feel that, because their performance is above average or in the 90th percentile that there's no reason to continue to report the measure. I can't say that we have found that to occur with the state reporting of the data, but, certainly, I think, you know, you have managed care plans who feel if I've got to trade off, then perhaps I should stop reporting.

And then the one measure for example we know we're doing decently on is the well child visits. This is a child measure, not the adult measure, but the well child visits for children in the third, fourth, and fifth year of life. I mean, that's a measure that we are almost getting at the 80th percentile, getting the well child visits at that age.

And so there have been some discussion, and we've heard that there's some

consideration of whether that's a measure. But I don't think it happens a lot in fee-for-service. Not to say that it can't and certainly not to say that the state reporting on that wouldn't make some decisions, but it just has not occurred to us or has not been brought to our attention that it's occurring in the fee-for-service world.

MEMBER DUNN: So this is Katie. That's really interesting because at least in the New Hampshire and a couple of other states, we've been looking at the fee-for-service claims data. Now, granted, most states don't have the infrastructure for the hybrid measures that require a chart review, which is really where your EQRO is such valuable tool. But we've been looking at using just the administrative data about performance on some of the big issues that tend to be policy questions that arise in individual state legislatures such as emergency department utilization for ambulatory sensitive conditions, as an example.

I can't recall to what extent an

assessment was done in terms of the states' ability to do two things. One is to actually collect the data. But then to the previous, the gentleman who spoke before the last speaker, the next evolution of having these measures is what do you do with them?

And so I know a number of states have started talking about so if you do see these positive results, how are the best practices being captured and shared? How are states using that information to say, okay, we invested extra dollars, for example, in well child visits for third, fourth, and fifth graders. That's doing well right now. That extra investment we made in focus we're going to move to a different area, maybe neonatal abstinence syndrome issues. And it's kind of the next evolution in maturity in data collection and using the actual results. And I think you're right. I don't know of many states that have been able to transition to that place yet.

CHAIR PINCUS: Other comments,

questions? Marsha?

DR. LILLIE-BLANTON: So I actually think, following up on Katie's last comment, that what could be added to this list, factors influencing state participation in reporting, is the use of the measure to drive change because, as she said, when states can see the value of the data in helping them to improve their performance, whether it's in reducing ED use or improving health that then results in less use of other high-cost services, then I do think that the state becomes motivated. So I think I would add to that list, to the other.

CHAIR PINCUS: So that raises a question for me and actually several of these comments raise a question because I think of sort of different measures in three categories. One are measures that are really more for sort of analytic purposes and descriptive purposes where the validity of the measure is uncertain in terms of its relationship to outcomes but where one might be using the measure to explore variation

and to understand what's going on. And it's unclear what the appropriate benchmark is but to look at where you think there's a lot of variation, and you try to look at, okay, what are the high-performers, so-called high-performers doing versus what the low-performers are doing. Is the difference really one of artifact in terms of how the data is collected? Have the people doing -- have the high-performers learned some secret sauce about how to do better, or is it really just a selective kind of thing in terms of the kind of patients that they're seeing, and what is that secret sauce that they've learned?

The second bucket is one for improvement where you don't need to necessarily -- you have a pretty good set of information that higher is better or that there's a difference, and you're using it to actually move change and perform. But it's usually local small steps of change that you're doing. It's not necessarily something that you would hold somebody accountable for because there are some flaws in

the measure. It may not be risk-adjusted sufficiently.

And then there's accountability purposes, which is for public reporting or for value-based purchasing where you have to have a considerable degree of confidence with regard to the reliability and validity of the measure.

One of the issues around this program is that it's kind of in between, and it has aspects that are related to all three of those categories. And I wonder if you could say -- Karen or Marsha could say a little bit more about how you see it fitting in because, in some cases, it's kind of an experimental program, and we're trying to get states to actually use it and do things with it. On the other hand, it is a reporting program, so that it is -- there's some skin in the game.

DR. MATSUOKA: Yes. So I think, and this comes back to the earlier comment about so what is it that we want these measures to do, what is the purpose of this? And I think you're

right that, in practice, we have been using it in all of these ways and maybe not as deliberately as we need to be.

I'll say that, for the accountability piece, I think we've tried very hard not to make this a shaming process, but it really is about transparency, and we can't help all states improve if we don't know where you are. And part of knowing how to help you is to know where you are relative to the high-performers and what the high-performers are doing. So I think that's the spirit of this.

So I think out of the three different things that you mentioned, I'd say accountability is the one that we, I think, emphasize the least. Certainly, when we report the measures, you see the bar graphs, and you can see the comparative information, but it's never meant to be about -- for example, payment is never associated to performance on these measures.

I would say where we're really trying to improve is on the improvement use of the

measure. And here's where I think, in addition to collecting the measures, reporting on the measures, we do have a series of things called infinity groups. You'll hear tomorrow from two of our initiatives, Maternal Infant Health Initiative and the Oral Health Initiative, where they're actually taking some of these core measures, either ones that have been adopted or ones during development, and really working with a handful of states to drive improvement at the state level. And I think, you know, to Harold's point, we're still in the very early stages of this. We just launched one around psychotropic medication use among kids. I think that is going to be one that is maybe, hopefully, more useful when it comes to helping with the analytic function as well as the improvement function, because I think that's a measure where it's a little bit easier to tell whether the number being higher is a better number or worse. And I think that's the kind of measure where we can also start to see improvement relatively quickly

at a state level, as opposed to, say, obesity rates.

So I think some of it we're trying. I think we are trying to perfect the way that we use these measures. You'll hear a little bit either later today or maybe when the child group comes together about the PQMP initiative where we're deliberately trying to get at varying levels of measurement, to your point.

So if what we're saying is that our core measures serve this very important analytic purpose of seeing where the variations are, how do we start to align measurement that's happening at the provider level, say at the ACO level, to roll up to a plan level, say Medicaid or Medicare? And then how does that roll up to the state level so that we don't have to have a state level measure doing all three functions? We can start to say more deliberately the state level measures are really meant to serve as analytic function, whereas the provider level measures are really meant to serve more the improvement

function.

We haven't made any decisions yet, but these are various different initiatives that are underway to help us to address those questions. But, Harold, I think you're exactly right that we haven't necessarily been very deliberate about saying exactly what we want the measures to do, and, as a result of that, I think we've been using them in a lot of varying ways to varying success.

But I think this space of, how do you use these measures to drive improvement to quality at the state level is certainly where we're headed. That's where we want to go. So then the question becomes, how do we do that in a way that's going to help the states the most? And, of course, all that comes back to what is it that the state level measures are meant to do relative to all the other levels of measurement that we're already doing?

CHAIR PINCUS: Other comments, questions? So one thing that we may want to come

back to is if it's not being used for accountability, how important is NQF endorsement?

DR. MATSUOKA: I think it's a very important question.

CHAIR PINCUS: So it's something we want to get back to. Other comments, questions? Oh, Cindy?

MEMBER PELLEGRINI: So I spend most of my time in the world of government affairs, and I tend to look at some of these issues through that lens then. I think one of the challenges here is that we haven't spent a lot of time, I think, trying to make measures understandable or useful to policymakers. And I think what ends up happening is that the middle three bullets on this list are all intertwined, that if these were perceived as more important by policymakers, the budgetary environment would improve and that then feasibility would improve because there would be more resources available to do things like chart review or some of the more challenging aspects.

Having said that, kind of everything

about quality measures and quality measurement makes it difficult to communicate them to policymakers, right? Especially elected officials and state legislatures and things like that. This is complicated. This is all about shades of gray; it's not about black and white. It is -- you have to have a lot of knowledge, I think, as a layperson, before you even start to understand what this is really about.

Progress is not quick. It's not easy; it's not dramatic. It's like, hey, we improved five percent on this measure, yay. That's not press release material, right?

So really making this compelling to policymakers is very difficult. We have tried in a couple of places. We're actually promoting a bill on perinatal quality measurement on Capitol Hill right now, and my colleague at the back of the room, Brittany Hernandez, is doing heroic work on this, but it is a major uphill slog.

So I think, collectively, we need to think a little bit more about how do we make this

more compelling to policymakers and, by extension, to the public so that there will be the support, because then the other thing that we've spent some time talking about at March of Dimes is I'm concerned that this is not right now a sustainable system, that having tens or hundreds of millions of dollars in exclusively federal funding is just not a viable long-term plan. So we need to be looking at the state, at the federal level, with private payers, with others, to say how are we going to incrementally restructure the system over time to actually provide the funding streams, provide the sort of feedback loops and so on that we can make this compelling, usable, and actually use it to drive change for the foreseeable future?

CHAIR PINCUS: Thank you. Diane?

MEMBER CALMUS: Well, I think kind of building on that, we do have to look at, I think, also the cost of all of this data collection. Access, obviously, in rural areas is a huge issue, and Medicaid is a huge piece of that

puzzle, as the residents in rural areas do tend to be poorer, older, sicker than their urban counterparts.

And so making sure that the focus is on what is actually making a measurable improvement for that population if we are going to be asking these Medicaid agencies to be taking funding and diverting it away from patient care and making sure that any measures are actually kind of moving that. And that's why I brought up population health previously, that we're kind of looking at the big picture. Access, again, is a huge issue, and we need to make sure that each measure is improving access and not taking away from it.

CHAIR PINCUS: Thank you. Marissa, then Kim, and then back to Debjani.

MEMBER SCHLAIFER: I think, to follow on some of the things that have been said, and I'm not sure where -- I think, in my view, this kind of falls to perceived importance and political will but probably could fall different

places.

As we look at getting more and more states participating, I know in the past there's been some philosophy of let the states have choice to -- states are more likely to participate given the ability to choose which measures they want to use. I think, as you talked about, looking at measures as a way to start the ball rolling or rock down the hill or whatever it was, I think in today's world, with more and more Medicaid going from fee-for-service to managed care and with national health plans and national PBMs that serve many different health plans, that awareness that the more alignment we can get across measures, we can use these measures not just to report out but actually to partner with health plans and the PBMs that work with them and other national organizations that work with them to really push the ball down the hill. But to do that, we need more alignment across measures and more states participating using the same measures.

DR. ELLIOT: Two things, actually. I think one of the changes in the final managed care regs that I think is going to really put a little bit of a shift in, right now the rules did not require that the states report all measures, that they did. The final managed care regs in the EQR reports does require reporting of all measures. So that's a big shift, so you'll see a lot more of what's actually being measured that the states may or may not be reporting right now.

But when it comes to sustainability, when we start focusing these measures more on outcomes versus the process, and you see the improvements in care, and you see the reductions in some of the more costly types of care like inpatient and ED, you're building your case for sustainability simply through financial savings, it not even the better outcomes in care and functional status perhaps of the individuals you're serving. But that also helps build the political will when you can really make a case that the outcomes of the constituents that have

been served by Medicaid are really improving and it's also reducing cost of care, that is a huge political message that our politicians typically, at least in the state that I come from, do pay attention to.

So I think there is sustainability, but you have to make that shift away from process towards real outcomes and show where those costs interlock or intercede.

CHAIR PINCUS: Thank you. So, Debjani, do you want to continue on some of the other issues?

MS. MUKHERJEE: Sure. So next slide, please. So in this slide, we go over some of the considerations as far as stratification came, and that was to assess disparities and disparities in care. But there was a caution that we not penalize safety net providers by stratifying too much and who might not be as big.

Important stratification parameters, looking at geography and individuals with multiple chronic conditions, individuals with

specific conditions such as persistent mental illness, also children with complex medical needs, as well as the NQF project.

Next slide, please. And with that, the questions change sort of perspective from alignment and feasibility of data collection, data stratification, to care coordination and care coordination of Medicaid adults, basically chronic health condition management, as well as maybe care coordination for individuals with disability, physical and mental and developmental, and their care coordination.

And with that, we had some questions for the group. How can care coordination be optimized for the Medicaid adult population? What are some essential elements of care coordination for this population? And can the core set be used to capture -- can the measures be stretched to capture care coordination?

And just to let you know, the next section just forays from care coordination into linkage and models of linking community with

medical and behavioral and how to sort of build, sort of moving from alignment down to sort of more specific parts of alignment.

Comments, discussions?

CHAIR PINCUS: You want to wait until the end?

MS. MUKHERJEE: Oh, okay. Next slide, please. So for the next slide, what we did was one of the elements highlighted by the Vital Signs report was community engagement and the interrelatedness of community engagement with health and well-being and getting to the overall public population health of individuals.

Next slide. And by linkage, we mean linking community resources with clinical resources, clinical providers with social service providers, activating patient and not only being patient-centric but patient empowered where they feel like they have a voice, referral follow-ups and not only providing a referral but actually following up to see was care provided or followed up with? And then addressing availability,

affordability, and accessibility of resources in the community.

And then with that, we had some questions about how can community linkage be optimized for -- next slide, please -- optimized for the Medicaid adult population, and how can current measures be stretched to capture that?

Next slide, please. The next slide. And so -- no, the one before. So what we did was provide some diagrams of what linkage would actually look like. I know it's kind of small, but it has the health system; it has the community; it has community partners; it has productive relationships and activated community with the patient. And sort of it gets from the individual level getting care, being able to self-manage themselves. It gets to the public policy, as like the big blue bubble and creating supportive environments to where, at the end of the day, at the bottom it gets to population health outcomes and functional clinical outcomes.

And I just wanted to, since we are

talking about community linkage and all the different types of linkage, have some sort of a diagram up there to sort of refer back to.

So discussion?

CHAIR PINCUS: Okay. Why don't we open it up for discussion? Care coordination and community linkage and stratification. So, actually, I had a comment. If you can go back to the stratification slide, I had actually two comments. One was the concern about penalizing safety net providers, and it goes back to the issue before about sort of what's the purpose and use of these measures.

In a sense, if they're not sort of accountability, per se, there's really not sort of penalties being applied. You're trying to avoid -- so, in some ways, stratification, in that sense, can be illuminated to understand where there are disparities and to understand where sort of new investments need to be made.

Going back to, I think, Ann's comments earlier that you could look overall for the

population, and it could look like you're performing quite well, but there are key groups, whether it's a severe mental illness or whether it's a certain socioeconomic or minority groups where you're not performing as well. For the purposes of this program, I'm somewhat less concerned about sort of penalizing but actually illuminating the problems for particular populations and identifying the need for more resources or different types of strategies to be applied.

The second comment I wanted to make had to do with sort of the coordination and community linkages, particularly for people with severe and persistent mental illnesses. And two points within that. One is that I think that's a particular issue there in terms of thinking about community linkages. Obviously, issues around connection, issues around sort of housing stability being a big one, and to what extent individuals are assessed for stability in housing, to what extent they're assessing

services and actually are getting stable housing is something to think about, because that's a key issue, especially with the sort of Housing First movement that has fairly well-developed sort of evidence-based approaches around providing that housing first, even before you're providing health and mental health types of services as being a more effective way to go. And that may be something to think about in terms of going forward. But also, to some degree, also linking to criminal justice as another sort of partner in the community and particularly as sort of jails and prisons have become sort of some of the main places where people are accessing services with severe mental illness.

And then, finally, there's an interesting program being developed in New York City around, that's being developed by the Mayor's wife. It's a whole range of different programs under the auspice of what's termed Thrive New York City, some of which are particularly focused on linking social services

with behavioral health services. And in this case, there's one component called Care to Community or Connections to Care that are specifically in providing resources to community-based social service organizations to link them up with behavioral health organizations by providing certain evidence-based services there and care management services.

Now, that would be very hard to collect information about the impact of that under -- you know, if a state or a city wanted to build that kind of program, I'm not sure where it would show up as an improvement in Medicaid. And to think about how one could somehow, if those innovations are being put in place, how one could capture the fact that that actually was affecting performance of Medicaid. And so it's worth thinking about some of these new innovative programs in terms of community linkage, to be able to use that as a way to demonstrate ways by which innovations can actually improve outcomes for Medicaid populations.

So Julia and Ann?

DR. LOGAN: To your point about disparities, for the Adult Medicaid Quality Grant, our state was able to look at several measures, to stratify several measures, and we were very surprised by what we found with each measure, that there were certain disparities that we didn't expect. And so I think that's very valuable information because it helps you to look at the measure and the outcomes in a completely different way.

There are several problems and difficulties with doing the stratifications. In Medi-Cal and Medicaid data in California we don't require that people, when they fill out their enrollment forms, that they specify what race or ethnicity they are, so a lot of times there are gaps in that data. So there are problems with that, but, overall, I think it's a really important thing to look at.

DR. WILSON: Julia, could I just ask you how did you stratify it? Because I know the

data, getting the right variables, but how did you stratify? What did you use?

DR. LOGAN: You mean what did we stratify by?

DR. WILSON: Yes.

DR. LOGAN: So certain things: race, ethnicity, age, male or female, rural status, SSI status. I think that was about it, from what I can recall.

CHAIR PINCUS: Ann?

DR. SULLIVAN: Yes, much of what I was going to say you said, Harold. I just want to make the point that we're all struggling with measures. And once you begin to move into these measures of linkages to community-based organizations, I think it gets increasingly complicated how you do it. It's critical, though, because we all know that that big pie chart that shows how much of your healthcare is determined by our provider system is small and how much is determined by everything else is very big.

So I think it's a real question as to how you look at this issue of community linkages and how you might measure it. And I mean, I think we probably have to begin the way we've done. For example, is your housing stable? And if your housing isn't stable -- first, you've got to ask the question just like you kind of do for diabetes. And the second question is, if it's not stable, did you get referred to somebody? And the last question is did you finally get yourself into housing that's stable?

How you measure all that is very difficult because that doesn't appear, by and large, easily in anybody's medical record to date. There might be places that do that kind of thing but probably not too many.

So I think that it's a real shift to start having providers think about these issues, and it's a big movement to get the medical community to think that they have some responsibility for these things down the pipe. In New York State, with a lot of the money that

came in with our CMS innovation, the district money, the major push is this, and, yet, the reality is that very few of the measures of outcome for that district are going to connect to this. So I think it's still this difficulty of measuring it.

So I think we have to really put our heads together to try to see if anybody has kind of measured these things and what might be something useful because the reality is, even when that's a big part of what we would like to see happen in New York, I know that in the outcome measures, it's not there. So, I mean, there's still the traditional other kinds of measures.

So it's fascinating but very, very tough to think about how you really make that movement into the community linkage.

CHAIR PINCUS: Thanks. So we have Katie and then Michael and then George.

MEMBER DUNN: Thank you. Just picking up on what the last speaker said, the community

linkages, what we're finding in many of the rural states is that you can ask the questions, but then there's a very strong possibility there might not be the resources to actually respond to the need. And I think that dampens states' willingness to ask the question because once you know that there's a need, if you can't help support that person, it's not a very positive feeling. It definitely can provide information to policymakers on what is needed out in the local communities, but I think that's really important if we're going to ask the question.

I also think there's challenges with the smaller -- many of our non-medical community entities across this country started off as little grassroots organizations that, at one time, might have just received, for example, a small community action program funding. And they would need a tremendous amount of support. It's not just putting in a new software program that will capture this type of community linkage type information and be able to get to outcomes.

There's a whole infrastructure there that we've seen some states do, but it's a pretty heavy investment if states are going to go down that road.

Another comment is around care coordination and how that gets back to what you were saying, which is we have -- we found that, depending on which providers we're working with, whether it's a primary care doc, a community mental health center, a federally-qualified health center, a developmental disabilities area agency-type structure, everybody has got a different definition of what care coordination means. And in many instances, because of the federal flow of funds, there is an unwillingness to go outside of the framework of what those funds do and don't allow you to do. And at the Medicaid director level, we've been talking about how, even though some of our key federal agencies, SAMHSA, CMS Medicare, CMS Medicaid, et cetera, are underneath HHS, there's still some issues with the silos of funding.

And the last comment I'd like to make around safety net providers, it's interesting that not every state, at least we've talked about this at managing level, most people, when they think of safety net providers, generally go right to the health centers. And we're not all dependent upon -- not dependent. The case mix at, for example, federally-qualified health centers, if you look across the country, it's not the same. In New Hampshire, for example, most of our clients, our Medicaid beneficiaries, are not seen at federally-qualified health centers.

And a couple of the states have done some studies, and, yes, it does definitely illuminate issues. It also illuminates success stories. And the messaging about that has been really difficult. Particularly working with health centers, you want to put the information out there, whether it's positive or negative, but there's a tremendous amount of sensitivity on how that message goes out. Thank you.

CHAIR PINCUS: Michael? Is your mic

on.

MEMBER SHA: I would echo Katie's point about the lack of a precise definition of what care coordination is. From a provider standpoint, we oftentimes talk about transitions of care, and I know the Society of Hospital Medicine and the American Medical Directors Association have done a lot of work regarding transitions of care, but I think part of my concerns regarding care coordination is really how it's perhaps best measured because, with the development of meaningful use, the development of Accountable Care Organizations, particularly for the dual eligibles, I think the processes may be already getting beyond our ability to sort of capture this.

But perhaps, if we are going to really make an effort of capturing it, the easiest way perhaps, from a CMS standpoint, is to code it and pay for it. I guess that's what I would probably offer.

CHAIR PINCUS: Thanks. George?

MEMBER ANDREWS: I agree with a lot of what's been said. I think comments relating to capturing sociodemographic information and how that drives patient compliance and working with their provider who is trying to deliver the best care to them. I think the community resources are critical, and I think, just like you mentioned, Harold, I think linking those resources encourages and touches on population health.

