NATIONAL QUALITY FORUM

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IN-PERSON MEETING
MAP MEDICAID ADULT TASK FORCE

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THURSDAY
JUNE 11, 2015

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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.

PRESENT:
HAROLD PINCUS, MD, Chair
GEORGE ANDREWS, MD, MBA, CPE, FACP, Humana, Inc.
ANNE COHEN, MPH
BEVERLY COURT, MHA, PhD, State of Washington Department of Social and Health Services
KIRSTIN DAWSON, America's Health Insurance Plan
DENISE DOUGHERTY, PhD, Agency for Healthcare Research and Quality *
NANCY HANRAHAN, PhD, RN, FAAN
SUE KENDIG, American Academy of Nurse Practitioners
MARC LEIB, MD, JD
DANIEL LESSLER, MD, MHA, FACP, National Association of Medicaid Directors
LISA PATTON, Substance Abuse and Mental Health Services Administration
CYNTHIA PELLEGRINI, March of Dimes
MARISSA SCHLAIFER, Academy of Managed Care Pharmacy
ALVIA SIDDIQI, MD, FAAFP, American Academy of Family Physicians
BROCK SLABACH, MPH, FACHE, National Rural Health Association

ANN MARIE SULLIVAN, MD

NQF STAFF:
MARCIA WILSON, PhD, MBA, Senior Vice President, Quality Measurement
NADINE ALLEN, Project Manager
SEVERA CHAVEZ, Project Analyst
SHACONNA GORHAM, Senior Project Manager
SARAH LASH, Senior Director
ZEHRA SHAHAB, Project Manager

ALSO PRESENT:
WOODY EISENBERG, MD, Pharmacy Quality Alliance
DAVID KELLEY, MD, Chief Medical Officer, Pennsylvania Department of Public Welfare *
MARSHA LILLIE-BLANTON, DrPH, Chief Quality Officer, Center for Medicaid and CHIP Services

JUNQING LIU, PhD, National Committee for Quality Assurance

*** present by teleconference**

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

(9:02 a.m.)

CHAIR PINCUS: I hope everybody had a nice rest yesterday. It was very productive. This morning we have a fairly sort of robust agenda to go through. We're going to be doing what the child group did on Tuesday. So it's a kind of a reversal.

Actually, I'm interested about what people thought about having the groups together and do we have thoughts about that? I thought it worked well. I thought that there was some redundancies, things that we have to both go over, but I think it worked out well seeing what they've been doing. Getting a sense of how we can coordinate.

We're going to have to -- today we're going to be going over some stuff though that they went over the first day and we're going to have to do our own voting on particular measures that might be added or eliminated. So we'll go through that.

Actually, let me clear the first line just to talk about what the objectives are. So one of the main things we want to do is we want to understand how states have actually implemented the Medicaid adult core set and get some feedback from CMS and actually from actual states about that. And then we're going to want to come back to the issue of looking at specific measures and gaps in measures and think about how to address those issues.

And then to think about -- actually go through a voting process to actually suggest additions or eliminations of measures. And then to give some more -- continue our discussion and get more specific about the adult core set with regard to overall strategic guidance.

Any questions about the agenda? Okay. So do we -- for specific highlights from yesterday, anything we want to bring up? Everybody was here and conscious? And we don't have anybody here that wasn't here yesterday.

MS. LASH: I'll just ask if Dr. Ruth

Perry is on the phone? Then the answer is no.

CHAIR PINCUS: Okay.

MS. LASH: With the exception, potentially, of Marcia Wilson, our Senior Vice President for Quality Measurement at NQF who was in and out in the audience, but observing a lot of yesterday's conversations.

CHAIR PINCUS: Okay. So we're going to be sharing the staff analysis of the adult core set reporting to see which states reported on which measures. And we're going to look at those measures that had not been highly reported across all the states.

We're going to consider which measures might be available to fill some of the gaps that we've identified in the past and that we identify now. And then we're going to vote and rank measures for potential addition to the set. And then we're going to add and identify other gap areas to report back to CMS.

So these are some specific requests that CMS asked of us. That they want us to think

about making incremental changes. We don't want to make changes that are too big too quickly because states are just learning how to get involved in this and how to report these measures. So big changes that occur too quickly sort of disrupts the learning process.