But as I look at the expanded chronic care model, I think that the -- under the section of informed, activated patient, that, to me, requires further expansion and additional elements incorporated, particularly engaged. You can have an informed, activated patient, but if they're not engaged you are not going to get the collaboration with their provider, their caregiver, or, for that matter, community resources.

I think to get to the final end goal of improved health outcomes, you need two pieces

of the puzzle, the deliverer of care and the receiver of care, to really agree on that common goal. Physicians are very often extremely frustrated by the fact that they're trying to improve, whether it be diabetes, whether it be cardiac management of their patients, and they can't because the patient is not quite there. And I don't have the solution, but I do think that some way of thinking about -- if our end goal is improved population health, we need, as a society, as policymakers, et cetera, to think about how can we get the individual, who we would like to help and want to be engaged, to be on board? How do we do that? How do we incentivize? What do we have to do within the limits of our ethical and other obligations in terms of trying to help that patient?

CHAIR PINCUS: Kim?

DR. ELLIOT: I think a firm or more definitive definition for care coordination would really be beneficial. What I see in Medicaid programs depends on the population served and the

type of program that they have. But, oftentimes, care coordination is wrapped up into case management, and it interweaves, and it's not really firmly defined. So sometimes it's a service, and sometimes it's an administrative activity, and it really matters when you're really trying to define what it is and what it should look like and, more importantly, what the outcome is.

So I'm also thinking that, from an outcomes perspective, and I know I go back to outcomes a lot, but that really is what it's all about is what really happens to an individual patient or member that's served by Medicaid. But if you look at simple things, like follow-up after discharge within a certain number of days, that could be a case management care coordination issue. But looking at what happened, did it result in an improved outcome because they had that follow-up after discharge? So linking back some outcome from that service and showing how, again, a fiscal impact, a quality impact for that

individual served, those are the things that ultimately matter. So it's not just measuring whether they had that follow-up but really what was the outcome of that follow-up.

CHAIR PINCUS: Thank you. I think we've had a pretty robust discussion on these issues. We're going to take a break now for 15 minutes? Ten? Okay. Ten minutes. We'll reconvene at 11:10, and we'll also fix the slides, and we'll come back and we'll hear from the states. So thank you.

(Whereupon, the above-entitled matter went off the record at 10:57 a.m. and resumed at 11:13 a.m.)

CHAIR PINCUS: So we're going to be hearing from two states, California and Oregon. And the kind of questions that we've asked them to talk about are dealing with some of these issues around what they feel are the most significant challenges they face in participating in the program, their thoughts about potential changes to the core set, and to think about how

some of the feedback from the states can actually influence our thinking about how we review the materials that we're going to look at this afternoon.

We also want to know a little bit more about how the states are using the measures, and we talked a little bit about that earlier, and also to hear more about some of the successes they've had in actually being able to measure quality both within the program but also outside the program.

So first we're going to hear from Julia Logan, who is the Chief Quality Officer for the California State Medicaid Program.

So Julia?

DR. LOGAN: So thank you so much. It's really a privilege and an honor to be here today. It's kind of like being at the Oscars of quality improvement or something like that.

So I'm really excited to share California's experience. And as Harold mentioned, we have a long list of things that we

should be talking about.

Also, as he mentioned, I work at the California Department of Healthcare Services, which is the state's Medicaid program, and we call it Medi-Cal. So if you hear me saying Medi-Cal, that's what I mean.

So I wanted to give you a brief overview of what I'll be talking about today. I'll give you a little bit of an idea of our demographics in California and how we aim for alignment in California and some of our successes and some of our challenges in that area. I'll also be touching on Medi-Cal 2020, which is our 1115 waiver, especially as it relates to care coordination and community integration and quality measurement.

I'll also be discussing how we drive quality at Medi-Cal, what our statewide mechanisms are for measure reporting, and how California decides which measures to report and then reporting and measurement challenges of the CMS core set. And, finally, I'll be talking

about areas that California has identified that need high-quality measures that we don't already have high-quality measures in.

So a little bit about our demographics. Medi-Cal provides healthcare services to 3.1 million beneficiaries through two distinct healthcare delivery systems: our managed care program and our traditional fee-for-service program. Medi-Cal managed care has grown tremendously over the past three years. In 2013, it served about six million members, and that number has grown to more than ten million members in the past three years.

Managed care provides healthcare services to children, pregnant women, seniors and persons with disabilities. We contract with 23 full-scope Medi-Cal managed care health plans and three specialty health plans.

We serve a very diverse population. As of September 2015, 46 percent of our beneficiaries are Hispanic, 22 percent are white, 13 percent are Asian and Pacific Island, and 8

percent are African-American. So that speaks to what I was talking about earlier about the importance of stratification.

California has a really strong commitment to improving health outcomes and to aligning across -- sorry -- across payers. In 2012, our governor, Governor Jerry Brown, signed an executive order to establish the Let's Get Healthy California Task Force. This set out to make California the healthiest state in the nation by 2022, so that's kind of bold and audacious.

This task force outlined three key health indicators focused around three distinct areas that you can see on this slide. Healthy beginnings, living well, so preventing and managing chronic disease and end of life, with three core issues addressed: redesigning the healthcare system, creating healthy communities, and lowering the cost of care.

The Let's Get Healthy California work and its key themes lead the foundation for

several other key groups and initiatives. Medi-Cal 2020, our 1115 waiver which I'll talk about a little bit more later, a statewide workgroup on overuse and misuse, so really implementing choosing wisely; a statewide workgroup on high-cost pharmaceuticals. The catalyst for this was the release of the new hep C medications. And a measure alignment with the three large purchasers in California: the Department of Healthcare Services, Covered California which is our health benefits exchange, and CalPERS, which is our California public employees retirement system which manages the benefits for more than 1.6 million public employees and their families.

This work has definitely has many challenges. The populations of these three large payers are very different. There's the different focus of control for each of these. Covered California has the ability to influence health plan contracts but not specifically influence provider behavior, so that's a big difference. And there are also different priorities among the

three payers.

Medi-Cal 2020 is the state's renewed 1115 waiver which was approved on December 30th, 2015. California received approval for four major initiatives: the Public Hospital Redesign and Incentives in Medi-Cal program, which I'll call PRIME; Whole Person Care pilots which I'll discuss in the next slide; the Global Payment Program which allows for payment of uncompensated care and alternative care models; our Dental Transformation Initiative which provides direct incentives to dental providers to provide preventive services for children.

The waiver establishes a foundation to support the transition to value-based purchasing. And another really interesting thing is it provides opportunities to test innovative measures, particularly in the PRIME program. So I wanted to explain a little bit more about PRIME because it relates most closely to measurement and metrics.

PRIME is a pay-for-performance, P4P,

incentive program for all of the designated public hospitals in California, of which there are 21, and all the district hospitals of which there are about 40. It was organized into three domains of care, which are the first outpatient delivery system transformation and prevention and the second is targeted high-risk or high-cost populations and the third is resource utilization efficiency.

An example of -- there are multiple projects per domain, and each project contains a set of quality measures that the hospital must improve on. And examples of projects include obesity prevention, the Million Hearts Initiative, cancer prevention, and there's a perinatal project, post-incarceration project, antibiotic stewardship, and high-cost imaging. So there are about 20 projects in total.

All totaled, the PRIME program contains about 75 metrics, 80 percent of which are NQF endorsed and 20 percent we're calling innovative metrics. Innovative metrics are used

only in incidences in which a project's current set of standard metrics doesn't adequately assess successful transformation.

So examples of these innovative metrics include patient safety. That's one of our projects. One of the metrics is abnormal results follow-up and another is ensuring adherence to prescription medications. We also have an opioid project within PRIME which addresses chronic non-malignant pain, and examples of innovative metrics in this project are checking the prescription drug monitoring programs, screening for depression in people with chronic non-malignant pain, and having a pain agreement in patients with chronic opioid use.

So through our federal waiver and through partnership with CMS, we definitely couldn't do this without CMS for sure, the Department of Healthcare Services is able to administer four groundbreaking programs within the last few years with the aim to improve and transform care in California. The Whole Person

Care Pilot, as you can see, is a voluntary county-based initiative, which focus on coordination of health, behavioral health, and social services for Medi-Cal beneficiaries who are high utilizers. So this speaks to what we were talking about previously.

Health Homes Program is another CMS program. It's led by managed care plans in counties scheduled for implementation, so there are about six of our 58 counties scheduled right now. It supports the development of a network of providers to integrate and coordinate primary, acute, and behavioral healthcare for high-risk high-utilizers of care. And as I said, it's led by the managed care plans.

Our Coordinated Care Initiative is a pilot program in seven counties, and it promotes the coordinated care for dual eligibles by combining a beneficiary's Medi-Cal and Medicare benefits into one healthcare plan. And then PRIME I already spoke about.

And so there are several common themes

within these key programs that kind of run through what we were talking about today. So improving care coordination, integration of care and of services in and out of the healthcare system, and high-utilizers of care.

Okay. So there are multiple ways that quality is driven at Medi-Cal. We have the PRIME program and other major initiatives that I just spoke about but also, through our performance expectations with our 23 managed healthcare plans.

The managed care plans are contractually required to perform in at least the 25th percentile, so a low bar, admittedly, for all metrics in the External Accountability Set, which is a set of metrics that we require them to report on every year. They're required to participate annually in a performance improvement plan around one of our four clinical priority areas, as outlined in our quality strategy. These priority areas are hypertension -- for this year -- are hypertension, postpartum care,

childhood immunizations, and diabetes management.

They're also required to be part of a PDSA cycle in areas that they're performing below the 25th percentile. So we require them to do small tests of change and then to scale up in those specific areas.

And then we also have other areas where we have ongoing QI projects and initiatives. We're working on immunizations, including prenatal immunizations, especially the use of Tdap because of our high rates of pertussis in babies; opioid overuse and misuse, which is a U.S. problem specifically; obesity prevention, we have a USDA grant to address this. We have a CMMI grant to explore incentives to quit smoking. We're working on the Million Hearts Initiative, which was one of the affinity groups with CMS. And because Medi-Cal pays for half the births in California, so about 250,000 births a year, we have a big stake in achieving the triple aim in that area, as well.

I thought it would be important to

describe what mechanisms there are to report on measures in California. First, we have a program-wide reporting of both fee-for-service and managed care through the Adult Medicaid Quality Grant. While the grant is over, sadly, but DHCS intends to report the core set of measures they reported in 2015 on a continuing basis.

One challenge that we face -- well, I'll talk about more of the challenges, but one specific challenge I wanted to address right now is validation of the measures. So while we report them internally and run the measures internally, we're not 100 percent sure that the measures are actually reliable and accurate. So one thing that we're doing is we're using our EQRO organization to validate some specific measures.

A second way of reporting is required reporting for the managed care plans through the External Accountability Set. So as I mentioned, it's a set of quality measures that closely

mirrors the Adult Core Set but not specifically that supports our quality strategy. And every two years, we review the External Accountability Set by an internal quality improvement committee. We review the Adult Core Set and look for measure gaps both in the core set and our own set, and then we look for areas that are no longer relevant, maybe the measure has changed, or where performance is good enough to take that measure off. And then we also try to align with other measures and initiatives in California. And we prefer the measures are NQF endorsed, and it's also helpful for the measures to be NCQA or HEDIS because of the ease of having baselines, or benchmarks rather.

There are also several measures, all pediatric at this point, that our state legislature has mandated for us to report, as well.

But lastly, I wanted to mention that our department is considering an internal accountability set. So what this would do is

this would allow the managed care plans to focus only on hybrid measures and allow our department to report on administrative measures only because right now managed care plans report both on administrative and hybrid, and so it would take the burden off of them for that and would allow us to report on more measures.

Okay. So I wanted to briefly show you the Medi-Cal managed care Adult External Accountability set. So this is our list of measures for the managed care plans, and I highlighted all the measures that are consistent with the Adult Core Set. So it's all-cost re-admissions, annual monitoring for patients on persistent medications, cervical cancer screening, two of the diabetes measures: hemoglobin A1C testing and then poor control of diabetes. We also have several other diabetes measures that we've debated about taking off, but our managed care plans actually really like these measures and they say it's not an additional burden for them to do that and we're not

improving in them, so we think it might be important to keep it on. Controlling high blood pressure is the core set measure and then postpartum care, of course.

So, obviously, you can see, just by looking briefly at it, that there are certain gaps in our External Accountability Set that we've identified. The first is behavioral health, and this is obviously a big issue in terms of high-utilizers and care coordination; opioid management, we have extremely high rates in rural counties and high rates of opioid overdose. And we have the highest rates of overdose that we've ever had, so it's a really big issue for us. And palliative care and advanced care planning.

Our state recently passed SP104, which is the implementation of a community-based palliative care program within our Medi-Cal program, and we need to implement that within the next six months, so it's important for us to find a way to measure the implementation of that

palliative care program.

We did look at the core set for these specific three areas: behavioral health, opioid management, and advanced care planning. There's no core set measure, of course, for end-of-life care or advanced care planning. We did review the NCQA advanced care planning measure, but it's not for the Medicaid population. It's for the Medicare population, so the measure would have to be modified. And we did hear that Oregon has been using this measure and changed it to age over 18, but apparently that caused some confusion, so maybe we can hear more about that offline.

And then the second one, opioid management, we did look at the core set measure, but there was a big concern that the N's would be too small because of the issue of having so many prescribers and pharmacy and that that wouldn't really get to the heart of the issue and really not focused on primary prevention and also the issue of it not being NQF endorsed. But I do

hear that it may be getting NQF endorsement shortly.

And then the third, for behavioral health, we looked at several of the core set measures. And for the antidepressant medication management measure, there was a concern for overuse of medication and using medications that may not be warranted or clinically appropriate for mild to moderate depression.

Other behavioral health metrics also require data from mental health providers, and we learned from our work in the Adult Medicaid Quality Grant that this is very challenging to get data that's not in our data set.

Okay. So I just wanted to talk about the Adult Medicaid Quality Grant and our experiences with it. We were so thankful to CMS for the opportunity to participate in this grant. It really allowed us to test and evaluate the core set of measures and offered a huge opportunity into driving quality improvement and even using the language of quality improvement

within our department.

In 2015, we reported on 16 of the 26 measures. Eleven were based on administrative data and four were mixed with managed care plan reporting, so hybrid and administrative, and one was based purely on hybrid data from our managed care plans.

Over the course of the grant, we were able to report on three different measures that required access to other data elements: the HIV viral load suppression measure, the early elective delivery measure, and antenatal steroids. We had to enter into contracts with external stakeholders to receive this data, and contracting within our state is very complicated and time-consuming and often is fraught with many delays. So we had a lot of trouble actually getting this data, and it was late, and so we're not going to be continuing with those contracts.

Okay. So I wanted to talk about some of the lessons that we learned within the Adult Medicaid Quality Grant on reporting and measuring

within the CMS core set. So the issue of dually eligible is very challenging for us. We only have a portion of the claim, so we don't have Medicare claims. So measurement is not an accurate reflection of performance of our Medi-Cal beneficiaries who may be dually eligible.

Another issue is our encounter data. So encounter data is the data that we get from managed care plans. It's separate from the claims data that we get on the fee-for-service side.

The quality of encounter data coming from the plans can be very variable. There are reliability issues. There are timeliness issues. So we have started, as a result of this grant, we've started an encounter data improvement project, so we're working on the quality of the data.

One big issue is also missing lab data. We learned through this grant that some of our plans were just not sending lab data at all, so we're trying to work through those kinks, as

well.

Another issue that I mentioned before is that clinical data is not available in our data warehouse. So some of the measures that require clinical data we cannot continue to report on.

Lack of provider data is also important to us and also a challenge. Provider data associated with NPI numbers really play an essential role in a number of the measures. As an example, provider taxonomy is required for numerator services in follow-up after hospitalization for mental illness. This data, however, hasn't been incorporated into our data warehouse. Additionally, state-level databases haven't adopted the NPI as an identifier for healthcare providers or health facilities. So we're lacking a lot of that data.

Look-back is required for cervical cancer screening, and that's also challenging for us because we have such a quickly-enlarging enrollment that we don't have that look-back

available. So we'd be missing much information in that area, as well.

Let's see. PQI measures are also very challenging for us. Dually eligible are under-represented in our hospital data because, as I mentioned before, Medicare is the primary payer. And some of our members have limited-scope benefits, so they're not eligible for preventive services and not really good candidates for the prevention quality indicator set.

And then the CAHPS survey is also challenging. We're only able to report it or ask our plans to report it every three years, so we can't follow things over time very well. We also have a very low response rate, maybe about 15 percent overall. And we've also found, as I'm sure other people documented very well, that there are a lot of cultural issues, and, because of our very diverse population, we found that different people in different cultures respond to the CAHPS survey in very different ways and we may not get reliable information.

Okay. So I wanted to talk about areas in need of high-quality and practical measures. I was in a meeting yesterday at the National Academy of Medicine on end-of-life care, and measurement came up again and again, people saying the only way to see change is to measure it. And I understand that, and I think that's important. But as Harold mentioned before, we can't flood the world with so many more measures. So it's definitely a balancing act of having too many measures. That being said, we can always have a wish list, and there are more areas where we could really use some high-quality measures.

As I mentioned, we're testing some measures in each of these areas: promoting outpatient safety, controlling the opioid epidemic, implementing choosing wisely, implementing behavioral health, and implementing palliative care services, and ensuring access through our PRIME waiver program. And we'll be able to see how the measures fared over the next few years, so, hopefully, we'll be able to report

back in that area.

And I leave you with this slide. We have a Medi-Cal website called Welltopia, and it's our area, our website for wellness. And I end on it because I think it reminds us all that we focus so much on healthcare and improving healthcare measures and process measures and outcome measures, but it's really important to ask are we really improving the health of those people we serve and are we really contributing to the well-being and quality of life of those people we serve?

So thank you so much. I really appreciate your time.

CHAIR PINCUS: Thank you. Before we get into discussion, why don't we hear from Charles about the situation in Oregon?

DR. GALLIA: So I'm going to introduce myself as not only from the state of Oregon but a principal investigator in our three-state CHIPRA demonstration project. So some of the things that you're going to hear about are informed from

that perspective, and I know that this is principally focused in on the adult side, but there's relevant lessons that pertain to both, and that's how I created this presentation.

The other thing is that, typically, someone would give you a little background about me and tell you that I know what I'm talking about. You're just going to have to take my word for it.

So as I mentioned, part of the perspective that I have is working initially on the CHIPRA demonstration grant, and this is one of the projects. I was in Alaska and I was doing some ice climbing, and I wanted to show you what perspective does. This was one viewpoint, and this is another. And you can see that it does make a dramatic impact on how you see things. As to perspective, how close or how far you are away can make a dramatic difference. And so what I'm going to try to do a little bit is describe some of my empathy for the national perspective, the experience that I gained from some of the multi-

state perspectives so I can address what the contrast effects are between different states, and then some of the experience that's occurred just within Oregon alone.

I start again with the CHIPRA demonstration grant because it presented at least one of the key concepts that I thought where we were headed and on which the adult work was built. One of the key components of it is a little phrase that I lifted exactly from the public law that says that CMS, and AHRQ subsequently, was supposed to develop a measure set that, when taken together, can be used to estimate the overall quality of healthcare for children, including those with special healthcare needs. And part of the reason I say that is because there's some unfinished work that needs to be done there.

What happened, though, is that in the adult grant this was taken up as one of the areas of focus. So the stratification that was expected on the children's side has actually

occurred on the adult side.

One of the other experiences I had was the joy of going through one of the review sessions, one of the first review sessions before NQF assumed responsibility for doing the work you have, and it was on the subcommittee, the National Advisory Council, at AHRQ. And it was work that was being done by measurement developers in the Centers of Excellence, and they would put forward and invest a considerable amount of time to making changes to this core set, and you're faced with the same kind of perspective today. You have a core set of measures. There are lots of great ones that are out there to think about. But really, more fundamentally, what you might be able to do is make an incremental change here or there.

So we added a few, we dropped a few, and mostly there were ones that just simply were, on face value, not working or there was substantive alternatives that proved at least as worthwhile. Again, I'm looking at, this is the

CHIPRA measures, and I dropped in the wrong slide here, but I highlighted a couple of examples of the contrasts that occur when just using this administrative data.

If you look at the first two yellow highlighted numbers, and, again, this is just the pediatric set, you'll see Oregon produced from administrative data that we have 0.4 percent of our population being overweight or obese. And on face validity, it's not true. West Virginia did a combination hybrid, so, while we were able to produce the measure and report on it, it's obvious that it's not valid, but, yet, the specifications permit that as a choice for states to produce. So even though it didn't have the face validity, we still included it, partially to inform the process to say this is something you need to check.

The other thing is that, within Oregon, we saw this dramatic change in developmental screening. There's some parallel measures that we did in depression screening in

the adults and what we call SBIR measures through the coordinated care organizations. So we saw a rapid increase in this number going from about 18 percent to 42 percent. And part of the reason that I'm highlighting that is to show or at least to bring to your attention that measures have life cycles. Marsha, you mentioned the high levels of performance on well-child visits. There's other measures that have been around for a long time, and the performance levels at those upper ends, the differences between the top tier and the bottom tier are pretty small. But when you first introduce any kind of measure in a system, it goes up dramatically. And then, eventually, they taper.

But when you're doing reviews of measures here, typically you're looking at a benchmark performance level or a subject matter that's precipitated by media, press, or some other system level novelty that says this is something we need to pay attention to, and then the measure follows.

So one of the ways that we identify problems areas or ways we can improve is we do look at the top-performing comparative information. That's one of the added values that sending this information to the federal level has provided states is that who is the top performer and how can we figure out what it is that they're doing that we could emulate? So the comparative information is extremely valuable.

So I'm going to just, this is going to be kind of a data dump, so bear with me. Nearly all the state Medicaid CHIP measures require some kind of modification, even with the technical assistance provided by the feds on the adult set and the child set, even the medical home set that exist, because they were designed for a single managed care system, not multiple systems and not levels of aggregation.

And if you actually follow the specifications, some of the ways that states are reporting them is not consistent with NCQA or even the technical specifications because of some

of the continuous enrollment criteria.

And we stratify almost any measure in Oregon, unlike your state. But I actually heard that you had some of the same issues. The numbers become really very small very quickly, and then you're faced with a choice is this a population that we choose to ignore because there's an insufficient N, or do we continue to report the measure and monitor it over time or develop other ways? So this concern also impacts our ability to trend changes or improvements over time, as well.

And then just as a word of advice or a request, actually, it would be great to find out what's in the works at a state level. So states can develop their own quality strategies instead of being essentially reactive to what's being proposed to plan ahead, so we can do the infrastructure investments that are necessary, prompt our organizations, the managed care organizations that we work with, and the provider communities to get feedback on the prioritization

that they would have particular areas.

And then this is going to sound a little bit like some of the hospitals that I heard talk that say, well, you know, you have to cut us some slack because our patients are sicker, and so here's a state saying but this is the Medicaid population. But there really truly are some distinctions that are important to consider. And when measures are produced, they have impacts on the results, and they may not be capturing the true population characteristics that are sought. And the states' primary responsibility, no matter where they are, is the population health, and a part of it is delivered through the managed care organizations or fee-for-service systems or the Medicaid, but it's really the population health. And when people move within the state, that means that they're no longer potentially in a measure, but it doesn't mean that the value of the care that they received at one point in time isn't as important or is not as comprehensive.

So the way that we segment measures isn't consistent with the population characteristics of Medicaid. We don't have the same level of stability in terms of insurance coverage, opportunities for enrollment change are not consistent at states. They have open enrollment continuously in some states, not in others. And those updated information doesn't kind of back into the claims systems that many states have.

And I would also caution, I had a little bit of a reaction, claims aren't all that bad. Encounter data isn't all that bad. And part of it, it is one method of obtaining information. The other part of it is that it gives the state the ability to check at a practice or provider level that doesn't exist if you don't have it that way. Turning in a measure is turning in a measure, but I can dis-aggregate the information through claims and MMIS. I can find out who the specific provider was at an individual level if I need to validate that

information, and it's part of the agreement that we have with our providers. So it's not all that bad. It is a payer system that's been washed, but it has its weaknesses. But it has some strengths, as well.

And part of the reason that I bring that up is related to the program eligibility groups that are there. Being able to segment population and knowing that their needs may be different, the help in the Adult Quality Grant to how it's considered disability as stratification based on, essentially, a basis of eligibility was something that I hadn't considered. I was looking for ways to use claims data to help identify disabilities. But using a programmatic eligibility criteria simplified the process, and I knew that other states would be doing something similar. So that allowed us to make some of the comparative information that's there.

And then, as I mentioned, the mobility of the population in Medicaid makes some of the claims reporting information and just that you

would, we see about a 30-percent drop between our total population and then those that are qualifying for some of the measures when we use continuous enrollment criteria. I'm sure that we're not unique in that regard either. Administrative dis-enrollments occur more frequently in some states than they do others, and, no matter how hard you try to characterize that missing population, it's really difficult.

Some of the age segmentation that we have is rooted actually in policies as funding. The CHIPRA program is one of the few federal programs that actually has required measures now. The CHIP measures, the well-child visits and EPSDT, those are actually required as a condition of the federal financial participation. But that program is going away, and so the leveraging that exists -- well, I mean, it's on the horizon maybe.

Okay. But encouraging states to participate is really going to be a heavy lift, and when I heard, it actually produced anxiety

when I saw the words mandate and then eliminating voluntary components. That was really tough for me to hear because one of the things that I learned in both the previous grant and this one was the minute that we start requiring measures is that's when they become marginalized. They're not in the forefront. What happens is they are a reporting requirement and not an area for people to rally around or to develop energy that's positive. We are in the production measurement mode, and that isn't the kind of environment that facilitates quality improvement.

So I mentioned the stratification by population, the population characteristics, and kind of the summary of the issues that I think that I would ask my colleagues at the federal level to take heed of. And I know they're working on it. They're not the only one in the game.

And then the characteristics of measures in general, I want to talk about those. The ones that are more general, they're easier to

produce, they cover more population, but they're also less actionable. So assistive care with the ambulatory care measures and some of the others that are there, they pertain to some other populations, they give us the ability to do stratification that we couldn't otherwise, but they aren't really the kind of granular-level kinds of measures that are important.

When we ran the measures past clinics to say which of these make sense to you, which ones would you use on a daily basis, the news isn't all that good. We published an article on it. It's about 20 percent of the primary care docs thought that our set, between the combination of both of the measures were relevant to their day-to-day actions or work. So I think there's some work that needs to be done about using some generative or some base level information from providers that serve not only Medicaid but other lines of business.

One of the things that we found was that the most compelling focal point for people,

practices, was using the CAHPS survey, clinician and groups version, not the health plan one, so we could provide practice-level feedback in concert with our managed care organizations to identify areas for improvement. Most of those were process-oriented, I'd have to say. And that might be just to those who like to focus in on health outcomes. But really where the system-level changes occur is on the ground, and it's supported by those managed care organizations. And being able to express or identify across payers and develop meaningful feedback mechanisms to the practices was probably the biggest facilitating course we've had in years. And part of that was a result of the Adult Medicaid Quality Grant, and we're trying to convert that work into a behavioral health setting, which we're finding this a little bit challenging because of the differences in organizational culture and the differences in how the steps are even set up. So the whole process is largely different. There's a lot of work that has to be

done around the area of patients experience of care in the behavioral health setting that we don't have.

And then, in the interest of time and getting to lunch, I want to make a point, and that is that I didn't use the word "burden." And when I mentioned this before, it was at the SNAC. Actually, it was Marsha who said, well, that's because you're Oregon. And we have an audience, a receptive audience, for the information. We have the political will and support that exists because they want to know what's going on. And they want to know specific areas where we don't know what's going on, and so that creates an environment where we're encouraged to explore and analyze.

The other states that I work with don't have that capability. They respond to, essentially, the directives and restrictions that are within the existing infrastructure, and thinking outside the box is really not one of the things that the states are supported to do. But

when we provide information effectively back to providers and to the states in ways that are usable, the perception of burden disappears. So it surfaces when the value versus the effort is not perceived, and that, in part, is based on not just generating the information but the interpretation, analysis, and use. So the feedback that we've provided to our practices and the managed care organizations was really critical in whether or not they thought that this was worthwhile.

And then it's also trending, too, over time. Not just one year's worth of results but the ability to look back over a period and figure out how sensitive their efforts were or how sensitive the measures were to their efforts. So that feedback loop was also essential in getting information and support for continuing the effort set measurement.

And that's the other outcome of the Adult Quality Grant that we found is that, while they didn't, at first it was, you know, do we

really have to do this and aren't there other systems? It's like are you really going to look at it? But then when we provided routine feedback to the organizations that we were working with, we found that they actually demand it now, as opposed to being resistant. So the concept of burden is relative to the value that's perceived.

I'm not going to have time to go through these next things. One of the things that we're doing in Oregon was to create an equity disparities index. And the reason why I'm just jumping to this framework, because I think it's relevant not only to, well, it's relevant to the topic that you're covering. And we started with a framework, and the first thing that we look at in assessing disparities is about the availability of healthcare insurance overall. So it's even before you hit the Medicaid program. Are you getting coverage? Is there equity in that area?

And then the next one is seeking care.

So, George, to your point earlier about what's the precipitating event that prompts somebody to go seek care, is it the same between different cultures and organizations? And so that's where -- so we used a select number of measures and dropped them in there. And then after they have coverage, after they have care, are they seeking access to coverage? Is it available 24/7? Is there a patient-centered medical home? And then once they are in those settings with quality of care within those venues.

And then the real disparities part comes into where there are measures where you know that there are disparities that exist. And then, finally, it's like having one primary outcome measure, either self-reported health status or improvements in self-reported health status or assessments of the managed care organizations, we use an endpoint primarily through CAHPS as the best judge of where they are is the person saying it themselves.

So I'm not sure how I'm going to -- I

mean, I'm at my time limit.

CHAIR PINCUS: How much longer do you have?

DR. GALLIA: Well, let's see. I think this is -- probably three-quarters of the way. Okay.

CHAIR PINCUS: See if you can finish up in five minutes so we have some time for discussion.

DR. GALLIA: Sure. So when we were producing this health equity index, we anticipated the issues. I just know they're there, and we had small numbers. We knew that there were going to be missing data, and we had to talk about whether they were describing relative versus absolute differences in health outcomes, and we had to think about how we were going to implement or use the improvement areas. And then we also had some other criteria, that it had to be statistically sound and usable for different areas, in addition to race and ethnicity. We wanted it to be applicable to

gender, disability, special healthcare needs or people with chronic conditions.

And this is just to give you one example. So just imagine, I mean, I can't imagine doing this at a federal level. So we have 16 coordinated care organizations in Oregon, and this is one measure. And we had to figure out, well, how do you incentivize differences between these programs? There's obvious difference in performance, and there's obvious differences that exist between race and ethnicity groups. So what do we do? You know, what is the key crux of how do you facilitate improvement? Do you hit a benchmark?

If we use a national or average benchmark, there's some populations who are going to be doing better than others. If we use the best-performing group, are we giving preference to a population that may have inherent benefits that they're experiencing that the other populations may not be? So even having all of this data actually didn't help us identify an

index, and that was just one measure, one measure.

And so I'm trying to convey it's a challenge. It's a challenge to not produce the measure because it's there. We can even stratify it by race and ethnicity, but how do you convert this into something that's actionable?

One of the things we did use and I wanted to give credit to the NQF. We prioritized those measures that were in this NQF report that are sensitive to healthcare disparities, and that helped us to use those.

One of the things that I was going to suggest that -- I'm going to skip past this -- is that when you consider measures, think about the added value that they have. So if there is, if there's layering that can occur between a state managed care and a practice level, those should be given priority over ones that only have one system level reflection. The same thing if you know that a particular measure is designed or is sensitive to disparities reduction, that should

be given greater emphasis, as well. So weighting those somehow, even if it's unconsciously, should be given some kind of priority.

One of the other things we had to do was that the CAHPS survey, which is one measure, one listed measure, has so much rich information that is really being grossly underutilized. One of the things we did was modify it a little bit in the three states and then continue to do it because when we do just managed care at a managed care level, translating that back down to a practice is really challenging. It's like, well, I don't know if my data is in there, I don't know if that even hit my practice. And if you have a response rate of 15 percent, you're not even going to be able to walk in the door and talk about it.

So what we did is a couple of things. We emphasized across payer, so when we report back we don't report back just on Medicaid, we do all payers. And we included people with chronic conditions and children with special healthcare

needs.

One of the other important things that we do is we added questions that are related to shared decision-making. So it's an area of the experience of care that's also not captured routinely at a national level. So if you're going to facilitate change, you're going to address the issue of concern about whether or not a patient is compliant or responds to their medications.

Having shared decision-making not only for adults but for children is extremely important. So we added that to the survey and made it so that it's adaptable for both the state and the practice level.

I'm just going to move to the last, my last points. When we started with -- why did we select measures? We do them principally for three reasons: they're required, we were asked to do it or requested, or we perceived that there's an area of anticipated need. In other words, there's enough other prevailing information that

we say, like, we need to do something in this area. And if we can, so it's taking the initiative. And that's not always possible in every state. Actually, I don't know many states that can do that.

So as I said, having something required means that it's going to be treated that way. But being asked, engaged, having supportive stakeholders for particular areas is really going to make, it's going to facilitate using the measure.

Data collection challenges are going to exist no matter what systems we have. I mean, and they're always in flux. And as the evolution of the eMeasures comes to play, that's going to have its own problems. So there was a question about the accuracy of each level of information. There's always going to be gaps. I mean, I think it's not a reach to say that we're never going to have a single perfect system of measuring healthcare quality across the country using a single data source or a few sets of measures.

It's an aspiration. But I think it's important to understand that you can do areas of focus and substitute measures over time. So you have to develop a system, a framework, that's organic, and it anticipates some of the information technology changes that are forthcoming. And knowing that don't bank it all on one measure. I think going back to some fundamentals with the thinking about what really comprehensively, when you take all these measures together, reflects the healthcare of adults, Medicaid, duals, those with chronic conditions, race and ethnicity, most effectively. That parsimonious set, you can test that. You can know that. And that's where I think the framework got to start.

And that's it.

CHAIR PINCUS: Well, thank you. A lot of issues brought up, a lot of possibilities for discussion. So why don't we open it up for discussion and comment by the task force? People feel overwhelmed with the information? Michael?

MEMBER SHA: I would like to thank

both of you for presenting your perspectives. I think this issue of asking states to supply measure results is a very difficult task.

I think the question I would have for Julia is the measure regarding controlling blood pressure, which is, I think, the external review set, it requires knowing the patient's blood pressure. So we've talked a lot about using claims data. How did California manage to capture the blood pressure values?

CHAIR PINCUS: And can I sort of add to that, as well, in terms of thinking about it. A number of the "innovative" measures that you described go well beyond claims, and that's an example of one. Talk a little bit about how you're capturing the data in those.

DR. LOGAN: Yes. Great questions. So that External Accountability Set is the one that we hold the managed care plans to, and so they're able to go and do a chart review into their data set. Certain healthcare organizations, like Kaiser, actually, they have that in their data

already, so they pretty much don't have to do any hybrid measures. They present all of their data to us administratively. So that's definitely a model to look to in the future.

And the innovative metrics are done with our public hospitals in California, and so they'll be able to do the chart review more easily even than the managed care plans would, theoretically.

But, yes, the controlling blood pressure measure is one that we're actually really proud of because we made some measurable change and we know change is small and incremental, but we did make some change. So we're proud of it.

DR. SULLIVAN: Just staying with that, did you use that measure, did you stratify -- I mean, did you look to see if, for example, patients with schizophrenia had their blood pressure controlled? Would that be difficult for you to do now with already doing the blood pressure control? Would that make it easier, or

is it something you've thought about doing?

DR. LOGAN: Yes. So the managed care plans right now are not obligated or required to report stratified data, and they've actually said that that would be an insurmountable challenge to them. And so that blood pressure data is provided by the plans, and so they wouldn't be able to do that fine look at people with schizophrenia.

DR. SULLIVAN: Do you understand why that would be such a challenge?

DR. LOGAN: I think partly because the enrollment data that they get does not necessarily have race and ethnicity. So what they do, because they do do some disparities analysis as part of their required PDSA cycles and performance improvement plans, but what they do is they look at primary language and they extrapolate from there any sort of disparity.

DR. SULLIVAN: Maybe by diagnosis, right? I mean, if you were taking a sub-population with a disability, like schizophrenia,

it should have that possibly.

CHAIR PINCUS: Yes, they did it by, you know, if people had a claim for schizophrenia over the same course, they could pull it out --

DR. LOGAN: Right. Although the way they do their measuring is through a sample, a sample of 411 members. So --

CHAIR PINCUS: So the N's would get small.

DR. LOGAN: The N's would get really small.

DR. SULLIVAN: Unless you sampled for that.

DR. LOGAN: Unless you, yes, over-sample or sample specifically for that, but we don't require that right now.

CHAIR PINCUS: So is the case, just to go back to my sort of add-on question, for the innovative measures that you described, those were all being done on a sample?

DR. LOGAN: They actually have the choice of either doing the full population or

sample.

CHAIR PINCUS: Other comments or questions? I had a question for Charles. It's actually several questions. One is your disparities framework that you described, is it essential that you go through all of those levels or can you pull out different stages of it, so to speak?

And also back to your point about some of the problems that you sort of raised about how actionable some of these things are, what do you mean by actionable? You know, going back to what we described earlier, some things are useful for analytic purposes, some things are useful for improvement purposes, some measures are useful for accountability purposes. And so how are you thinking about actionable?

DR. GALLIA: So the index and the framework, in order for it to be a comprehensive assessment, what we did in identifying those areas was those were trigger points where there were disparities, and they're cumulative. So if

you're not assessing disparities in coverage, then the subsequent population or each one of those are layered. And so it's important to take them at a total framework.

In terms of actionability, states' policies can impact who has coverage and who doesn't, whether or not outreach efforts and enrollment processes are simple or complex, whether they're passive or active. Those are decisions that can influence whether or not people have continuous coverage or not.

And then so that's actionable. We even have pilots --

CHAIR PINCUS: So you don't have to do the whole thing. Different components of it could be actionable for different purposes.

DR. GALLIA: Right. And, in fact, we have a PCORI grant that, with our, a select number of FQHCs that we're using just like a smoking cessation alert that would come up on a screen that says this person's insurance or child's insurance is due to expire. And so it's

a prompt to the provider, as well as to the front office, to say that they need to conclude the administrative paperwork so they don't have a break in coverage.

So there's an opportunity to engage practices, clinics, and groups in making sure that continuity exists. So that's another example of actionability that's found, and you can go through each one of those and make the same kind of connection. That's what I mean.

CHAIR PINCUS: Okay. Because I was worried you were painting too pessimistic a picture, but my sense is that, actually, a lot of the things you mentioned are, in fact, actionable.

DR. GALLIA: Oh, yes, they are, they are. No, they are. It requires getting past some of the administrative barriers, it requires getting past some of the administrative barriers, having a team of people and colleagues that are willing to work on a project. So it's possible to address them all, yes.

CHAIR PINCUS: Other comments, questions? Oh, Katie?

MEMBER DUNN: Yes, thank you. Reflecting back on some of the questions and one in particular about any points of feedback from the states need to influence the decision process about specific measures and what both speakers said. And, by the way, thank you. They were really excellent presentations.

I think Charles mentioned at the beginning, you know, whose interest should CMS and the states try to speak to so that the work that's being done from a quality measurement perspective is considered important? And I think one of the things states struggle with is is it possible to develop a set of measures and a reporting tool that can be used by all the potential audience members. I mean, I think it's one thing, at a state level, to write multiple versions of, say, a PowerPoint presentation because one day you're going out to the public and the next day you're going to policymakers and

another day you're going to the governor's office. But when it comes to this sort of effort, which is time-consuming and resource-intensive, how do we balance those needs that gets to the task force work of if that's an important part of whether a state is able to execute all the measures as to the expectations of CMS, then who really is our audience? We may not be able to answer that today, but I do think it needs to be kept in the back of our minds.

CHAIR PINCUS: Either of you want to comment on that?

DR. LOGAN: Well, Katie, this is Julia. Like you were talking about, the PowerPoints change based on your audience, I think the audience changes, you know, who is your audience for reporting the measures, I think that changes. It can be the lay public, it could be members, it could be advocates and stakeholders, CMS, ourselves. So sometimes that can be very challenging.

And to your point about this all being

so resource-intensive, and I think Charles is going to strangle me if I say this, but about the mandate, whether or not the core set should be mandated or continue to be voluntary, I'm not sure that it's still up on the table or if it ever was up on the table for whether we have input on this, but, from our state perspective, we would actually prefer it to be a required core set because it is so resource-intensive and because we do have many different audiences who ask us for this data anyway. But if we're required to do it by CMS, our state legislature would probably be much more likely to provide us funds to do the work that we need to do.

CHAIR PINCUS: Charles?

DR. GALLIA: I understand. I'd agree with you if I thought you were right. No, but I really do -- I think when I mentioned the burden idea, the measure is -- implementing and reporting the measure isn't the endpoint. And so when the calculus of the core set, what truly needs to be in a core set, I think it's incumbent

upon the states and CMS to calculate what the potential costs are across a system of implementing it and moving the measure towards a desired objective. In other words, how much effort is it going to take to move this measure and what will be the net benefits? I mean, really think about it in terms of implementation, not just the production part. But I mean working with practices and facilitating some of the changes that are going to be essential in order to have them on the ground.

Producing a measure and sending it to a report is just one facet of it. We have to make the commitment all the way through to making improvements, and it's not just on one measure at a time. We should be really mindful about, if they're going to be required, that there's the organizational commitment, as well as the resources, to be able to address it because, otherwise, we're going to set up a system of helplessness, and I don't think that's an effective way to implement quality measures.

CHAIR PINCUS: I think that is a good point, that we should always anticipate not just the cost of reporting but the cost of doing something about it and also the opportunity costs of doing something about A and not doing something about B because I think that's also critical.

Other comments, questions? Marsha? Oh, oh, Kim?

DR. ELLIOT: I was just going to say that I agree with everything that was said. It's really important to really understand those factors. But also, when you're looking at what's actionable and really looking at the measure set and looking at what other organizations are doing from a community and stakeholder perspective, and I know, Julia, you touched on that a little bit, that's really one of the keys to successes is whether you can align all of those community organizations, the Medicaid program, and any other area that's working on it. And that's where you're going to start to see your biggest

successes and your ability to really measure the outcomes and the personal effect of those different areas that you're focusing on. So I think it's great that you're doing that.