Also to think about how much effort is required to adopt and implement a new measure. So think about measures that would have -- if we're going to add new measures, think of measures that would have limited impact or would not require big changes in the process of collecting the data that's required by the states.

And again, CMS is particularly interested in measures that can fill critical gap areas that we've identified in the past. Which measures that provide limited incremental value. To also try to focus on ways in which it actually incorporates or is incorporated in the CMS measurement quality domains.

And again, the discussion we had

yesterday, it's all about alignment and how we can get measures that are well aligned. So, again, it reduces redundancies and inefficiencies in the measurement enterprise or what I sometimes call the quality measurement industrial complex. So first we're going to get an overview of the adult Medicaid population. So, Zehra?

MS. SHAHAB: Good morning, everyone. I am going to be giving the overview of the Medicaid-eligible adult population and then Shaconna will be presenting the key points from the staff review of the 2014 adult Medicaid core set.

So, first I'll describe the population that's eligible for Medicaid. As you already know, adults with Medicaid are both poorer and sicker than low income adults with private health insurance. So as you see this figure, it shows selected characteristics of adults who are at less than 139 percent of the FPL, federal poverty level.

Among these adults, those who have

Medicaid report both worse health and worse mental health compared to those with employer-sponsored insurance and even those that are uninsured. And as you see in the chart, adults with Medicaid are two times more likely to have poor health than those who are uninsured.

And in addition, adults with Medicaid who have more than one chronic condition are at a higher percentage compared to those on employer-sponsored insurance or no insurance. And this is also true of those with any limitation at all.

In this next slide, you can see that this describes the health status of the current working age adult Medicaid enrollees, particularly describing their health conditions and their risks. So this is the segment of the population that's growing most rapidly. An estimated 57 percent of adults age 21 to 64 are covered by Medicaid are overweight, diabetic, hypertensive, have high cholesterol or a combination of these conditions.

Also for the Medicaid population,

overall morbidity is estimated at more than 50 percent, greater than those that are privately insured. Nearly two of three adult women on Medicaid are in their reproductive years, between the ages of 19 and 44 and an estimated 48 percent of births that were covered by Medicaid in 2010 were ranging from a high of nearly 70 percent in Louisiana and a low of less than 30 percent in New Hampshire and Massachusetts.

Medicaid covers approximately two of every three publically funded family planning services and these can include either prenatal or in postpartum care, gynecological services, and testing or treatment of sexually transmitted infections.

So it's also important to note the diversity of the adult Medicaid population. Among the Medicaid enrollees, racial and ethnic minority populations are disproportionately represented among Medicaid enrollees. Also, across geographic regions, approximately 21 percent of the population has been enrolled in

Medicaid.

As of February 2015, an additional 11.7 million adults have enrolled in Medicaid. So the Medicaid expansion decisions and eligibility levels as a percentage of FPL varies by states, ranging from 138 percent to 300 percent of the FPL. And these eligibility levels for adults remain low in states that have not adopted Medicaid expansion at this time, which results in gaps in coverage.

So there's also disparities in the growth of the Medicaid population that are observed between states that have and have not expanded Medicaid coverage, 8 percent versus 27 percent. Only half of the states that have a majority rural population are expanding their Medicaid coverage currently.

So in the next slide, I will describe in more detail about how many states have adopted the Medicaid expansion. So, as you see, it shows the current status as of 2015 and to date, more than half of the states, exactly 30 states

including D.C. have adopted the expansion. And three states are discussing the adoption currently and 18 states are not adopting the expansion at this time.

And you can see the ones that are adopted are in blue. Light blue is the three that are under discussion and orange is not adopting at this time. So this is -- compared to 2014, only 27 states including D.C. had adopted the expansion and five were in an open discussion.

So there's no deadline for the states to expand, but for those states that do expand, the federal government will pay 100 percent of Medicaid costs of those newly eligible from 2014 to 2016. And the ACA fundamentally reformed Medicaid by establishing eligibility for non-elderly adults and also putting in place a uniform national minimum income eligibility threshold of 139 percent of the FPL for nearly all individuals under age 65.