CHAIR PINCUS: Marsha?

DR. LILLIE-BLANTON: So I wanted to return to Katie's question because I think it is the right question to ask and then we have to try to answer it, and that is whose interest are we trying to serve? And I think it's really easy for us to fragment interests, but I view the partnership at the federal and state level being a similar interest or a common interest. And, ultimately, the main interest we're trying to address is that of the beneficiary, the enrollee. I mean, what we want is to improve the health of the beneficiaries we serve. And so trying to identify the measures that best help us do that, that help us drive improvement, while still controlling costs and managing those costs, I think is ultimately what we're trying to do.

CHAIR PINCUS: Charles?

DR. GALLIA: I wanted to, actually -- you set the framework for that a while ago, and I say "you." There was a relationship that was created between, a unique relationship between the states and CMS through these two grants, and that was because it was learning. It was a learning opportunity, and it was like what you do, a learning collaborative, but at a national level in many ways. And shared decision-making, the people we could talk frankly about where there were weaknesses and strengths without having to fear any kind of repercussions, and the states learned from one another because of the table that was created by CMS. And I have to applaud Marsha for helping facilitate that setting and continue to do so. It's been probably one of the biggest resources that I've used within our own state because I can say that providers in managed care organizations have the opportunity to influence this larger system because they're listening and that dialogue has really made it important to facilitate change.

So thank you.

CHAIR PINCUS: Other comments, questions? So I had a question to pose to both of you and maybe also to Karen and Marsha. But what would it take for the states to actually be able to access, for quality measurement purposes, clinical data through EHRs?

DR. LOGAN: Did you say what would it take or how long?

CHAIR PINCUS: No, what would it take.

DR. LOGAN: Oh, okay.

CHAIR PINCUS: We'll get to the how long afterwards.

DR. LOGAN: Oh, boy. My microphone is still on, so I guess I'm obligated to answer. I think it would, you know, I think you were talking about that you have to really, you really need to get alignment in each state. There's a lot of health information exchanges, but they're really lacking. I think that's one thing that's really important.

There's a few things that are

happening in our state where there's sharing across EHR systems, like health systems who have Epic can share back and forth but they're still not sharing with the state. That's one thing that we're trying to do with our PRIME program is have the hospitals share their clinical data with us in kind of a two-way exchange, and so we're testing that model.

But I've heard from several people that are very knowledgeable in our state that, to answer my question, I guess, about how long, but it would be ten years or so before that really, that exchange really happens. There's so many steps that needs to happen.

DR. GALLIA: Did you say how long would it take to see clinical level --

CHAIR PINCUS: Not how long. What would it take? What structures and processes would need to be put in place?

DR. GALLIA: One of the articles that we produced out of the CHIPRA quality demonstration grant was a comparison of the

clinical-level data and administrative data.

CHAIR PINCUS: Could you get closer to the mic?

DR. GALLIA: So one of the things that we did was a comparison of the clinic-level data and the administrative data. So we can do it, but it's a handoff. It's still a manual system, it's not automatic. So it's not populated. But we're moving towards establishing eMeasure specifications within the state so they're more real-time. It's still not what I would consider clinic-level data in that, you know, it's a snapshot. It's usually handed through different systems, but it's close. And we can do that essentially now.

CHAIR PINCUS: Because, I mean, what I was saying, it doesn't necessarily require that the state get all the data, but it could be done in a federated way where it's collected through the EA charge and then it's reported to the state. You know, again, it's sort of one of those perfect is the enemy of the good kind of

things where it may not necessarily need to cover the whole population but could cover a substantial portion of the population so that you get a reasonable picture.

DR. GALLIA: Articulating that outcome makes some providers and organizations extremely nervous and particularly in the behavioral health arena. The idea of not having more individual-level controls about sharing information and being able to do it --

CHAIR PINCUS: Yes, but it could be totally de-identified data.

DR. GALLIA: But even so, it's still, it just creates a lot of angst. And that's one of the things in implementing our adult quality grant in the behavioral health home. We had to work through with practices and organizations about sharing information, what was okay and what wasn't and how to do it. I'm not disparaging the notion. I just mean there's certain subjects and topics that are going to create a lot more anxiety, and that's one.

CHAIR PINCUS: I'm sort of pressing the issue, but I'd be interested in hearing from you guys. But why couldn't sort of each health system be responsible for reporting data on, you know, they would presumably have this information in their electronic systems of, you know, Medicaid participants, and they would also have data on hypertension, on their blood pressure, and report sort of aggregate information in a de-identified way from their healthcare system.

DR. MATSUOKA: I would say it's possible, and I've seen some states farther along on this than others. I came from Maryland where we had all of the hospitals sharing data with each other but then also aggregating data up at the state level.

And, of course, the meaningful use, health IT funded dollars. You know, every state has some participants, and states are essentially sitting on a lot of data but haven't necessarily built up the data infrastructure to do work with it. And we've tried to put out informational

bulletins around how you can use 9010 match dollars to build that out.

So I think there are ways to do it, but it's very challenging. And I think the states that have gone along the farthest have, to Charles's point, identified the sort of business case, whether it's the clinical business case or the payment reform business case first, and then the will was there to develop the data infrastructure support, the delivery reform that will make the business case for the people who are supplying the data.

So I think there's an infrastructure issue but then also making sure that the infrastructure is linked always back to delivery reform and payment reform is going to be critical. So it's challenging. It's very challenging. There are ways to get there.

The other, not low-hanging fruit but something that I was very curious to hear Julia talk about was data sitting in other federal areas where, potentially, you know, the HIV viral

load measure is something that I think about all the time because that's a HRSA measure. I think about where health IT adoption rates have been relatively healthy. That's at the FQHCs. I know that HRSA and CDC has HIV linkage to care initiatives that are state-wide in four states, and it was curious to me to see -- and Maryland was one of them -- it was curious for me to see that none of the four states in those grants are the four states that reported on the viral load measure.

So I think, even at the federal level, there are things that we might be able to do to unlock data to get at some more of these outcome measures so not necessarily getting to the HR data.

CHAIR PINCUS: One of the technical questions that I'm not sure who to address it to is, you know, the issue of the stability of the Medicaid population has come up several times. How has the relative degree of stability changed with Medicaid expansion? Has it gotten worse or

better?

DR. LILLIE-BLANTON: I would say that, at least in those states that have expanded which we're now at, we're about 31 states that have expanded, the stability has improved because those individuals, first of all, the range of coverage is greater and the opportunities for coverage are greater, so that even if someone no longer qualifies under Medicaid, they can move into the marketplace and there are opportunities for someone, you know, for example if they're a pregnant woman, there are some opportunities for them to stay with their provider if they choose to. So I think we're moving in the right direction in terms of stability of coverage. I do think we're still challenged in those states that have not expanded but in the others we are.

Interesting, too, I also wanted to mention that, while there is a lot of concern about stability of coverage, the few studies that have been done, Urban Institute has done a few of those studies, and it's not as bad as people

think. I mean, you know, it's somewhere between 9 to 11 months stability of coverage. But it's still, you know, I think for those states that haven't expanded coverage, it's still an issue.

DR. LOGAN: Yes. To add to that, we recently looked at how long people are staying in their managed care plans. And as I mentioned earlier, about 90 percent of our members are in managed care plans and about 70 percent of our members stay in a managed care plan over a year-long period. And they have the ability to change every month. I know that's not in and out of coverage, but that's at least stability within managed care plans, which is important for our plan to need to keep track of these measures.

CHAIR PINCUS: Other comments, questions? Katie, do you have anything further? Oh, Kim.

MEMBER DUNN: No, I'm all set. Thank you.

DR. ELLIOT: When I was at the Medicaid program, I was also responsible for the

EHR incentive program, so I did spend a lot of time looking at the linkages and how we could better utilize the EHR data going into the HIE, and one of the biggest things that was really important to work on and focus on was the ability in the agreements that are made between providers in the exchange and the health plans in the exchange and even the state in the exchange was just allowing the use of the data that's put in for quality improvement purposes, and that kind of takes some of the risk away of what you're going to be using that data for, from a government perspective.

And the other thing that really was a complicating factor is that, even though all of this money has been out there for incentives to put EHRs in place, there's still a huge gap. And the ability to use that data is still somewhat limited because it's only a small fragment of providers that are still reporting it, which creates additional challenges and barriers.

And then the third thing I would say

about that is it's also looking at the measure specifications and how that data in the exchange is considered. Is it considered administrative data? Is it considered chart data? And what's acceptable from the owners of that measure set to be able to use and how you would use that data coming out of that. But it definitely, in the next maybe ten years, should become a very viable source of information because more and more providers will, of course, be using EHRs and those that aren't may be retiring.

CHAIR PINCUS: Thanks. So now it's time to hear from any public comment.

OPERATOR: If you'd like to make a public comment at this time, please press star 1 on your telephone keypad. Again, that's star 1 to make a public comment. And there are no public comments.

CHAIR PINCUS: Anybody in the room wish to make a public comment? So why don't we break for lunch and come back at 1:00? Thank you.

(Whereupon, the above-entitled matter went off the record at 12:37 p.m. and resumed at 1:10 p.m.)

CHAIR PINCUS: So the main focus this afternoon is going to be discussion of individual measures and voting as well. We're going to be going through a measure by measure review. We're going to be asking - a number of people have made recommendations for measures that should be considered.

We'll also consider measures that, because of low levels of reporting, or because they're not functioning well, that we want to, you know, potentially recommend removing from the measure set.

And again, for the majority of them, they really don't - we don't need to have a detailed discussion of each and every measure for the ones that are pretty much functioning well. So Shaconna, do you want to begin to walk us through this?

MS. GORHAM: Sure, so as Harold said,

we'll do a measure by measure review, and really, the majority of the measures appear to be functioning well, so we're only going to look at the measures of - that had low levels of reporting, if you will, what we can learn about the measures that are a good fit for the program based on the relatively few states that reported on those measures. Next slide.

So I wanted to start by giving you just how NQF chose - how we chose some of the measures, the staff picks, and some of the measures that you will be voting on. So the measure selection criteria are developed to assist MAP with identifying the characteristics that are associated with an ideal measure set, so either for public reporting or payment programs.

So these are consistent across all of the MAP work groups, as well as the task forces. They are not absolute rules, but they are meant to provide general guidance on making the measure selection decisions.

The central focus should be on the

selection of high quality measures that address the National Quality Strategy, competing priorities often needed to be weighted against one another, and these measure selection criteria can be used as a reference point when evaluating the relative strengths and weakness of a program measure set.

So in addition to using the measure selection criteria, some other factors that will influence your choice of measures, as discussed and you heard a little earlier, we also like, we favor endorsed measures when possible because of the confidence in their scientific properties.

The ability to use administrative data captures a reasonable broad segment of the Medicaid population. Could the measures catalyze quality improvement actions in an area with low performance or recognize disparity, measures designated for use at the health plan or population level, and whether those measures are aligned with other programs such as HEDIS, Joint Commission's, Meaningful Use, and such.

So I'll just kind of briefly read the seven points. So the program measure sets adequately address each of the National Quality Strategy three aims. The program measure set is responsive to specific program goals and requirement. Program measure set includes an appropriate mix of measure types.

Program measure set enables the measurement of person and family centered care and services. The program measure set includes consideration for healthcare disparities and cultural competency, and the program measure set promotes parsimony and alignment, so those are the seven things that we really look at. Next slide?

So potential reasons for removal from the core set, so staff looked at reasons listed on this slide while considering the measures currently in the core set, specifically for considering measures for potential removal, so measures with consistently high levels of performance, multiple years of very low numbers

of states reporting, change in clinical evidence, or measures that do not provide actionable information. Next slide?

So these are the decision categories, and you actually have a handout in front of you at each place. We wanted you all to have that. We have three decision categories, support for immediate use, conditional support, and do not support.

MAP uses decision criteria, and again, these are the same across all of the work in all of the task forces. The decisions are used to provide consistency and clear direction to HHS, and then in addition to the decision category, there is usually a statement providing the rationale behind the decision.

So for this particular review, the two categories that you would most likely use are support, which would be used in the case of measures that are ready for immediate use and address and identify a gap, and then the conditional support category is appropriate for

measures that are either still going through the NQF endorsement process and are pending endorsement, or there is something that needs to be changed or addressed by either the measure steward or working with CMS to confirm the feasibility before it would garner a full support. MAP can express this condition as open ended.

So here's how to think about it. Support will be a green light, so we're signaling that CMS should move forward or we recommend that CMS move forward with the measure. Conditional support would be a yellow light, so we're signaling to CMS that we like the measure, but maybe we need to hold up for a little while because maybe NQF endorsement is needed and so forth. Next slide. Okay, so you saw this - yes?

MEMBER PELLEGRINI: Just a quick process question. We usually meet in December, right, to make recommendations for the next year? Is that -

CHAIR PINCUS: That's for the overall

MAP.

MEMBER PELLEGRINI: Right.

CHAIR PINCUS: This is on a different time frame.

MEMBER PELLEGRINI: Okay, thank you. Sorry, I'm getting my committees mixed up.

MS. GORHAM: Okay, so you saw this slide earlier, and this represents the four measures with zero to five states reporting. So we want to dive a little deeper into the measures just to see just some things about the measure and whether or not you all wish to consider removal or the measures are fine. So we'll go to the next measure, I mean, I'm sorry, the next slide.

And so we'll look at HIV viral load suppression. This was adapted into the Adult Core Set. So stratified and reported for two age groups, 18 and 64, and 65 and older. There were six TA requests submitted by four states. So those topics included use of the SNOMED codes, the numerator definition, clarification on

measurement period, continuous enrollment criteria, and allowable gaps in adoption of HVL for fiscal year 2014 reporting.

We also have reasons for not reporting the measure. They include 30 states reported reasons for not reporting the measure. The most common reason was that data were not available because of the requirement for medical record review.

So the number of states reporting the HIV viral load suppression measure in 2014 was three. The measure was not a part of the core set in FY 2013. In FY 2014, two states reported the measure using the Adult Core Set specifications which are based on HRSA's 2014 specifications, so this is to give you a little bit more information about the measure. Okay, next slide?

The PC-03 measure is a part of a set of five nationally implemented measures that address perinatal care. The measure was originally specified for reporting at the

hospital level. No TA requests were submitted for this measure. But reasons for not reporting the measure, 31 states reported reasons for not reporting the measure. The most common reason was the data were not available due to requirement for medical record review.

So the number of states reporting the PC-03 measure decreased from five states in FY 2013 to three states in FY 2014. Six states reported the measure at least once during the two years. Okay, next slide?

So care transition, transition record transmitted to health care professionals, the number of states reporting the care transition timely transmission of transition record measure remain unchanged from four states reporting in 2013 to 2014. Six states reported the measure at least once during the two years.

The measure was originally specified for reporting at the inpatient provider level. Two TA requests submitted by one state. Topics include calculation of denominator, chart review

process, and exclusion criteria.

Reasons for not reporting the measure, 30 states reported reasons for not reporting the measure. The most common reason was that data were not available because medical record review and data linkage are required.

So among states reporting the measure using the 2014 Adult Core Set specifications, median rate for ages 18 to 64 was 59.4, and the median rate for ages 65 and older was 40.5. Next slide?

Measure 0418, screening for clinical depression and follow-up plan. The number of states reporting the screening for clinical depression and follow-up plan measure remain unchanged with five states reporting in 2013 and 2014. Seven states reported the measure at least once during the two years.

In the fiscal year 2014, four states reported the measure using the Adult Core Set specifications which were based on CMS's 2014 specifications. Two states used the Adult Core

Set specifications for both years. The measure was originally specified for reporting at the provider level, and this measure is aligned with PQRS, CMS QIP, Home Health Core Set, and MSSP.

Reasons for not reporting the measure, 29 states reported reasons for not reporting the measure. The most common reason was that data was not easily accessible. Next slide?

Okay, so those, I just wanted to give you more information about those measures so that you had a broader picture. But based on staff review, none of the measures currently being reported were identified for potential removal. We thought that more experience and data points were needed, but I will turn it over to Harold for discussion.

CHAIR PINCUS: So these are the measures selected because, you know, primarily on the basis of - for discussion, primarily on the basis of the fact that states were not reporting it, and it sounds like in each case, it was because of the difficulty in getting data from

the medical record.

And so the question is do we think we should remove these measures because of that barrier, or should they be retained to see if states over time are able to begin to develop methodologies for reporting that? So we'll take nominations from the floor for any of these measures that might be nominated to be removed. Cindy?

MEMBER PELLEGRINI: I just have a question here. It seems to me like data not available is a vague statement, and so I was wondering if CMS can help us understand. Does that kind of mean the same thing from one measure to another, whether it's this group or others, or is that really kind of four different issues that we're putting in the same category?

DR. LILLIE-BLANTON: I would think it's multiple issues. So for example, early elected deliveries, it's about data that is needed from vital records as well as from a hospital reporting system, whereas of course,

care transition is about data not available for information that's largely at a hospital.

So the key thing about all of these measures is that they're not strictly - I would - I mean, I'd have to - I'm not looking carefully at them, but none of them are claims measures.

CHAIR PINCUS: Right.

DR. LILLIE-BLANTON: So the data's got to come from a source other than claims.

MEMBER PELLEGRINI: So this is a case of most likely multiple systems that are needed to be communicating with each other that just can't for one reason or another, but it's not like the same two systems over and over, okay.

CHAIR PINCUS: Well, it is in the sense that it's the medical record, you know, requires that somebody actually, you know, you have to hire somebody to go through the medical record and find the data, and so that's - and it's a limitation that's at the state level to get that reporting.

One question I would have is are any

of the other measures that were more frequently reported also require that kind of effort? Because it seems to me that controlled hypertension would also require that, and I'm not sure how many states are reporting that measure, and how do they do it?

MEMBER ANDREWS: Just a question on that. Isn't that - there are codes, I believe, for controlled hypertension or controlled blood pressure that can be used by the provider at the submission of the claim that can indicate that blood pressure is under control.

CHAIR PINCUS: Is that how it's reported?

MEMBER ANDREWS: That's how we try to collect it if providers usually work with that.

CHAIR PINCUS: Julia, maybe you could help us with that?

DR. LOGAN: So the difference with the hypertension measure is that, well, it's a very high priority for many, many states. It's also - it is clinical data, but it's clinical data

through, you know, a traditional medical EMR, not through a mental health EMR or a hospital where it's more difficult to obtain. So it's clinical data, but easier to obtain.

MEMBER CALMUS: So this is kind of a follow up to what Karen was talking about earlier, as well as kind of Cindy's question. Of these measures, it seems that there's a crossover in other places where they're being required. Have we seen it kind of reach the critical mass in those other areas?

The viral load I wasn't as familiar with, but with the care transition, I know that's a big focus on the Medicare side. So I guess my question is I don't know how well entrenched it is on the Medicare side quite yet. I know it's something that's really being pushed as a part of MIPS.

So the question is does it just need to reach a critical mass in another area before they're like, "Oh, we're already recording this data," and that infrastructure is there on the

provider side to get that information?

DR. MATSUOKA: I think that will definitely help, but then there becomes the issue of the aggregation issue as well, so all of those are going to be collected at the provider level, the ECL level, or whatever the level is, and then how does that roll up to a state level measure?

So it will be a two-step issue, but I think you're right, that I think that's what the CCSQ, AHIP, AAP effort is trying to do is trying to get alignment around a core set of measures at the provider level, critical mass around that, and then figure out how that can roll up to higher levels of aggregation.

MEMBER ANDREWS: Yeah, I'm curious to understand the staff's recommendation when more experience and data points are needed. I mean, the basic issue here is the fact that you need the medical record to retrieve that information which increases the burden on the system, on the providers, etcetera. So what exactly additional data points are needed, that the staff thought is

needed before these measures should be removed?

MS. MUKHERJEE: I think the thinking was that some of these measures have not been around a long time, so states might not have had the opportunity to implement and gather all of the data, or maybe proxy data, or even try to implement it.

And so to give them a year and then be like, okay, four states only submitted data, and these core sets on top of that are fairly new, so to give them some time. Like if this was year eight and they hadn't submitted data and there were still four states only, it's reached a tipping point where you can say, "Okay, you've had eight years."

"Whether you're building infrastructure, or you're getting sort of your providers on board, or making it a priority, you've had enough time to hit all of the policy, the infrastructure, the burden, you know, all of the sort of steps that might be used as sort of rationale."

But being that these measures, at least some of them, have not been around for long at all, I think on the staff side, it's difficult for us to just look at the data we get and be like, "Okay, this should be up for removal," because we would be doing a disservice to the state not giving them the opportunity to try and then not be able to do that, so data points not in specific data points, but data - longitudinal data, and maybe proxy data.

CHAIR PINCUS: Ann?

DR. SULLIVAN: I just have a question. If these - there are some states that are reporting. Do we - I mean, is it promulgated how they do it to the other states? Do they have to ask for technical assistance or do we kind of say to them, you know, "These are possibilities?"

I mean, do you give - if you're going to leave them there for a while to give them - spread the information about how maybe some states are doing it to some of the other states? I mean, does that happen or - I mean, does that

happen like on a regular basis or just if I ask from the state?

DR. MATSUOKA: So, it depends. So definitely any state that chooses to ask for technical assistance, we provide it to them, and then in some of these affinity groups and health initiatives that you'll be hearing about tomorrow, we do provide concerted technical assistance around how to report the measure, and then through some of these prior grants, that was a big focus of the grant program is technical assistance around reporting the measure.

So I think the answer is for selected measure - any states that asks for assistance, we provide, but the concerted sort of proactive outreach to states typically happens around some kind of focus area, whether it's an affinity group, like we have the antipsychotic for kids affinity group that's just kicked off.

A core piece of the work that we do with those states is going to be around, "If you want to measure this - or if you want to report

on this measure, here is some help in how to do that," and we do the same thing for the maternal and infant health developmental measures that you'll be hearing about tomorrow, as well as the sealant measure for oral health.

DR. SULLIVAN: I just think it might be a little early to kind of not see if states will figure out a way to do this, partly because many of the things we're thinking of in terms of outcomes, at least until medical records get a lot more robust, are going to require something like this.

So I think to just start to let them go just because they're not claims basically, or very easy, might not be the best move. I mean, on the other hand, I agree if it goes for a while and nobody picks them up, it might be best to just let them go, but I'd give them a little more time.

MEMBER DUNN: Hi, this is Katie, excuse me, this is Katie. One of the things, or a couple of thoughts that came to mind is

understanding that these measures represent important issues.

You know, our - have any of these measures been mapped to perhaps other measures that the states are using to monitor the outcome that we're trying to assess through these measures, and if so, is there more value in going with the measures that we know they can do, or are these so important that they absolutely have to be assessed at a population level, which is where we're looking at this, not on - not on an individual level, nor at an individual program or funding source level?

And I think I agree with, I think it was Ann who said, if you really want to build capacity here, I think that there is work that is going to need to be done to make that happen, but I would start by looking at if these are really important issues, explaining why they need to be monitored, how to go about it, and make sure that there aren't other measures that perhaps the states are saying, "These make more sense to me."

CHAIR PINCUS: Kim?

DR. ELLIOT: From a state perspective, you really do have to weigh where you put your resources if you're going to do chart review. So when I look at some of the measures, when I look at the prenatal one, for example, that one there, if a baby was born premature, we're already going to do a quality of care investigation and make sure that all of the care and service delivery was appropriate, and our health plans, of course, would as well, so that wouldn't necessarily rise unless we saw a lot of issues with the care and service delivery to the level of population performance measure or even performance improvement project. So we weigh things and balance them that way because there's such a limited resource to go out and do the chart reviews.

And for one like the viral load, we're looking at population size and adverse outcomes in determining whether there's an issue before we put it on as a continual performance measure in a

contract with a managed care organization.

CHAIR PINCUS: Cindy?

MEMBER PELLEGRINI: So I'm really fixating on this idea that some of this data is available in other data sets. I'm thinking about the perinatal measures that are on some of these lists.

You know, antenatal corticosteroids, that information is in the 2003 birth certificate, which I know the birth certificate data has some issues, and there is some lag time in it, but it's there. It just would need to be crosswalked, right, and matched against patient records.

Similarly, early elective deliveries are being reported as part of the hospital IQR or the Medicare IQR. So do you all get many inquiries about how to use these data sets together, or are states just kind of not even there yet thinking about it?

DR. MATSUOKA: Marsha can talk more about the experience that we've had with data

linkage. We have provided some outreach to states on how to do data linkage. It turns out to be less, I think, of a technological barrier and more of a, I think, a cultural barrier of a willingness to share -

CHAIR PINCUS: You need to get closer. You can bring the mic closer to you.

DR. MATSUOKA: So we do help states with data linkage, and we look specifically at vitals and claims for exactly this issue. And I think states have run into what seems like a fairly straightforward fix. It turns out to be fairly complicated in practice and for a number of different reasons.

Some technological, but actually in our experience, it turns out to be much more cultural, political, little p political in terms of how do you draw up the data use agreement so that, you know, both the data giver and the data receiver are comfortable with it, you know, things of that nature beyond just the technology aspects of data linkage and making sure it's done

in a valid, reliable way.

So the short answer is yes, we are working with states to do this, and I want to say it's - how many states? So we're making some headway, and efforts continue, but it's not, you know, all pervasive.

CHAIR PINCUS: Charles?

DR. GALLIA: So I wanted to talk about the measures and I'm going to speculate a little bit by the uptake based on some of the decision making that we did internally about whether or not to pursue some of the measures. One of them was this one, and part of it is we're going to have to explain it to somebody.

And it's really easy to explain depression screening or even the PQIs, as complicated as they are, because just the way that their topic is labeled. This one is more complicated and that means that you have to have somebody -

CHAIR PINCUS: When you say this one, which one?

DR. GALLIA: The HIV, the viral load. Combining the data set component isn't really, I mean, we did the early elective delivery and we did use the C-section, and we combined with vital records.

Combining data sets isn't too complicated, but it requires a staff that's dedicated to that, that can execute it, and follow it through, and do the project management that's necessary on both sides, public health usually, so those partnerships.

Even though we have some automatic data feeds between the two systems, it still requires a fixed step to do a specific project. That means that it has to have some authorization at some level. So if it's exploratory, then it's unlikely to go forward, but if it's something that's maybe required, then it might be more likely to happen.

So my point bottom line is sometimes the title itself can be an impediment about whether or not a state even considers looking at

the details behind what it is and what it means.

CHAIR PINCUS: So coming back to the central question, is there anybody that would make a motion to remove one of these measures? It sounds like no. Okay, so we're not going to be recommending removing one of these measures, but I think there is a note of caution that's been expressed that we should not let this go on for too long, that it is one -

The issue, I think, that Kim raised, is, you know, there is a certain - and, you know, in some ways reinforced by Charles, there is a certain level of resources that is required to sort of, to reach, to be able to gather the data for these measures, and that, you know, in some ways, it's that the states are voting with their feet, but in some ways it also may be waiting for some technological advance or capacity advance for them to be able to do that.

And so we're, you know, so we're holding off on suggesting removal, seeing if that hypothesis that might be true, that it's an

advance that will be able to reach a kind of critical mass to be able to capture these kind of data. Does that seem like a summary of the discussion? Karen?

DR. MATSUOKA: So I'm curious, so I mentioned earlier that the HIV viral load measure that we use is a HRSA measure, and that HRSA is ahead of the game in terms of the number of community health centers that have the capacity to generate this data, and to a similar extent, our public health partners who administer the Ryan White Program have this data, and so just like we do for the CLABSI measure.

Is there a desire or is there enough overlap with regard to the Medicaid populations that are served and will be in these other data sets to say, maybe not retire the measure, but is it okay that we use the data source being HRSA, you know, what we get out of the HRSA data set or out of the Ryan White data set? Is that another way to look at it if we can parse it out state by state?

Is that another way to get at viral load, not in a perfect way, and we won't necessarily be able to parse it out by Medicaid and non-Medicaid, but similar to what we've done with some other of the measures like the CLABSI, is that something that would be desirable and helpful at the state level to be able to see that kind of comparative information?

CHAIR PINCUS: I mean, just from my perspective, just thinking about that, I think that it depends to what purpose you're going to use it. So that, you know, looking at overall population, it's kind of like a dipstick into the population of getting it from the people that use FQHCs.

But the real question is if you did it that way, is it something that states will actually use in a more generalized way to improve their processes? And I don't know the answer to that. Kim?

DR. ELLIOT: Well, we did look at linking with vital statistics, and some states

have had good success. What we found with linking with some of these data sources is that they were more than willing to have us, as a Medicaid program, dump all of our data into their system. They weren't really willing to share just the very couple of pieces of information that we needed to be able to do some of the measurement on the prenatal side.

But linking with other data sources such as Ryan White and some of the others would be an excellent way, but an easier way probably would be just to try and collect the data directly from the labs. The labs do generate that information to health plans and they could put in their requirements and scope of the contract to get the -

CHAIR PINCUS: Yeah, I mean, it sounds doable.

DR. ELLIOT: Yeah, it's doable.

CHAIR PINCUS: So, but I think it still stands that we're not going to be recommending the removal of any of these

measures. Okay, so why don't we move onto measures that have been proposed? Oh, yes, actually we should introduce Sue, and David, and Lisa, who have joined us. Do you guys want to introduce yourselves?

MR. HUNT: Sorry, I was running late this morning. I'm David Hunt. I'm with the Office of the National Coordinator for Health IT, and you can kind of think of me as the new downscale version of Kevin Larsen.

DR. PATTON: Lisa Patton from SAMHSA. I'm the division director for evaluation, quality, and analysis within the Center for Behavioral Health Statistics and Quality. I'm glad to be here.

MEMBER KENDIG: Hi, I'm Sue Kendig, and I am a women's health nurse practitioner and attorney from St. Louis. I'm here representing the American Academy of Nurse Practitioners. Thank you.

CHAIR PINCUS: Welcome, and thanks, so -

MS. MUKHERJEE: Do you mind disclosing your DOI?

DR. WILSON: Yes, so it's just what they did on the webinar. It's a verbal disclosure of any conflicts of interest that you might have.

Thank you.

CHAIR PINCUS: Okay, so, Shaconna, should we move onto measures that have been proposed for --

MS. GORHAM: So although my slide says opportunity for public comment and break, we are moving ahead of schedule, so we'll skip this and come back to break and public comment a little later. Next slide.

Okay, so measure by measure review, potential gap filling measures for addition. If you all remember, a number of you submitted task force recommendations for measures to fill gaps, so we'll review the gap areas we went over during the web meeting, and then we'll get into the actual staff recommendation or staff pick, if you

will, and then task force recommendations or picks. Next slide.

So before you, you have the recommendations for high priority gap areas. So at the end of each meeting, we'll ask for gap areas, ask whether or not you think a gap area should be removed because we have addressed it, or if there are additional recommendations for gap areas.

The MAP recommended that the measure set be strengthened over a long term by the addition of measures in the key areas that you see before you. Gap areas are identified from state feedback, review of the 2014 reporting, and data on prevalent conditions affecting the adult Medicaid population.

Again, some areas recommended in 2015 as well as 2014 are on your slides, and that asterisk denotes the newly identified gap areas. Next slide? So this is a continuation of that list. So as you can see, MAP identified quite a few gap areas over 2014 and 2015. Next slide?

Again, just to remind you before we get into voting your decision categories. So the decision categories that we will mainly focus on are support and conditional support.

Okay, so in your very, very huge Excel spreadsheet that I sent you all, we identified measures in the particular gap areas, so perinatal and maternity care which we will discuss tomorrow, health related quality of life, we identified eight measures, behavioral health and substance use, we identified 24 measures, home and community-based services, we identified one measure, and engagement and activation of care, we identified two measures, and then finally work force, we identified one measure. Next slide?

Okay, so the staff pick or our recommendation for strengthening the Adult Core Set was Measure 2152, preventive care and screening, unhealthy alcohol use screening and brief counseling, and of course that would address the behavioral health and substance use

gap area.

Feel free to open up your Excel sheet if you want to get more information about the measures. I'll give you a brief overview and just highlight some areas, but if you want to get a full look at the measure, you can definitely access your Excel sheet.

So this measure addresses the substance abuse gap area. The measure steward is AMA PCPI. It is an NQF endorsed measure. This measure includes patients who are screened at least once within the last 24 months for unhealthy alcohol use using a systematic screening method, and who received brief counseling if identified as an unhealthy alcohol user.

It is a process clinical level measure. The data source is electronic clinical data. There are a number of definitions included in the numerator statement that are not included on your slide because we couldn't fit them, but they are in the Excel spreadsheet.

And the rationale for this staff pick is to foster the principles of care coordination through screening and then counseling. So screening without follow up services such as counseling is not as beneficial since it defeats the purpose of identifying those at risk. This measure also looks at access as well as covers behavioral health. So that is one measure for your consideration.

MS. MUKHERJEE: The yellow one is the staff pick?

MS. GORHAM: Yes, on your Excel sheet, yes, the yellow. The measure highlighted in yellow are staff pick - is a staff pick.

MS. MUKHERJEE: Is there just one staff pick in each area?

MS. GORHAM: We only chose one staff pick total. No, just total, exactly.

MS. MUKHERJEE: On each tab, is there one?

MS. GORHAM: No, so the only staff pick for the Adult Core Set -

MS. MUKHERJEE: Is this one?

MS. GORHAM: - is that one, and that falls under behavioral health and substance abuse.

CHAIR PINCUS: There are others that have been recommended by members.

MS. MUKHERJEE: Right.

MS. GORHAM: Yes.

MS. MUKHERJEE: Also in that Excel tab, there are colors which say that in 2014, and '15, they were also recommended, so this Excel not only has our staff pick this year as well as our committee picks, but also recommendations from previous MAP work.

MS. GORHAM: And we'll get to that a little later as we go through.

DR. LILLIE-BLANTON: Can you tell us more about the decision making for why - how one measure versus - for that one area? So for example, long term services and supports is one of the gap areas, so how was the decision made that a measure was not recommended for that area?

MS. GORHAM: So what we wanted to do, we wanted to one, pick the measure or measures, if you will, that we thought was a good fit based on the measure selection criteria, and we didn't want to overwhelm with a lot of measures. I think last year we maybe did two staff picks. So we try not to choose too many measures, and because behavioral health and substance use was a huge topic last year, we chose that measure versus another area.

But not to say that measures in the other areas are not as important, but we wanted to focus our choices, narrow them down, follow the measure selection criteria, and then just give one staff pick knowing that the task force members also had the opportunity to recommend, and we received five recommendations from staff from the task force members in other areas as well.

MS. MUKHERJEE: Also for the long term care, we know the HCDS project is looking at a lot of those measures, and we wanted to sort of

wait for that project to sort of bring so that we can tie into other NQF efforts and really use their knowledge and what they find to inform future MAP work.

DR. SULLIVAN: Yeah, I think that last year there was a lot of talk about the substance use indicators, measures, and I think the opioid one was the one that went forward, but I think there was a lot of discussion about the importance of looking at alcohol.

And just especially I think in the Medicaid population where it can be a very big issue both on the medical side as well as the behavioral health side, lots of medical problems are caused by chronic alcoholism.

So I think this in particular is one that is particularly good because it requires not just that you screen, but that you go to the next step which I think is important because a lot of our measures are screening measures and then you don't know what happens.

So this one, I think, is better

because it's screening plus that you get some kind of outcome. And certainly the actual detection of alcohol use is extremely low. I mean, they kind of know it's there, but it's not screened for. It's not detected, and the long term consequences are bad.

So I think that was a lot of the discussion last year about the importance of this kind of measures, which is probably, I'm assuming, why the staff and some put it on for this year. You didn't want to overload with substance abuse last year.

MS. MUKHERJEE: Exactly, well said.

CHAIR PINCUS: I was wondering, Lisa, do you have any comments? I know that you've looked at these kinds of measures, and if you - from SAMHSA's point of view?

DR. PATTON: Yeah, 2052 has been a core measure for SAMHSA with our National Behavioral Health Quality Framework since at least 2013, and we have really worked to, you know, get word out to the field and educate

around the use of this measure, and we've had a lot of interest in it from broad stakeholders, and a lot of support from CMS and others around using this.

And so I think it is a measure that is, it's utilized a lot, and I think it's also, you know, when we kind of talk about, you know, more palatable for a wider audience, this one seems to hit all of the marks for that. People feel comfortable, I think, implementing it more so than some of the other measures that we've looked at in substance abuse and behavioral health.

CHAIR PINCUS: Marsha?

DR. LILLIE-BLANTON: So I see that it's - the data source is electronic clinical data. Can you give us any information on reporting using the electronic clinical data sources?

DR. PATTON: Yeah, I'm not familiar with where the reporting is on that. I know that, you know, we're constantly looking at the

measure. We're working with AMA PCPI on that measure ensuring that it stays updated and that it is more broadly implemented with the e-specs and so forth. So I know my colleagues at the Center for Substance Abuse Treatment are in frequent communication with AMA around that and other similar measures.

CHAIR PINCUS: Other comments, Michael?

MEMBER SHA: You know, I don't doubt the importance, value, in fact, probably broad acceptance of this type of measure. I suspect it's going to probably fall in the same line as the depression screening. The data is not going to be available in claims databases, therefore it's not going to be widely reported.

You know, having said that, you know, I'm not necessarily opposed to supported this measure because of its importance. You know, at some point in the future, we may be able to develop data sources to have this measure reported, but I suspect it's probably going to

follow the same line as the clinical depression screening.

CHAIR PINCUS: I have a comment or two. One is that I think, if I'm not mistaken, this has been part of meaningful use so that there has been -

DR. PATTON: Yes, that's right.

CHAIR PINCUS: - that capacity. And also, can one file a claim for providing the screening and counseling?

DR. PATTON: Yeah, now we can. Yeah, now the providers can.

CHAIR PINCUS: So there is the ability to do that I think now. The other thing that, I mean, just to speak in favor of it, is that, you know, there already is the initiation and engagement measure, and that is a reasonable measure because it basically is looking at whether people who once identified with an alcohol or substance abuse problem, whether they get - sort of initiated and engaged in care, meaning that they've had one or two follow ups

over a sort of specified period of time.

The problem with that measure is that depending upon whether you do screening or not, the performance of that measure is highly sensitive to how people are identified. So in places where you're not screened, the people that come in tend to be highly motivated, and those places get - that population basically, you know, has higher performance as compared to a place where people are screened and get identified, and they may be less highly motivated, and therefore they're less likely to follow up.

So it kind of, you know, doesn't quite disincentivize, but it, you know, if you screen, you do worse on the initiation and engagement measure. This would sort of level the playing field, you know, by having it as a screening measure. So in some ways, in addition to being a performance measure, it's also a balancing measure.

MEMBER DUNN: This is Katie. If I may, although there are mandatory, and of course

optional Medicaid benefits that the state Medicaid program has to provide, there is no mandatory list of codes or billing codes that must be turned on within any one state's Medicaid program.

And although it might make total sense to all of you sitting around the table that the appropriate code for a screening for substance use would be a code that was active and was paying within a Medicaid program, I don't think we can assume that that in fact is the case because it is left up to the individual states.

The other part is states are being, state Medicaid programs are being asked to move into different alternative payment methodologies. There are a lot of questions coming up from providers that are saying, "Well, if you're going to pay me a bundled rate, then why do I still have to submit to you the individual billing codes?" And we are trying to explain why they still need to do it, but we are meeting some resistance to it.

MEMBER CALMUS: I just wanted to, you know, obviously this one is very important to rural areas. We're seeing, you know, decreased life expectancy as a result of alcohol use, particularly in rural women. I guess my question is the brief counseling and how much that entails, and how much that then gets intertwined with access issues?

Because we know that while there's a lot of substance abuse problems in rural, there's not a lot of resources for that follow up care. So I guess my question is how do we, you know, separate those issues without having to necessarily separate those issues and make sure that it's not just a box checking exercise? Which, you know, the depression screen was kind of talked about in the same -

CHAIR PINCUS: Lisa?

DR. PATTON: Yes, so I think that's a very good point, and one of the activities that we are undertaking at SAMHSA and have been for a while, but more so now, is to really provide that

kind of technical assistance and training so that there is that linkage between screening and brief counseling and what's appropriate.

We're also looking at the behavioral health workforce shortages and how that impacts on the ability to provide any needed referrals, where those shortages are, and, you know, different ways to approach that with telehealth and so forth.

So we're really trying to look at the big picture of how these measures get implemented and actually used in the field, and including the reimbursement issues that were raised by Katie. So, you know, we're working with CMS on that, really looking at ensuring that those codes do get turned on and that they are - that we see the measure, you know, particular core measures across programming where possible.

There's also an HHS wide effort looking at core measures among different programs, NCMS, SAMHSA, HRSA, and so forth, and more information will be available about that

going forward, but it also includes 2152 as a key measure for that effort.

CHAIR PINCUS: Other comments for or against? Okay, so I guess we're ready to vote. We're not?

MS. GORHAM: No, so we'll go through all of the measures including the task force recommendations, and then we'll vote.

I think they're going to be on the screen, yes.

CHAIR PINCUS: Oh, so we're not voting after each one?

MS. GORHAM: No.

CHAIR PINCUS: Okay.

MS. GORHAM: So the next slide? Okay, so the measures you have before you are those the task force members recommended. So there are five measures and we'll go through them individually, so the first measure 0055 comprehensive diabetes care eye exam performed.

This measure includes patients 18 to 75 with diabetes type 1 or type 2 who have had an

eye exam performed. The measure steward is NCQA. It is an NQF endorsed measure. It is a process measure.

The data source is administrative claims, electronic clinical data, paper medical records, electronic clinical data pharmacy. So the task force member recommended this measure because it is a composite measure for diabetes. The measure can facilitate the interpretation of quality data.

The task force member acknowledges that diabetes may not be an ideal specific ambulatory condition to consider for a composite measure given the need for lab data which may not be available for many Medicaid programs, but there are a few ambulatory clinical conditions with available NQF composite measures.

And I'm representing or I'm speaking for a task force member as they emailed me their comments, but feel free to weigh in as I go through the measures if I misstate something.

Okay, so our next -

CHAIR PINCUS: Yes, I think we should have questions or, you know, people speaking in favor or against as we discuss each measure.

MS. MUKHERJEE: And I would say the task force member or whoever has submitted, please feel free to chime in and sort of provide more elaboration. I'm looking at Dr. Shaw, but, you know.

MEMBER SHA: Yeah, so there are a few ambulatory chronic care conditions that have composite measures. There are only a few ambulatory chronic ambulatory conditions that have composite measures. Diabetes is one of them. Currently two of the other measures that are part of the composite measures are a part of the adult care core set. This would be in addition to it.