So, now that I've described the adult

Medicaid population and the 2015 Medicaid expansion, I wanted to review MAP's measure-specific recommendations from fall of 2014. So last year, MAP had recommended that CMS focus in the short term on addressing known challenges in data collection and reporting, and that CMS monitor the program's continuing development and also consider the measure-specific recommendations.

As you see, MAPs reported the continued use of most measures in the Medicaid adult core set. It recommended that 25 of the 26 measures continue to be used to provide stability in the early years of the program. And also to provide an opportunity to gain additional experience and data.

MAP had recommended that number 0063, Comprehensive Diabetes Care, the LDL-C screening, be removed because the clinical guidelines around the lipid management had changed and also because NCQA was retiring it from the original 2015 version of HEDIS. So as a replacement for this

measure, MAP recommended that there be a phased addition of NQF number 0059, Comprehensive Diabetes Care, Hemoglobin A1c Poor Control, greater than nine percent.

And in addition to that Measure, MAP recommended two additional measures, NQF 1799, Medication Management for People with Asthma as a complement to 2083, Asthma in Younger Adults. And NQF number 0647, Transition Record with Specified Elements Received by Discharged Patients. And these are all measures that are included in the Excel sheet for you to look at if you want to look at any of the details.

So, this next slide shows CMS's update for the adult core set for 2015 reporting and this was issued in December 30 of 2014. So CMS retired the one measure that was recommended by MAP, the Comprehensive Diabetes Care, LDL-C screening measure. And CMS added the one measure that was suggested as a replacement by MAP, the Comprehensive Diabetes Care Hemoglobin Poor Control.

So there were also two other measures that I showed in the slide before this that were not added: 1799 and 0647. These are still an option for continued support, but that's only if the Task Force would like to stress again this year that they be added. And there's additional details included for this measure in the Excel. And so we'll ask you a little bit later today to rank these along with others that you support for inclusion later today.

So, these next two slides show the list of measures in the current Medicaid adult core set for 2015 and we have provided this on a one pager for you as well. And I'll quickly read each of these measures to refamiliarize you with them.

The first one is the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment by NCQA. There is the CAHPS Health Plan Service v 4.0, Adult Questionnaire with CAHPS Health Plan Survey v 5.0. This is by AHRQ. Then there's the Controlling High Blood Pressure

measure.

There's also Medical Assistance with Smoking and Tobacco Use Cessation, NCQA. Cervical Cancer Screening, NCQA. Chlamydia Screening in Women Ages 21 to 24, NCQA. Flu Vaccinations for Adults Age 18 and Older, NCQA. Comprehensive Diabetes Care Hemoglobin A1c Testing, NCQA. Comprehensive Diabetes Care Hemoglobin A1c Poor Control, NCQA. And Antidepressant Medication Management. PQI, Diabetes Short-Term Complications Admission Rate. PQI 05, Chronic Obstructive Pulmonary Disease or Asthma in Older Adults.

And the second page has a few more. Congestive Heart Failure Admission Rate. Adult Asthma Admission Rate, both AHRQ. Screening for Clinical Depression and Follow-Up, CMS. Elective Delivery, Joint Commission. Antenatal Steroids, Joint Commission. Follow-Up Hospital After Hospitalization for Mental Illness, NCQA. Care Transition Record Transmitted to Health Care, AMA-PCPI.

Prenatal and Postpartum Care, Postpartum Care Rate, NCQA. Plan All-Cause Readmission Rate, NCQA. HIV Viral Load Suppression, HRSA. And Annual Monitoring for Patients on Persistent Medications, NCQA. The Breast Cancer Screening, NCQA.

And then the two non-NQF endorsement groups, Adherence to Antipsychotics for Individuals with Schizophrenia, NCQA, and Adult Body Mass Index, BMI, Assessment, NCQA.

So, as you know, the NA reflects measures that are non-NQF-endorsed and out of the 26, we have 24 that are NQF-endorsed and two that are non-NQF-endorsed. And there's further details of each of these measures in the Excel file.

Now, I'm going to turn it over to Shaconna to provide more details about the adult core set based on what we observed in the data states submitted.

CHAIR PINCUS: Any questions for Zehra? Sue?

MS. KENDIG: Are the core sets, are these measured across settings or are they only specific to, say, primary care or -- so they're across settings, so because on the demographics we talked about a majority of the -- a large number of the Medicaid beneficiaries being women and a large number of women's health services GYN, family planning, and so forth. So if they are accessing those services, the tracking on hypertension, diabetes and so forth is still reported from those settings? Is that correct?

MS. SHAHAB: Yes.

MS. GORHAM: Good morning, welcome back.

CHAIR PINCUS: I actually had one question. When we say phased addition, what do we mean by that, and how does CMS interpret it?

MS. LILLIE-BLANTON: So, we have had latitude in how we interpret that. And so for -- we try to understand what makes sense for our state partners and what information would be helpful. I can tell you that when the pilot --

when the Child CAHPS was reported as phased, we were concerned that we needed to do pilot testing before we could include it as part of the core set.

So what we like about the phased is that it gives us that latitude to say, what more do we need before we would make a decision about including that in the core set. So it's not a definite, understood, I think you all have not been precise and I'm not sure, I mean, I think I can ask that question of you as well. Because as I said, we interpret it as giving us the latitude.

CHAIR PINCUS: No, I think that, that's a good point. It's very helpful. Because I think we'll come back to that, I think, when we hear from the states to think about what kind of steps would need to be taken with regard to the addition of new measures to make it more effective in terms of this phasing notion. Okay. Brock?

MR. SLABACH: I have a question that

may be somewhat bigger picture, I suppose. But one of the themes that I hear when I travel around the country about Medicaid expansion in states that haven't expanded is the lack of available physicians and manpower because of people not enrolling, providers not enrolling in Medicaid. And this then prevents people from getting access.

And so if we expand Medicaid, then it's just going to further that burden. This, of course, is important to the discussion because if there's not a primary care physician or practitioner, non-physician practitioner, it impedes our progress in terms of improving the health of the population.

I'm wondering about statistics on that. I've not seen any data. I hear people talking about it, but I don't know that there's any evidence. And I'm just curious about that.

MS. LILLIE-BLANTON: So let me just tell you that while that certainly is a concern in a number of states, the main thing that we

have found from the literature is that people who have coverage for Medicaid do better than those who are uninsured.

So while certainly there still is a challenge in a number of states, even those that have not expanded, but certainly those that have expanded, bringing in the pool of clinicians to serve is a challenge. Our evidence shows that having coverage is better than not.

There is one study, and there are probably others, but one that the Urban Institute did with colleagues from, I think it's Harvard, but it's a Boston school so I'm not sure which one for certain, where they actually looked at the impact of the fee increase, or what they call the bump, and basically found that while there were some longer wait times, that the wait times weren't very different.

And so you did have some similar levels of access in those states where there had been expansions and an increase. And it's not to say that the bump was the decisive factor, but

that was just one of the things they were studying.

CHAIR PINCUS: So it's something that we may want to come back to when we think about gaps, about issues around access. And to look at what current Measures are actually assessing access.

MS. LILLIE-BLANTON: I also want to mention that I think the difference between primary care and specialty care is a little different. That's something we're still working as best we can on. But there are a few more challenges in the specialty care.

CHAIR PINCUS: Okay. Sue?

MS. KENDIG: Just in response to the provider question, I think it's important to remember that there are many different provider types who are recognized to provide care to Medicaid patients. And there are opportunities to leverage all of those providers.

However, at least from the data in the state where I work, a lot of where the advance

practice clinicians are working tend to center around the urban areas because that is where the educational programs are located.

So one of the underlying causes is also looking at how we are educating professionals and moving them out into the rural areas and making that available so that we have the workforce and leverage all of our providers working collectively to meet the needs of the population.

CHAIR PINCUS: Thank you.

MR. SLABACH: The other thing I wanted to mention is that 63 percent, by my calculation, I did a quick study of this, of physicians in rural communities are employed by their hospitals. And the clinics are being absorbed into these systems because of retention.

And we have now, we're up to 53 hospitals since 2010 that have closed in rural communities. And that is expected to go up considerably. So that's going to be another exacerbation of issues going forward in terms of

access. If the employer source for these physicians and non-physician practitioners are out of business, then it's going to disrupt that community.