I think there may be further alignment, particularly with the IOM's vital signs report since the diabetes composite care measure is one of - part of their evidence-based domain. So I think if we could gradually add in

more items of the composite measures, we could probably eventually get to the point where we can actually report out the diabetes composite measure.

CHAIR PINCUS: Other comments or questions? Julia?

DR. LOGAN: Yeah, so, excuse me, as part of our external accountability sets or the measures that we hold our plans accountable to, we have this measure, and we have, I think, about four measures that we require them around diabetes, and the eye exam measure very closely correlates with the other diabetes measures, so the - especially the core set measures and the hemoglobin A1c poor control measure.

So some of us in our department think it may be a little bit duplicative because if you're already doing quality improvement around diabetes and control, that it may be kind of an extra burden that's unnecessary.

CHAIR PINCUS: Other comments? Cindy?

MEMBER PELLEGRINI: So I'm not going

to pretend I know much about diabetes outside of the fact that it's really important, but could you explain a little bit more about what the value added is beyond the four diabetes related measures?

I understand the composite and I think that is important, the composite aspect, but are there other settings or other providers here that we're measuring that we're not getting with the other measures or something of that nature?

MEMBER SHA: So I think if you're talking about a particular type of providers that we're not actually currently capturing with the core sets, I mean, for example, we are not assessing, for example, ophthalmologists or ophthalmology.

There are no core sets that address eye care within the core sets, and, you know, I think it's going to be hard to develop that composite measure without using all - eventually giving all of the components of the composite within the core set.

CHAIR PINCUS: Other comments, questions? Okay, so why don't we move onto the next member recommended measure?

MS. GORHAM: Okay, Measure 0541, proportion of days covered, PDC, three rates by therapeutic category. This measure includes the percentage of patients 18 years and older who met the proportion of days covered the threshold of 80 percent during the measurement year.

A performance rate is calculated separately for the following medication categories, RAS antagonists, diabetes medications and statins. A high score indicates better quality. It's a process measure. The data source is administrative claims. It is an NQF endorsed measure. And I do not have a rationale for this measure if the task force member who recommended it would like to speak up.

MEMBER SCHLAIFER: So I think the reasons for recommending this measure - and there is also an asthma measure on medication adherence. I think right now it's widely

accepted that one of the biggest issues we have in healthcare right now is patients not being adherent to their medications, and I think as we discussed a year ago, the attempt to try and add a medication adherence measure to the quality measurement set to provide more attention to that area.

I think some of these measures may be more natural and easy in a MCO or a Medicaid managed care setting, but the data, the prescription drug data is available in both Medicaid managed care setting and in the fee for service side equally.

So the attempt on this was to get some awareness with - you know, after we consistently talk about the issues of medication adherence measures, there are no medication, true medication management measures in the current set.

There is the anti-depressant medication management, but that's a physician follow up measure. It's not really a mediation -

it's not a true medication, "Are you taking your medications" appropriate measure, so this was an attempt to get that type of measure into the set.

And like I said, there is also, from what was recommended last year, there's the asthma measure, the 1799. So, you know, that one - I can see either one, not both. That one would go across both child and adult. So I could argue for this one or argue for that one, but I do think that we need to get Medicaid managed care plans paying more attention to medication adherence.

CHAIR PINCUS: So are you suggesting that if this was added, you would remove the asthma one?

MEMBER SCHLAIFER: The asthma one was recommended last year, but not moved forward, so I could go with either one. I think partly because the asthma one wasn't moved forward last year, the assumption might have been that maybe there are other - because there are other asthma measures, that this might be better. I can also

say that I think asthma in the Medicaid setting may be a better recommendation.

So not knowing exactly why the asthma measure didn't move forward, this is kind of an attempt to put two out there to see which one -

MS. MUKHERJEE: So, we will revisit asthma this year. And more measures.

The Coordinating Committee wanted us to sort of consider some other measures. And there wasn't enough time.

So, there are a couple of asthma measures we will discuss tomorrow. And at that point, it's going to be the Joint Adult/Child.

So, everybody will --

MEMBER SCHLAIFER: Okay.

MS. MUKHERJEE: Get to voice their opinion about asthma. So, whichever one --

MEMBER SCHLAIFER: So, I guess my suggestion, which people may or may not agree with, is in not knowing what direction the asthma measures will go, I would recommend that this move forward.

MS. GORHAM: Just a note for process. Today we'll vote on the measures. And then we'll rank the measures.

But, tomorrow we'll also look at maternity care as well as asthma care. And then you have the opportunity to vote and re-rank the measures.

So, if you like this measure, you vote on it today. No worries, you'll vote tomorrow asthma. If you like that better, then you can re-rank.

MEMBER SCHLAIFER: Okay.

MS. GORHAM: And then that will be fine.

CHAIR PINCUS: Okay. Other comments? George?

MEMBER ANDREWS: Yes. I will agree with including this measure with Marissa. Even if -- for a number of reasons.

The ease of capturing the data. This is administrative unlike what we have seen with the data challenges on the hybrid measures.

Additionally, even though this reflects a process kind of measure for various disease conditions, cardiovascular, diabetes and blood pressure, and also renal protection for diabetes with the RAS antagonists, these are medications that essentially improve outcomes.

So, indirectly helps support the outcome that we want to see. So, for all of those reasons, I think this is an excellent measure to incorporate.

CHAIR PINCUS: Other comments for or against the measure? Cindy?

MEMBER PELLEGRINI: Sorry, I'm probably the only person in the whole room that doesn't know the answer to this question. But, can you tell me exactly what proportion of days covered means?

MEMBER SCHLAIFER: Yes. Yes. I can -- if I can get exactly right. So, the proportion of days covered, it's gotten to be accepted, and even though clinically this probably isn't entirely true.

That if someone takes 80 percent of their medications, that that is considered being adherent to their medications. Obviously, we would prefer that people take 100 percent of the medications.

So, proportion of days covered looks at in 100 day period, what percentage of days did that person take the medication. The way it's determined is you look at over a one year period where you would have 365 days.

You know, how many days of tablets were dispensed in that period. So, it's calculated based on pharmacy data, pharmacy refills.

We do know, and it's, you know, obviously while accepted that just because you get a prescription filled, doesn't mean you take it. But, if you don't get a prescription filled, then you obviously don't take it.

So, you know, it's not the perfect esti -- you know, it's not an outcome's measure. We don't know someone actually swallowed the

tablet.

But, it's as close as we can get. And a lot of works been done over the last six or seven years at trying to get to the perfect medication adherence measures.

And this is accepted as close as we're getting it. It is included in the Medicare Star measures for Medicare Part D plans.

CHAIR PINCUS: Yes, this -- I mean, actually a number of years ago I chaired -- co-chaired the Medication Management NQF Endorsement Committee.

And there were a lot of different ways by which adherence was being measured at the time. And the Committee recommended this standardized way of doing it.

MEMBER SCHLAIFER: Yes. At the time that that meeting was held, there was debate between kind of two -- there was two different factions.

There was the MPR group, the medication physician ratio, and the proportion of

days covered that kind of debated it out in NQF. While I think more people at that time were using MPR, NQF went with proportion of days covered.

And that's become the standard.

CHAIR PINCUS: Any other comments?

(No response.)

CHAIR PINCUS: Okay. We'll have the next one.

MS. GORHAM: Okay. Measure 0027, Medical Assistance with Smoking and Tobacco Use Cessation. This measure addresses the behavioral health gap area.

The measure steward is NCQA. It is an NQF endorsed measure. And it is -- the detailed description of the measure is in your Excel sheet.

But, I will read it, because it's not on the screen. So, this measure assesses different facets of providing medical assistance with smoking and tobacco use cessation.

Advising smokers and tobacco users to quit. A rolling average represents the

percentage of patients 18 years of age and older who are current smokers or tobacco users and who receive advice to quit during the measurement year.

Discussing cessation medication. A rolling average represents the percentage of patients 18 years of age and older who are current smokers and tobacco users, and who discussed or were recommended cessation medications during the measurement year.

And now I'll finish discussing cessation strategies. A rolling average represents the percentage of patients 18 years of age and older who were current smokers or tobacco users, and who discussed or were provided cessation methods or strategies during the measurement year.

This is a process measure. A health plan/patient reported measure. The Task Force Member rationale for including this measure, but this -- it went past me.

We -- this measure's actually already

in the core set. But, -- right? And it totally -- I totally just had a brain fart I guess.

But, I'll also read the Task Force Member rationale. It could be reported for those with a serious mental illness as well as the general population.

But, it is already in the core set. So, we can move onto the next measure. I guess so. So, --

CHAIR PINCUS: Well, but this actually raises a question. Do we -- does recommending kind of a stratification, does that constitute sort of a separate recommendation that we would need to vote on?

Or does that -- or is that something that is sort of -- we don't need to vote on since it's already, you know, collected data?

DR. LILLIE-BLANTON: You're asking me?

CHAIR PINCUS: I'm not sure what the recommendation was. Was it adding that -- so, it's already part of the core set.

But, if we -- if that's being

nominated to be stratified by severe mental illness or schizophrenia, does that require an additional recommendation?

DR. SULLIVAN: I did this.

CHAIRMAN PINCUS: Yes.

DR. SULLIVAN: Just to say -- I mean, I would just suggest, I don't know what that means relative to what this group should decide on.

And so I think it was just a suggestion perhaps. Or should we think about stratifying it for the seriously mentally ill?

Because we know that the smoking rate amongst the seriously mentally ill is so much higher. And it's so much more difficult to get them to stop.

So, I don't know if that would be a recommendation to look at for the future or a gap? Or if that was something that could be stratified into the measures.

So, that's why I've kind of put it there. More for discussion then saying there was

an actual measure that had been codified. If you know what I mean.

CHAIR PINCUS: Yes. This came up actually several times before. Not so much in the, you know, in the contested element process.

And so like last time, you know, measure 1932 was added. Which is an existing measure.

But, it was sort of added as an additional measure, you know, the diabetes screening for people with severe mental illness it was, you know, it was a stratified measure.

And so the question is, does it -- since we're not -- it sounds like Ann that you're not -- you weren't recommending it be an additional measure. But, it would be stratified.

DR. SULLIVAN: No. I was just recommending stratifying it so that you could also pull out those with serious mental illnesses.

As long as you were kind of doing it, you know, to pull out those with serious mental

illness, bipolar, schizophrenia, and measure their -- whether they're getting the same thing.

You know what I'm saying?

DR. LILLIE-BLANTON: I wouldn't say that we would add a separate measure unless it was a -- we would add a different measure unless it really is a different measure.

CHAIR PINCUS: Um-hum.

DR. LILLIE-BLANTON: This is the same measure. And all we have to do is ask and encourage our State partners to stratify.

Whereas the other measure was actually a separate measure --

CHAIR PINCUS: Right.

DR. LILLIE-BLANTON: With a separate number. A separate methodology for collecting it and technical specifications.

So, I would -- you know, I think this would just be an encouragement to state -- our State partners to stratify.

CHAIR PINCUS: Okay. Or you can just use one of these.

DR. LIU: So, we're talking about whether there's a separate measure on tobacco screening and the brief counseling for people with serious mental illness.

There is a measure that's NQF endorsed. I can get you the number in a minute, the NQF number.

So, there is a separate measure of tobacco screening and the brief counseling about people with serious mental illness. So that if you are considering another measure for this sub-population, so that's an option.

CHAIR PINCUS: Lisa?

DR. PATTON: Yes. I was going to say, I think that one came up for discussion with the previous meeting of this group. It was part of the portfolio of 11 that included the SMI and diabetes measure 1932.

It was part of that portfolio. So, I think it may have been discussed at a previous meeting.

But, I don't have the number either.

But yes, it is available.

CHAIR PINCUS: Okay. This sounds like it was discussed the last time. And it was not endorsed or not supported.

DR. PATTON: That's right. I think the cardiovascular and the diabetes Screening went forth. But, that one did not. Yes.

DR. LIU: So then, the NQF number for that is 2600.

CHAIR PINCUS: Okay. So Ann, are you proposing that measure or -- formally or not?

DR. SULLIVAN: I think, you know, in terms of keeping things not too many, I think it would be -- I'd be -- personally it would be okay with me if we could suggest the stratification of this measure rather than adding the other measure.

If that would work. I mean, that's a fine measure, I'm not saying. But, I think in terms of just the numbers of measures, that that might make sense with that.

CHAIR PINCUS: Okay. So what -- any

other comments on this?

(No response.)

CHAIR PINCUS: Okay. Let's move onto the next one. No, let's go back.

MS. GORHAM: Okay. So, Measure 2111, Antipsychotic Use in Persons with Dementia.

This measure recently underwent maintenance review in our Neurology Project. And the Standing Committee recommended continued endorsement for this measure.

This measure includes the number of patients in the denominator who had at least one prescription and greater than 30 days' supply of an antipsychotic medication during the measurement period. And do not have a diagnosis of schizophrenia, bipolar disorder, Huntington's Disease, or Tourette Syndrome.

It is a process health plan measure. Data source is administrative claim. The Task Force Members recommended the measure.

The measure access is appropriate treatment for Dementia, which is a gap area. The

measure attempts to at least track and bring to the attention of providers if there is a high and chronic use of these medications in these patients.

DR. SULLIVAN: I put this one out as well. I think there's the simplicity in gathering this information, much like the other pharmacy one.

This is pharmacy administrative claims data. So, I think it falls to whether or not the Committee feels that looking at this particular issue is important enough.

And I think that theirs could be some different thinking about that. But, I thought it was worth at least mentioning.

Because I do think this is a gap area. And we need maybe to discuss. And maybe there could be other measures in the future if necessary.

But that it is important to think about this growing population of dementia. And this is a -- this particular one is tricky

because it's a harmed induced thing to some extent.

It's like doing the wrong thing. And you want to make sure that too many people -- that people aren't doing the wrong thing by over prescribing.

So, I brought it forwards partly to bring up the issue of the gap measure. And then I think it's just a decision on the group's part as to whether you would think at this point in time this was important enough as a con -- as an issue to bring forward.

Certainly there's an overuse of this. Certainly there's a growing population of dementia.

Certainly in the Medicaid population where a lot of people, especially in nursing homes, et cetera. This is not an unusual problem.

And this would give you the ability to track and look at it. And it's easy to do.

So, I just wanted it open for, you

know, for discussion.

CHAIR PINCUS: Comments?

MEMBER DUNN: Again, this is Katie if I may?

CHAIR PINCUS: Uh-huh.

MEMBER DUNN: Thank you. So, following up on what was just said, if this is a measure that is indicative of a wrong scope of practice, then it raises the question, what immediate response -- or what response does a State Medicaid program have to take with this data?

The other thing I would mention, I think it's, you know, I understand the importance of the measure. But, when we've tried to work with different providers, particularly those with a specialty in prescribing antipsychotics, we often get a lot of push back about off label use of certain drugs.

So, to the extent that that could be an issue with individuals diagnosed with dementia, that might be something to consider.

I'm not an expert in this area.

So, I'm just putting that out there.

CHAIR PINCUS: Other comments? Oh, Marissa?

MEMBER SCHLAIFER: I was going to say, I have not been directly involved with the Pharmacy Quality Alliance, or PQA for several years. But, this was -- when it was brought up, it was brought up as a recognized gap area.

And an area that needed to be addressed. And PQA was asked to create this measure. I don't have the details.

I mean, I could easily get them. But, not before we vote probably. But, I know that off label utilization was discussed a lot as this measure was being created.

I could try and see if I could contact someone and get information on it. But I don't have that now.

But, I do know that that was something that was addressed. And felt like this was -- that these medications should not be used in

these things.

But you can probably state too far better than I can.

CHAIR PINCUS: Well, let's let other people comment. So, Julia, George, Michael.

DR. LOGAN: So, a couple of things about this measure. The measure -- the population age is over 65.

So, it may not be completely appropriate for the Medicaid population and the issue with the duals and not counting dually eligible individuals. It may also be difficult.

And also, I don't have very much experience in this area. But I'm pretty sure that dementia can be under diagnosed.

So, we may be missing the boat with this measure. Because people who actually have dementia may be not diagnosed and then vice versa.

CHAIR PINCUS: George?

MEMBER ANDREWS: Yes. The comment that I want to make here is this particular

measure, the way I see it, impacts patient safety.

Prescribing a medication that is not for a specific and correct disorder, antipsychotics have effects on the cardiovascular system. Particularly the -- what is called the electricity as a system of the heart, the AV node.

Which can result in heart block and a need for pacemakers, et cetera. So it could be a patient falling, et cetera.

So, it is something that to me, if not appropriately used, it can have a negative health result.

CHAIR PINCUS: Michael? Then Kim.

MEMBER SHA: Well, as the Geriatrician in the room. I think there are a lot of good points being made here.

I would just sort of caution everyone that I think what we're talking about here is routine use of anti -- of a likely inappropriate medication.

I think there are situations of which it can be appropriate to use an antipsychotic in a patient with dementia. So, I would just ask everyone to sort of perhaps moderate some of their perspectives on this issue.

CHAIR PINCUS: Kim?

DR. ELLIOT: And I was just going to say that because at 65 and older, there will be a lot of Medicare claims involved. And I know that there have been initiatives with quality improvement organizations for Medicare to work with Medicaid on this particular topic.

And the data had to come from multiple sources. It wasn't strictly Medicaid. So, it would be a more challenging measure for a Medicaid program to measure.

CHAIR PINCUS: Ann?

DR. SULLIVAN: I think that the Duals Group is considering? Do we know anything like this? The dual eligibles?

MS. MUKHERJEE: So, they looked at -- they did look at dementia. And I'm not sure if

they specifically addressed this.

But, they did look at mental behavioral health and connections. And sort of connections across.

And I will check to see if this specific measure was recommended. But, I know they do have measures related to dementia and patients with dementia and treating them.

So, the Duals are looking at that. They're really looking at connections to community, connections of clinical and behavioral health.

And they tried to sort of see what measures they could find or what's sort of the gap area in this.

DR. SULLIVAN: Would it be appropriate -- have they seen this one? I mean, would it be appropriate for us to suggest that they --

MS. MUKHERJEE: So, their meeting happened a month before. The report is about to go to public commenting soon.

So, you can definitely public comment

on the report. And I will let you know quickly. Let me look at that about dementia.

DR. SULLIVAN: Okay. Because I was just wondering if there might be a route to ask them to look at it. If not right now, at a future date if they're going to continue something like that.

MS. MUKHERJEE: Well, definitely comment on it when the report comes out. And it should be early June.

DR. SULLIVAN: Great.

CHAIR PINCUS: I want to make -- let me step out of as the Chair while I make a comment on this one. I kind of agree with George.

And I think I agree with Michael as well. In that this measure is talking about continued use.

So, it's, you know, it's 60 day -- you know, more then 60 days in a year. So, you know, which sets sort of a threshold beyond sort of very short term use.

You know, there is a black box warning for these drugs indicating that they can produce death. Which is a bad thing.

And I also think that, you know, State Medicaid programs do, even though they may, you know, for people that are in nursing homes that may be duals, they do have a responsibility to those people as well as the Medicare programs.

And so I would speak in favor of this. Other comments?

MS. MUKHERJEE: So yes, it is in the Duals family of measures. And also their starter set, which is sort of a subset of their family.

Which is the place where we would like people to start when looking for measures for the Duals population.

CHAIR PINCUS: So, this goes along with alignment? Okay.

Julia, did you have another comment?

DR. LOGAN: No.

CHAIR PINCUS: Okay. And any other comments on this?

(No response.)

CHAIR PINCUS: Okay. Let's move to the next one.

MS. GORHAM: It's 2607, Diabetes Care for People with Serious Mental Illness, Hemoglobin AC -- A1C, poor control.

This is an NQF endorsed measure. This measure includes the percentage of patients 18 to 75 years of age with a serious mental illness and Diabetes Type 1 and Type 2, who's most recent HBA1C level during the measurement year is less than 9.0 percent.

And this is an outcome measure. The Task Force Members recommended this measure because it complements 0059 already in the core set.

This measure would require those with serious mental illness be reported separately. The purpose would be to look at disparities in the treatment of individuals with serious mental illness compared to the general population.

If there are disparities then there

would need to be a targeted strategy within this population.

DR. SULLIVAN: I put forward this one too. This is the same one I think that we recommended last year. But it wasn't accepted.

And my -- after hearing from California, I think it is interesting how you, you know, if you're doing a whole State population, it would probably be easy to do. It might be harder if you're doing samples.

But, you could also sample a group of individuals who have a diagnosis of schizophrenia. I think the point of this is again to begin to try to look at disparities.

And I think when you have a diagnosis that you know can end up with disparity by having a diagnosis of schizophrenia or bipolar disorder. But, that pushes you into the world of just seeing if they're getting the same level of care.

And this one's particularly nice because it would show you if they're not. If they're getting a -- if their Hemoglobin and A1C

is high. And if that rate was higher with this group, then the other group.

So, it's getting again to that question of look at and comparing the groups. And trying to pull out segments that might show a problem.

And we kind of know that control and -- amongst individuals with serious mental illness is not as good. So, this would then highlight that to the Medicaid providers, and the importance of focusing on that group.

So, I was just going to put this for -- I was suggesting we put this one forward possibly. Again, it was presented -- it was sent forward last year.

CHAIR PINCUS: Sue?

MEMBER KENDIG: You know, it strikes me that this also gets to some of the quality issues being addressed in emerging integrated primary care, behavioral health, medical homes.

So, it's -- it really does call out some of those unique issues that might be able to

give a quality picture of those types of clinical integration models.

CHAIR PINCUS: Lisa?

DR. PATTON: Yes. The real intent of this measure along with the health disparities aspect was to get at that care coordination -- piece. It's really a proxy for that, so.

CHAIR PINCUS: Other comments? Cindy?

MEMBER PELLEGRINI: I'm finding myself just a little ambivalent here. Clearly a really important issue.

But, I think I'm feeling the tension between wanting to create a core measure set that is generally applicable to the entire Medicaid adult population. And the desire to pull out some of those disparities in sub-populations.

CHAIR PINCUS: Sue?

MEMBER KENDIG: But I think it also -- and I understand that point Cindy. But, I think it does also go too really looking at populations that are driving poor outcomes, higher costs, looking at -- that sometimes gets lost in a more

generic measure.

And again, when we're looking at emerging clinical integration models. I think that's really where some of this can be really, really important for us to think about in a way that maybe we didn't in prior years.

CHAIR PINCUS: So, let me step out of the chair's role and make a comment on this.

So, I think this is kind of a three-for. And going beyond a two-for.

Where number one, it's the amount of effort to do this -- is not much more since we already have sort of an overall population comprehensive diabetes measure for hemoglobin A1C performance.

And this simply is a pulling out a stratum. So, that's sort of one, it's not a lot of effort.

Number two, is that it kind of reinforces the notion of shared accountability and integration and linkage between behavioral health.

Because it indicates that whoever's responsible for the diabetes care and for the schizophrenia care are mutually responsible for getting this kind of outcome. So, it reinforces that notion of integration and shared accountability.

And number three, it's focused on a, you know, clearly a population that is significantly at risk for dying early. And in many cases because of diabetes or other similar metabolic consequences.

So, I would speak in favor of it. Diane?

MEMBER CALMUS: I guess I would just follow onto what Cindy was asking. If we're using this as a proxy to demonstrate the connection between the behavioral health and the physical health side.

I guess I -- my question, and I have no idea, is this better than the diabetes screening metric? Or is that not showing that same -- same --

CHAIR PINCUS: I would say it's complementary to it. So, number one, are you able to identify them?

And number two, once identified, are you getting good outcomes? Because actually, if you don't identify them, they wouldn't be in this denominator.

MEMBER CALMUS: No. Yes, I absolutely understand.

CHAIR PINCUS: And so they're kind of complementary.

MEMBER CALMUS: Yes.

CHAIR PINCUS: It kind of goes along the -- sort of the logic trail that Charles presented earlier today. You know, it's sort of the -- you know, it sort of makes sense.

MEMBER KENDIG: And I would take that even a step further to the clinical integration piece. Because, you can identify them, you can even treat them.

But, if you don't have that care coordination, you will not meet the metric or

come close. And I think that's what this is telling me.

That it's more than just identifying them and treating them. But, it's also recognized the -- recognizing the whole person and the importance of that coordination piece.

So, I would speak in favor.

CHAIR PINCUS: Julia?

DR. LOGAN: Yes. So, I think it might be more of a heavier lift then the diabetes Screening for people with schizophrenia or bipolar. Because that includes serious mental illness. Which is also severe depression.

And so, you have to look at inpatient claims for an inpatient visit for major depression. So, that would be an extra, you know, looking at the hospital claims as well. Just a consideration.

CHAIR PINCUS: Cindy?

MEMBER PELLEGRINI: Does anyone -- can anyone in the room give us even a very rough estimate of what percentage of adults on Medicaid

have both diabetes and serious mental illness?

I don't have a good idea of how big this population is.

CHAIR PINCUS: There's a substantial comorbidity between people with schizophrenia and -- so, looking at the denominator of people with schizophrenia, there's a substantial comorbidity with diabetes.

In part because of poor self-care, obesity. In part because of the secondary side effects of antipsychotic medications.

MEMBER PELLEGRINI: Sure. But are we talking about tens of thousands? Hundreds of thousands of people? Millions of people?

CHAIR PINCUS: Lisa?

DR. PATTON: I think Junqing can speak to that.

DR. LIU: So, when we developed in the measures looking at diabetes care for people with serious mental illness, we did look into heart problems and also disparities in care.

We found that the prevalence rate of

diabetes among people with serious mental illness is doubling the rate among the general population. So, it's showing it's a higher prevalence.

And we know in Medicaid especially there's a high concentration of people with comorbid medical and behavioral health conditions.

DR. LOGAN: So, I'm just trying to get again the size of the pop -- if the proportion maybe very high. But if the starting population is modest, then the subset of that is going to be small.

So, does that make sense?

MEMBER SHA: Right. So, the prevalence of diabetes in the general population is about 67 percent. So, if you're talking about double, you're talking about 12 to 14 percent.

CHAIR PINCUS: Other comments? Lisa?

DR. PATTON: So, this may not be the time. But, I'll just mention again, 2152 really cuts right across the broad swath of the Medicaid

population.

The alcohol screening and brief counseling, and one of the ways that we look at it is really the impact on care management for a lot of these conditions.

So, if we were looking at a measure that really gets a lot of bang for the buck, that's certainly one of them.

CHAIR PINCUS: Other comments? Negative or positive?

(No response.)

CHAIR PINCUS: Okay. Let's move onto the next one.

MS. GORHAM: Okay. So --

CHAIR PINCUS: And then we vote.

MS. GORHAM: That is actually our last Task Force recommendation. And I just want to clarify, 2607 although we discussed and you all voted on that measure, when we prioritized, it didn't actually make the cut.

So, that wasn't actually a 2015 recommendation. But, we did discuss it and voted

on that measure.

So, now you have before you the measures that we will vote on. And we'll go individually and vote on each measure.

Again, we have upgraded here at NQF. And so you will use your blue clicker. And Katie, if you would chat me your vote, then I will vote for you. I have your clicker in my hand.

And before we start, I think Michael has a question.

MEMBER PELLEGRINI: A process question?

CHAIR PINCUS: Yes?

MEMBER PELLEGRINI: I know we're going to have a chance to re-prioritize and vote on other measures tomorrow. Not knowing what those other measures are, I'm just -- I'm thinking about a specific one that I expected to see on this list.

Not because I nominated it. But because I thought it would show up there anyway.

So, will there be a chance at some point to nominate additional measures? Or was that it?

MS. GORHAM: So, now is the chance. So, if you have other measures that you did not send to us earlier, then we can consider those now.

We can pull up the specs for them real quick. And we'll consider those before we actually vote on individual measures.

So, now would be the chance to do that.

MEMBER PELLEGRINI: Well, could you tell me if tomorrow we will end up voting on any of the contraceptive measures?

MS. GORHAM: Yes. So, tomorrow --

MEMBER PELLEGRINI: That's all I wanted to know.

MS. GORHAM: We'll discuss the maternity care as well as the asthma measures. So, we just broke the days up. We wanted --

CHAIR PINCUS: So, the contraceptive

and maternity?

MS. GORHAM: Yes.

CHAIR PINCUS: Okay.

MS. GORHAM: Yes.

CHAIR PINCUS: Because if you have contraceptive care you don't get maternity.

MS. GORHAM: Exactly.

(Laughter.)

MS. GORHAM: Yes. We wanted to do the measures that cut across both Task Forces on the days that we had both Task Forces here.

But, if you have other measures that apply only to the Adult Core Set, now would be the time for us to pull up that information if you want to put that forward.

CHAIR PINCUS: Michael?

MEMBER SHA: So, if we are going to talk about measures that were recommended in the last cycle that were not adopted by -- for the current set of core measures, then I might suggest 1927.

CHAIR PINCUS: Say what that is.

MEMBER SHA: Cardiovascular Health Screening for People with Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications.

MS. GORHAM: So, I can pull up the specs for that real fast. Let me see if we can get that on the screen.

Yes, it should be in the spreadsheet. If you go to your Tab that says 2015 Recommendations, it should be there. I'm pulling mine up as we speak.

Okay. So, if you're on the Tab 2015 Recommendations, I pulled that one up first. If you're on line four of that Tab, then 1927 is the measure that Michael put forward.

And that is Cardiovascular Health Screening for People with Schizophrenia or Bipolar Disorder who are Prescribed Antipsychotic Medications. That is NQF endorsed.

It is a process measure. Administrative claims, electronic clinical data, electronic clinical data pharmacy.

It's a health plan level measure. The care setting is ambulatory care, clinical office, clinical behavioral health, psychiatric outpatient and other.

And the steward is National Committee, NCQF.

MEMBER SHA: I think this measure addresses one of the identified gaps. I think it's a bridge between two different disciplines.

You know, we sort of focused on the risk that patients with, you know, serious medical -- mental health conditions have regarding diabetes. I think there are those high risks for cardiovascular disease.

So, I think it's worthwhile for the Committee to reconsider or re-nominate this measure.

CHAIR PINCUS: Charles?

DR. GALLIA: So, the question about the prevalence in the Medicaid population. I was in the back because one of the performance improvement projects that we did through the

Adult Quality Grand was related to diabetes care among people with schizophrenia.

That was our first attempt. But, we had to include bipolar disorder in order to have sufficient numbers in order to make it -- and I hate to use the word actionable again without a definition.

But, you get the population prevalence. So, with the combination of both bipolar or schizophrenia, it represents about 3.6 percent of the population, of the adult population in the Medicaid programs.

But, we did have -- it was a sufficient number to do a whole performance improvement project around that when we -- even stratifying it by the number of coordinated care organizations.

And they were able to demonstrate improvement. So, I'm saying that it was worthwhile. We implemented it.

The population while small, was still sufficient in order to take action on. And we

were able to demonstrate results using a modification of the measure.

CHAIR PINCUS: Thank you. Other comments on this measure?

(No response.)

CHAIR PINCUS: So, we should add it to the list. Okay.

So, are we ready to vote?

MS. GORHAM: No more recommendations?

CHAIR PINCUS: Um-um.

MS. GORHAM: Okay. Yes?

CHAIR PINCUS: Yes. Okay. So, let's go over, what button do we press for what? I can't see that far.

MS. GORHAM: And so let me just make a statement for the record. So, only Task Force Members are voting on the measures. Federal Representatives are not voting members.

And so we will state each measure number and measure title. And you will point towards Alexandra over here against the wall. And we will record.

And when we have greater than 60 percent, then that is a vote to include the measure into the core set and recommend.

MS. MUKHERJEE: So, once we're set up, we'll read out what one means and two means. And then we'll do a test run.

So, right now we're just setting up. So, if you bear with us one minute. Thank you.

MS. GORHAM: So, while they're setting up voting, I think we have one comment on the last measure recommendation.

DR. LIU: Oh, thanks for reconsidering the Cardiovascular Health Screening Measure. I would like to make several notes here.

Actually, I would recommend that the Task Force to consider another measure. I wonder whether that's the measure the second gentleman over there was referring to.

There is a Cardiovascular House Monitoring Measure for People with Cardiovascular Disease and Schizophrenia or Bipolar. It's also NQF endorsed. I can find the number in a minute.

So, the reason for recommending the monitoring measure rather then the screening measure is mostly because of the new guidelines by ACHC and American Heart Association.

Their new guideline is not recommending annual LDLC Screening for patients who do not have established cardiovascular conditions. Therefore, we are thinking the Screening measure maybe not the most appropriate.

Rather the cardiovascular monitoring measure, which is addressing patients who already have established cardiovascular conditions as well as schizophrenia and bipolar. Thank you.

MS. GORHAM: So, hearing that, do we still want to put that forward as a recommendation? Or do we want to -- how do -- okay.

MEMBER ANDREWS: Is the Screening for cardiovascular meant to be for people with established cardiovascular disease? Or is it meant to be for individuals with behavioral conditions that you're screening for

cardiovascular?

DR. LIU: That's a distinction between the two measures. The monitoring measure is intended for people who have established cardiovascular conditions as well as the serious mental illness.

In the screening measure, it does not require the denominator has a cardiovascular condition. So, that's the purpose of the Screening measure.

So, that is the correct NQF number you were referring to.

MS. GORHAM: And that number is 1933.

MEMBER SHA: So, I think the other difference between 1927, which is last year's recommendation, is that that measure covers patients with bipolar disorder as well as schizophrenia.

And 1933 only covers patients with schizophrenia. Which I mean, I'm just mentioning this primarily for informational purpose.

MS. GORHAM: So, Michael would you

like to -- cut your mic on.

MEMBER SHA: I would probably accept the recommendation for us to consider 1933.

CHAIR PINCUS: And not the other one?

MEMBER SHA: Correct.

CHAIR PINCUS: Okay. Are we ready to --

MS. GORHAM: Let me pull the title of 1933 then. Because we don't have that.

Well you can -- we're going to go through all of them and you're going to vote. And then we're going to --

MEMBER SHA: But no, I meant we vote -- we all vote for every --

MS. GORHAM: So, we're going to go through each measure, vote. And see which measures we get more than 60 percent Task Force support.

And then those measures left are the measures that we'll actually rank. So, for example, say that all five measures receive support of 60 percent.

So, then we'll take those five measures. And you all can pick your top three. And that's how we'll rank the measures.

And then tomorrow we'll add in the asthma and the maternity measures to rank.

MEMBER SHA: So, we should try to be selective? Or --

MS. GORHAM: You definitely want to be selective when we get to the ranking part. But, right now you just want to vote on all of the measures that you think would be a good fit.

Because we need at least 60 percent or greater in order to actually make that a Task Force Recommendation.

CHAIR PINCUS: So for this vote, people vote each measure independently. It's not a comparative thing.

Each measure is rated on its own merits.

MS. GORHAM: Okay. So, the measure that is being recommended is 1933, Cardiovascular Monitoring for People with Cardiovascular Disease

and Schizophrenia.

CHAIR PINCUS: Okay.

MS. GORHAM: So, give us one minute so that we can upload the measures.

So, I want to make sure, because we did not have this measure on the Excel sheet. Did you all want me to pull up the specifications?

And do you want to walk through the measure? Or are you okay with the measure?

CHAIR PINCUS: I think we'll be good to go.

MS. GORHAM: Okay. You're good. Okay. Catch a Michael at --

MEMBER ANDREWS: Yes, look at the specs.

MS. GORHAM: Okay.

CHAIR PINCUS: If you want to see the specs, we should -- yes.

MS. GORHAM: Okay. So, let's take a five minute break. Let me pull up the specs real fast. And we'll put it on the screen.

Okay. Well, she has the specs. All right.

MS. MUKHERJEE: Okay. Too many mics on. Okay.

So, Measure 1933, Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia.

So, the measure description is percentage of patients 18 to 64 years of age with schizophrenia and cardiovascular disease who had an LDLC test during the measurement year.

So, the numerator has one or more LDLC test performed during the measurement year. The denominator is patients 18 to 64 years as the end of the measurement cycle, December 31, with a diagnosis of schizophrenia and cardiovascular disease.

No exclusions. Not applicable. Risk adjustment, no. It's a process measure. It's a population health measure.

And the conditions it covers is mental health, cardiovascular disease, serious mental

illness. It's ambulatory care, clinician's office setting.

Administrative claims, electronic clinical data, electronic clinical data laboratory. And then level of analysis is health plan integrated delivery system.

And then, let's see, and it's an NCQA measure. Yes, any other information one would like?

MS. GORHAM: Okay. I think we're ready to vote. We are missing one person.

Okay. So, the first measure that we're going to vote for potential addition to the core set is 2152. You just want them to bring the slide up? Okay.

All right. So, the first measure again that we're voting on, and again, we need greater than 60 percent of votes. One is yes and two is no.

Again, Katie, if you chat me your vote, I will vote for you. And for those in the room, if you point at Alexandra.

(Voting.)

MEMBER DUNN: Hi, it's Katie. I sent my vote. Just so that you're -- you know it's coming through.

MS. GORHAM: I got it. Thank you.

CHAIR PINCUS: So, do we -- what's the number we're aiming at?

MS. GORHAM: Nine, ten. We have nine in the room and one on the phone, so ten.

MS. OGUNGBEMI: We had a bit of technical difficulties. Could we vote again, please?

CHAIR PINCUS: Tell us when. Why don't we just raise hands?

Should we be pressing the button now or? Okay.

MS. GORHAM: So, I might have misstated. We might have to go back to the old ways everybody.

MS. OGUNGBEMI: One more time. Go ahead and vote, please.

(Voting.)

MS. GORHAM: So, the measure passes. Seventy percent of the Task Force voted yes to support this measure.

We'll move to the next measure. 0055, Comprehensive Diabetes Care, Eye Exam Performed.

CHAIR PINCUS: When do we press?

MS. OGUNGBEMI: Voting is open.

(Voting.)

MS. GORHAM: Katie, please send your vote to me, please? Via chat. Yes, I got it.

MEMBER DUNN: Okay. Great.

MS. GORHAM: Okay. They're having technical difficulties with the voting system. Let's take a five minute break and then come back and vote.

(Whereupon, the above-entitled matter went off the record at 3:07 p.m. and resumed at 3:13 p.m.)

CHAIR PINCUS: We're ready to redo it, so if everybody could come back to their seats, or at least be in range of the -- whatever it is we have to be in range of.

(Pause.)

CHAIR PINCUS: Yes, we're missing some people.

(Pause.)

CHAIR PINCUS: Okay. So I think we're all here.

Okay. Okay. Right.

(Pause.)

MS. OGUNGBEMI: Okay. We are now voting on whether Measure 0055 should be added to the Core Set. Voting is open.

(Pause.)

CHAIR PINCUS: Has everybody voted or attempted to vote?

MS. OGUNGBEMI: We need one more vote, just one. He is not included, yes, thank you, okay.

Results are 60 percent yes, 40 percent no for whether 0055 should be added to the Core Set.

CHAIR PINCUS: We had 60 --

MS. OGUNGBEMI: It has to have been --

it has to be greater than 60 percent.

Yes. So the votes have to be greater than 60 percent, so greater than 60 percent is required in order for the measure to pass, if you will, for recommendation for addition to the Core Set.

CHAIR PINCUS: So that means 7 out of 10 people have to vote.

(Pause.)

MS. OGUNGBEMI: We are now voting on whether Measure 0541 should be included in the Core Set. Voting is open.

CHAIR PINCUS: Say again what the name of it is so everybody hears that.

MS. MUKHERJEE: It is 0541, Proportion of Days Covered: 3 Rates by Therapeutic Category.

(Pause.)

MS. OGUNGBEMI: The results are for Measure 0541 80 percent yes and 20 percent no. This measure is going to be added to the Core Set -- recommended to be added to the Core Set, not certainly.

We are now voting on whether Measure 2607, which is Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c Poor Control is going to be -- or is recommended to be added to the Core Set. Voting is open.

(Pause.)

MS. OGUNGBEMI: Results are 70 percent yes and 30 percent no. This measure is recommended to be added to the Core Set.

We are now voting on whether Measure 2111, Antipsychotic Use in Persons with Dementia, should be recommended to be added to the Adult Core Set. Voting is open.

(Pause.)

MS. OGUNGBEMI: Results are 60 percent yes and 40 percent no. Because we did not reach 61 percent, the measure will not be recommended to be added to the Core Set.

We are now voting on whether Measure 1933 should be added to the Core Set. I cannot recall the title -- and the -- the -- Measure 1933, Cardiovascular Monitoring for People with

Cardiovascular Disease and Schizophrenia.

(Pause.)

MS. OGUNGBEMI: Results are 60 percent yes and 40 percent no. The measure will not be recommended to be added to the Core Set.

MS. GORHAM: So those are the measures that we wanted to look at individually and vote on individually. Our thought was that we were actually going to prioritize today, but I think -- they'll pull up the results of the voting, but I think we only have support for three measures, and that being the case, I'll put it before the task force, do you want to prioritize those three measures, or do you want to hold onto those measures, vote on the asthma/maternity measures, and then prioritize after all of the measures are voted on?

(Pause.)

MS. GORHAM: Okay. So we had a motion and a second to just prioritize tomorrow after we vote on the asthma and the maternity measures and contraceptive measures, because you can't have --

(Laughter.)

MS. GORHAM: So -- so we'll do that. And just for the record, Alexandra, can you state the measures that the task force supported?

MS. OGUNGBEMI: Yes. The task force supported Measure 2152, Preventative Care and Screening: Unhealthy Alcohol; Measure 0541, Proportion of Days Covered: 3 Rates by Therapeutic Category; and Measure 2607, Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c Poor Control.

MS. GORHAM: Thank you. Okay. So we'll hold onto these measures. We'll discuss asthma, maternity, and contraceptive tomorrow, and we will then prioritize after that.

CHAIR PINCUS: Do you want to do public -- public comments?

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

(No response.)

OPERATOR: There are no public

comments from the phone line.

CHAIR PINCUS: Any public comments in the room?

DR. LIU: Can you hear me? Sorry I have not introduced myself. I am Junqing Liu, Research Scientist at NCQA.

So I'd like to make several comments regarding three measures. The first is the eye exam for people with diabetes. That measure actually shows the largest performance room for improvement among the diabetes measure set. Of all kinds of indicators, that indicator had the lowest rate. That's showing room for improvement.

And we did see correlations among the ten indicators. However, each of them is addressing a different aspect of care for people with diabetes, and that particular measure had the lowest rate.

So my second comment is about follow-up after emergency department visit for mental illness and alcohol and other drug dependence.

That's NQF number 2605. I believe that measure was discussed last year by the task force, but it was not recommended. I just wanted to give some update of the new developments since last year for that measure.

So that measure is now approved and included in HEDIS's 2017 measure set. So Medicaid, Medicare and commercial plans will start reporting that measure using 2016 calendar year data. That's just something for your consideration.

And also, that measure is used by CMS Medicaid Innovation Accelerator Programs. There were about a dozen states participating in that program, and they used Medicaid fee-for-service and managed care plan data to report that measure because they think that's an important measure because mental health and substance abuse issues are the top-ten conditions among Medicaid beneficiaries for ED visits, and there is also evidence showing that those who receive follow-up care -- who do not receive follow-up care are six

times more likely to be readmitted to the ED. And that measure is a pure claims-based measure, so that's more feasible to report.

So I would encourage the task force to consider that measure given the new developments and the evidence in support.

Another measure I would like to recommend is the NQF 2601. That is BMI Screening and Follow-Up Care for People with Serious Mental Illness.

I think we are all aware that metabolic risks are higher among this population, and our evidence find that there is higher prevalence of obesity and overweight for people with SMI, and that they receive lower quality of care. Our testing results showed that the performance rates on BMI screening and follow-up for people with SMI is half the rate for the general population. So 27 percent for the SMI, and a 54 percent for the general population. So it is definitely showing disparities in care.

So those are the three measures that

I would encourage the task force to consider. That's the follow-up after ED measure and the BMI measure, and also I made a note about the eye exam for people with diabetes.

CHAIR PINCUS: So I am -- actually, I have a question for NQF staff, just it's unclear to me why we have the voting before the public comments. It seems to me that you -- one would want to have public comments to inform the voting.

MS. GORHAM: We can -- so we can. We can --

CHAIR PINCUS: Just as a general rule. It's just --

MS. GORHAM: Right.

CHAIR PINCUS: -- I am curious to understand how that --

MS. GORHAM: So that's --

CHAIR PINCUS: -- process --

MS. GORHAM: -- definitely good feedback, so we can definitely make sure we do that, and we'll do that tomorrow as well as Day

3. But because I am assuming you -- you like some of the measures, and we can definitely put those back --

CHAIR PINCUS: I am just wondering whether --

MS. GORHAM: -- for consideration.

CHAIR PINCUS: -- you know, that information, you know, would influence people's thoughts about whether to reconsider or add some additional measures for consideration. So let me sort of open that up for nominations from people, having heard the comments from Junqing, are there any members of the committee that would like to reconsider any of the measures, or consider, because some of them weren't considered, measures again? Ann?

DR. SULLIVAN: The ED follow-up measure, where -- I mean, is that something that we could consider, or where is that measure -- has that been NQF-endorsed, the ED follow-up measure? Yes.

And it's being -- I mean, in terms of

the concept of alignment and doing things that to some extent kind of make sense, I don't remember that one actually from last year, but --

CHAIR PINCUS: It's a recently endorsed measure.

DR. SULLIVAN: Recently. So I would propose perhaps that that be considered. Is that possible, that we could add it?

CHAIR PINCUS: I think it's possible.

DR. SULLIVAN: I don't know if people are interested or not, but.

CHAIR PINCUS: George?

MEMBER ANDREWS: Yes, I know NCQA already has follow-up after hospital discharge, seven days and 30 days, and I know the results on those measures, or the performance on those measures, is pitiful in terms of the level of follow-up percent-wise, okay?

Emergency room is even tougher because a lot of the population that we're talking about uses emergency room as the primary care setting. So to get a follow-up post-emergency-room visit,

the access becomes a major and a critical issue, and -- and I know access, and I think we mentioned it earlier, is an issue.

Now, having said all of that, do I think it is important? Absolutely, definitely so. I think that, you know, addressing those patients that have had a visit to the emergency room, whether you are being followed by PCP or not, is a must, so I'm not sure what message I am saying, but I -- I do -- I guess overall, what I am saying is it's a tough one to manage because it encompasses again that access issue that I think is a critical one.

CHAIR PINCUS: So does that mean you're speaking in favor of it?

MEMBER ANDREWS: Yes.

CHAIR PINCUS: Okay. Other comments? And this is specifically on the follow-up after emergency room visit.

MEMBER SHA: So I think it's Measure 2605.

CHAIR PINCUS: So Ann, are you putting

that before us to vote?

DR. SULLIVAN: Yes, I'd like to propose that we consider Measure 2605.

CHAIR PINCUS: Can -- can we hear the specifications for that?

MS. GORHAM: Sure. The measure description, the percentage of discharges for patients 18 years of age and older who had a visit to the emergency department with a primary diagnosis of mental health or alcohol or other drug dependency during the measurement year and who had a follow-up visit with any provider with a corresponding primary diagnosis of mental health or alcohol or other drug dependence within seven and 30 days of discharge.

It is an NQF-endorsed measure. The numerator statement, the numerator for each denominator population consists of two rates, mental health and alcohol or other drug dependence. There are -- the denominator statement, patients who were treated in discharge from an emergency department with a primary

diagnosis of mental health or other alcohol or drug dependence on or between January 1st and December 1st of the measurement year.

This is a process measure. The care settings: ambulatory care, clinical office, clinic, behavioral health, psychiatric, outpatient, hospital, acute care facility. The data source is administrative claims. The level of analysis is health plan, population, state. And it is an NCQA measure.

DR. PATTON: Harold?

CHAIR PINCUS: Yes, Lisa.

DR. PATTON: Yes, so I think the meat of the discussion the last go-round was about the mental health or substance use being the primary diagnosis, and so there was some concern from the panel about -- about how the diagnosis would be categorized, that it might be secondary, or it might be coded as secondary, and so that would -- those numbers would be lost in the -- in the measure, in capturing it.

CHAIR PINCUS: Yes, so but I guess

this measure is designed to be less sensitive and more specific.

DR. PATTON: I just recall that as part of the reason it didn't go forward before.

CHAIR PINCUS: Other comments about this measure? Kim?

DR. ELLIOTT: I just want to voice some concern about the challenges in identifying those Medicaid members that are in the ED. There is no requirement under federal law now for hospitals to let a health plan or a primary care doctor know when a patient has entered the ED, like inpatient, so for them to be able to impact and get that follow-up care initiated is going to be extremely challenging. Sometimes they may not find out until those claims come in 30 days later, so the follow-up after discharge within seven days, the accountability and responsibility is going to be extremely challenging to apply to a health plan, a managed care organization or to a primary care doc.

CHAIR PINCUS: Other comments? Ann?

DR. SULLIVAN: I -- I absolutely agree on kind of how challenging it is. I think that it's very difficult. But I also -- it's a major I think failure of our system that we don't have more follow-up out of EDs, and I think when you talk about the opioid epidemic and you talk about the drugs, I mean, I think that one of the biggest areas for catching those individuals is when they're in the emergency departments, and we just don't pay enough attention to that. That is a big group of the Medicaid population.

So I -- while I -- I think what it would do is shine the light on the problem. I think it would be difficult to fix, but I don't know that that's a bad thing. I don't think any state would come out of this looking very good if they decided to run these numbers, but we talked -- we thought about access, et cetera, if there isn't access in the emergency rooms, and that's an issue, if people aren't getting the follow-up, it's an issue.

So I think it's the kind of thing

where you're not going to expect good numbers at all, but if you shine the light on it, I would hope that people might think a little bit more about what has to be in those emergency rooms to change this tide of phenomena that -- we keep saying too many people are going to emergency rooms, but we don't kind of emphasize enough what has to happen there.

So I would just -- so I would think it's an important measure.

CHAIR PINCUS: Diane?

MEMBER CALMUS: That was very similar to what I was going to say. I mean, this one seems like one of the measures that might be helpful from a policy perspective of providing information and really just getting -- getting that message to people who could actually, you know, change some of these issues and -- and make that follow-up possible, so for that reason, I think it's an important measure.

CHAIR PINCUS: Julia?

DR. LOGAN: Yes, I think it -- I think

it's definitely a very important issue, obviously. I think it would fall into the category of very few states reporting because of the difficulty with obtaining mental health data because they can -- the person can follow up with a mental health provider, so that would be very difficult for states to obtain.

CHAIR PINCUS: Explain a little bit why it would be difficult. If they put in for a claim, for an encounter, for a -- for a visit, for an outpatient visit, why wouldn't it be captured in claims?

DR. LOGAN: Well, it would be difficult for managed care plans to obtain. They can't obtain it. The state, the overall state program could obtain it, but the mental health claims for the managed care plans are very difficult to get.

CHAIR PINCUS: I am not sure I understand. Why is it different from other claims?

DR. LOGAN: It --

CHAIR PINCUS: Is it carved?

DR. LOGAN: -- is carved out, yes.

DR. LIU: If I could offer some notes here. So the measures we recommended for HEDIS Health Plan reporting do require corresponding benefit for the follow-up after ED for mental illness. It requires mental health benefits. And the follow-up after an ED visit for an alcohol or other drug dependence requires chemical-dependence benefit.

So those were carved out. The behavioral health benefit would not be required to report the measures.

The other note is that, when we develop a measure, we discuss with the -- our measurement advisory panels, they noted that there may be challenges in sharing that information between ED visit and seven and 30 days follow-up, but they thought that this measure, when it's out there, it would encourage providers between the EDs and outpatient to coordinate and communicate that information

sharing.

So they thought there is a gap in care, and that this measure would help to address the care coordination follow-up for this vulnerable population.

CHAIR PINCUS: So let me step back of being Chair and just comment on this.

So I -- I agree very much with Diane that this is kind of a broad-based policy issue that can push the needle, I think. Number one, I don't think that, you know, if there's a carve-out, they should get a pass, that actually, that states should be encouraged to require that, if they're going to have carve-outs, that that information should be shared and available and that's not insuperable. It happens in a number of states. And so that can be done.

And number two, it also encourages hospital EDs to develop a network of outpatient providers that they have sort of ready connections and access to, to be able to get follow-up. So I think at a policy level, I agree

with Ann, it's not going to look good initially, but it is something that shines a light on it and can encourage, you know -- you know, a bad situation to get better.

MEMBER DUNN: So this is Katie. I agree that the -- I am sure the measure will shine a light on the issue, but there's a huge feasibility issue here.

My experience, and I would think that experience of other Medicaid directors, is that the hospitals and their emergency departments are not the place for this type of system development. I venture that we could not pay them enough to do this sort of work when we can't even get them to have a dentist in their emergency room.

May I make a recommendation that this particular measure, if it's not included this year, that it go out to the Medicaid directors and actually do an assessment of what the feasibility is? I think between cooperation from the emergency departments as well as issues of

privacy and concerns about sharing mental health and SUD diagnoses, you would see a tunneling and a lack of coding of those -- of those diagnoses. Thank you.

CHAIR PINCUS: Other comments?

DR. LIU: Actually, I would like to share our testing results of the two measures. We tested the measures in Medicaid claims data, and the results, the performance results is 60 percent for seven-day follow-up and 80 percent for the 30-day follow-up. Actually, the rates are a little bit higher than the follow-up after hospitalization for mental illness. We discussed with our measurement advisory panels, they thought this makes sense because the ED population is different from the hospitalized population.

So, and for the AOD, our testing also, alcohol and other drug dependence population, our testing results show that there is sufficient denominator for that ED visit for alcohol and other drug conditions.

MS. RANEY: And in terms of testing, this measure is part of the Certified Community Behavioral Health Clinic Demonstration Pilot. It's one of the required measures that are going to be part of that pilot going forward, so while all the states have not yet been collecting that measure, it is part of that -- that measure set for -- for attempted collection and reporting.

CHAIR PINCUS: And 24 states had planning grants --

MS. RANEY: Twenty-four states had planning grants, and I think eight or so will be selected in January of 2017.

CHAIR PINCUS: Any other comments?

(No response.)

CHAIR PINCUS: So are we prepared to vote on this?

(No audible response.)

CHAIR PINCUS: Okay.

MS. OGUNGBEMI: We are now voting on whether Measure 2605 should be added to the Adult Core Set. The title is Follow-Up After Discharge

from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence. Voting is open.

I am not sure the system was capturing responses, so you -- could you please vote?

For those listening on the phone, we're having some technical difficulties that we're trying to resolve.

Let's go to a manual vote, please. Okay. So we are voting on Measure 2605, Follow-Up After Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence. We have nine voters. Katie, I have your vote. Raise your hand if you support the measure.

(A show of hands.)

Six, yes. So we had six members vote in support of the measure. And can we have hands raised high for those who do not support the measure?

(A show of hands.)

Three. Okay.

So for the record purposes, we have six task force members in support of Measure 2605, and we have three task force members that do not support the measure. So that is 67 percent in support of the measure, so this measure we will vote later after we vote on asthma as well as maternity, whether this measure will be included into the Core Set as a recommendation to CMS.

CHAIR PINCUS: So are any -- is there anybody else proposing any other measures?

(No response.)

CHAIR PINCUS: Okay. So why don't we move on to --

MS. OGUNGBEMI: Gaps.

CHAIR PINCUS: -- gaps.

MS. MUKHERJEE: So the last section of the day is a discussion about the gaps, the gaps that we have identified so far and any additional gap areas that have come up today.

One that was mentioned was stratification, but this is the -- the MAP gap

list as it stands right now, and the elements are beneficiary-reported outcomes; access to primary, specialty, and behavioral health care; care coordination; and some of these have some sub-points like quality of life; integration of services, especially medical and psychosocial; primary care and behavioral health integration; cultural competency of providers; efficiency, and by efficiency, misuse, overuse, inappropriate emergency department utilization; promotion of wellness; work force and chronic opiate use; polypharmacy; engagement and activation in health care; trauma-informed care; treatment outcomes for behavioral health conditions and substance use disorders; maternal health, which we will deal with tomorrow and look at all the measures; and then long-term supports and services.

And just a note that the HCBS, the Home- and Community-Based Services project is still ongoing, and they are looking at sort of the universe of HCBS and measures and everything there.

And then the one extra point we discussed today that's not on this list is stratification within a measure based on severity based on type of mental illness, and -- and now, I turn it over to Harold for a discussion of these questions and addition of any gap areas to this list.

CHAIR PINCUS: So, I mean, we should probably go back, but I -- I guess the -- go back to keeping that in front of us, the list.

So looking at this list, do people think that, with our recommendations that we have made so far -- and actually, could we just remind everybody about what those recommendations were, specifically? Because I guess the ones that we've formally recommended are -- I think there were four measures that were officially recommended?

MS. GORHAM: So I can tell you quickly the numbers. I have to -- it would take me some time to get the title of all the measures. But 2152, 0541 --

CHAIR PINCUS: We -- you've got to tell us what they are --

MS. GORHAM: Okay. Give me a --

CHAIR PINCUS: -- and not just the number. It's hard to keep a spreadsheet in our heads.

MS. GORHAM: Okay. 2152, Preventive Care and Screening: Unhealthy Alcohol Use Screening and Brief Counseling was one measure recommendation. 0541, Proportion of Days Covered: 3 Rates by Therapeutic Category was another recommendation.

2607, Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c Poor Control was the fourth recommendation. And 2605, ED visit, was another recommendation. 1933 did not pass.

CHAIR PINCUS: So just looking at that, it seems that there was two that relate to behavioral health, although it's not specifically with regard to access. And screening for -- yes, it's alcohol, and also the one for, yes, for

diabetes, so it was three that relate to behavioral health, so they are not specifically for access.

One of them is partly related to outcomes in terms of the diabetes one, although it's -- it's outcomes in relationship to a comorbid chronic illness. And it's not clear whether the fourth one, which is the -- the days covered --

MS. GORHAM: We'll put them on the screen --

CHAIR PINCUS: Yes.

MS. GORHAM: -- so that you can see them.

CHAIR PINCUS: -- is specific to any of the gaps mentioned. So the -- it's not clear. That would be a leap because you -- I mean, people think of wellness as something that's more preventative, not for people that have, you know, a chronic disease and seeing whether they're taking their medication.

MEMBER SHA: So would the diabetes

care of patients with serious medical illness address the primary care and behavioral health integration?

CHAIR PINCUS: Yes, that would be one that does.

So I mean, do -- do people have any suggestions, given what we just voted on, that we should remove any of these gaps? Any proposals to remove gaps?

(No response.)

CHAIR PINCUS: Can you maybe go back to the gaps list? Marissa?

MEMBER SCHLAIFER: The only thing I thought was worth mentioning, and I don't -- I don't think it addresses it, you can just take it off, with the opioid use. I think they're completely different, but I just thought I would throw that out there.

CHAIR PINCUS: Okay. No, that's a good point.

MEMBER SCHLAIFER: I think they are different, but --

CHAIR PINCUS: Yes, but the question is is that -- do people think that there's sufficient coverage given some of the new measures that have been proposed to eliminate any of these gaps?

MEMBER SCHLAIFER: And I would say no, but --

CHAIR PINCUS: Okay. So anybody, going once, going twice, going three times?

(No response.)

CHAIR PINCUS: So no gaps are being removed. Are there any gaps that people feel should be added based upon the review of what we just looked at both in terms of what has been proposed and what has -- and what is currently in the measure set? Oh, Kim, did you just put your thing up?

DR. ELLIOTT: It -- it doesn't really fit into any of those buckets, but I continue to be concerned about access to care on the behavioral health side, and there really aren't good measures to capture that.

And I think everybody that provides care and services on the behavioral health side is extremely important to the system, but every measure that I've looked at over the last several years doesn't focus on the assessed need of that individual and getting them in to a behavioral health professional. It really focuses on many of the supportive types of providers, which are critical in the system but may not be addressing the fundamental need of that individual from an access to care perspective.

So I just want to throw it on the table that we really need to start looking at developing a measure, if there isn't one being developed, related to addressing the access to care to behavioral health professionals.

CHAIR PINCUS: I should say that a few colleagues and myself actually have proposed developing such a measure in a grant proposal to NIMH that was not funded, yes, essentially developing at a -- at a health-plan level an accessibility to -- to behavioral health care

index.

DR. ELLIOTT: Well having managed the quality of care and adverse outcomes for the Medicaid program for many years, I just see the adverse outcomes that have occurred as a result of -- and we all know that there's a lack of providers available, but if you're not measuring it, there is not much you can really do to address that issue.

CHAIR PINCUS: Yes. So yes, so it's -- basically, you're putting sort of added emphasis onto that category and added urgency.

Any other comments, suggestions for things that are left out?

(No response.)

CHAIR PINCUS: Okay. So let's continue with this gap and hopefully that we can encourage -- and one of the issues is who is it that we should be encouraging to develop these measures? I -- I think that one group that we should certainly as an audience for this, is NQF itself, as they, you know, develop some of their

new procedures in terms of thinking about the, you know, measurement -- measure incubator process and those kind of things, so I think that would be an audience that I think is worth, you know, really specifying. Also CMS, which still has, I think, a load of resources for measure development.

DR. MATSUOKA: Less so on the Medicaid side --

CHAIR PINCUS: Yes.

DR. MATSUOKA: -- yes.

CHAIR PINCUS: And obviously NCQA as well.

Okay. So any other final comments?

(No response.)

CHAIR PINCUS: Do we have public -- any reports from the public at the end?

MS. GORHAM: So we moved public comment up.

Operator, if you can open the line for public comment please?

OPERATOR: Okay. At this time, if you

would like to make a comment, please press star and then the number 1.

There are no public comments from the phone lines.

CHAIR PINCUS: Any public comments from the room?

DR. LIU: So I noticed one gap area that this task force identified is access to care, so we -- NCQA has two relevant access to care measures I would like to mention.

One is Adults' Access to Preventive or Ambulatory Health Services. I can search to see if that one is NQF-endorsed. If so, we can find the number.

The second measure is Use of First-Line Psychosocial Care for Children, Adolescents on Antipsychotics. That measure, I believe, is NQF-endorsed. I know there will be a Joint Child and Adult Task Force meeting tomorrow, so the idea of that measure is to promote use and access to psychosocial care around the prescription of antipsychotic medications.

CHAIR PINCUS: So -- and I think that's actually a good point that I think is worth putting on the agenda for tomorrow's discussion, or tomorrow and/or on Thursday, because last time, there was a recommendation from the Child Task Force for multiple antipsychotic use which was not -- which was actually proposed for endorsement but was not endorsed by NQF.

DR. LIU: Actually, the use of -- the first-line -- use of first-line --

CHAIR PINCUS: Right, but the -- but the one for multiple -- multiple antipsychotic medication was not endorsed, and so it -- and that was the one that was recommended for the child Medicaid set.

MS. GORHAM: Yes, and the Child Task Force will have that conversation on Day 3.

CHAIR PINCUS: Okay, so we make sure that goes. Okay. Thank you.

So it has been a -- a busy day, intense, and thank you, all. I want to thank all

the members of the task force. We have another busy day tomorrow.

I especially want to thank NQF staff. You know, it's a lot of work to prepare for this, so we really appreciate it. So I will see everybody tomorrow.

MS. GORHAM: Yes, and I definitely want to thank you all for your patience with our voting problems, but we hope to have all of the technical issues straightened out for tomorrow. I know that a few members are going to dinner, so if you all would like to all go together for dinner, then definitely let us know. Thank you.

(Whereupon, the above-entitled matter went off the record at 4:02 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 Forces

Before: NQF

Date: 05-24-16

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