The other thing I'll mention quickly is that we have around 4500 rural health clinics in the United States currently. And all of those entities are exempted from any quality reporting.

And I didn't know how that interfaced with Medicaid's efforts to try to collect the data that we're talking about here. Because this is a huge program, now 4500 and growing, that is exempted completely from any quality reporting to the government.

MS. COURT: So this is Bev Court from state of Washington, but we include them, just like we do anyone else. I think one of the challenges is that they're paid on an encounter basis and so what we worked on is strengthening their reporting of their encounter data.

MS. LILLIE-BLANTON: I think Washington's experience is similar to most other

states. That as long as our measures can be generated from claims, then the potential to get that information exists if it's reported. And of course, there's sometimes challenges with encounter data.

And that's similar with community health centers. I mean, we have worked very hard with HRSA trying to better improve reporting from community health centers. Because oftentimes there's a general code about a service encounter, but not specific so that you know what kind of encounter. Whether it'd dental or whether it's a primary care visit.

So we might know that a Medicaid enrollee obtained care, but we don't know what kind of care or what type of provider. And oftentimes, the specifications require you to know one or the other of those.

CHAIR PINCUS: So -- oh, Anne?

MS. COHEN: This might not be the right time to ask this question, but I'm curious if we could talk about the challenges with the existing

core set and any particular measures that may not have had --

CHAIR PINCUS: We're going to get to that.

MS. COHEN: Okay.

CHAIR PINCUS: Yes. We're going to get to that. So, before Shaconna presents some material that actually is pertinent to that issue, Lisa, do you want to introduce yourself?

MS. PATTON: Thank you, Harold. Good morning, everyone. Hi. I'm Lisa Patton from SAMHSA, the Substance Abuse and Mental Health Services Administration.

And I apologize for not being able to be in the room yesterday, I was able to listen in for much of the discussion, but a couple of things arose on Tuesday that required me to be in the office yesterday.

And, as you all know, it was a very rich and interesting discussion. And so I really appreciated all the thoughtfulness that went into that. And I'm glad to be here today.

CHAIR PINCUS: Thanks. Shaconna, do you want to sort of walk us through some of the state reporting of --

MS. GORHAM: Sure.

CHAIR PINCUS: -- the measures so far?

MS. GORHAM: So, before I begin, I just want to bring your attention to some of the resources. In your meeting materials, you received the CARTS for 2014, adult CARTS report, as it's affectionately named, the one pagers. So that of course is only for the eyes of the core set, I just want to say that again. It is not for public viewing.

And then at your seat when you walked in, you had an additional handout and that gave you more information about the reporting and the reporting per state so you actually see the numbers. Again, that is only for the eyes of the Task Force. Okay.

So while we did our staff review of the 2014 adult CARTS reports, or the one pagers, we gleaned information about the states' uptake

of measures and the patterns apparent in technical assistance requests. The data also helped us to identify any measures for potential removal and revisit priority measure gap areas, which we will definitely get into more detail later on.

So, the adult core set participation is strong. Of course, there's room for improvement. As the next slide will illustrate, the most frequently reported measures were focused on postpartum care visits, diabetes care management, and women's preventive health care, cervical cancer screening, breast cancer screening, chlamydia screening.

The TA requests decreased in 2014. Often there were between zero and five requests per measure.

So on your screen, you have a chart of all of the measures reported by state in 2013 and 2014. We wanted to show you a comparison of the two years. The bold red horizontal line divides the 15 measures with high levels of reporting,

the seven measures with moderate levels of reporting, and four measures with relatively low reporting.

The way we divided the high levels, moderate levels, the measures considered high had 24 to 34 states reporting. The measures considered moderate had 6 to 23 states reporting. And the measures considered low had zero to five states reporting.

So, before you, you have the high levels of reporting. The 15 measures that at least 24 states reported. I just want to draw your attention to four measures that showed the most growth with an addition of at least six more states reporting in 2014.

So the Adult Body Mass Index Assessment had ten more states reporting in 2014 than 2013. The Chlamydia Screening in Women had seven more states reporting in 2014. And the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment had seven more states reporting in 2014. The Antidepressant Medication

Management had six more states reporting in 2014.

The next slide shows the measures with medium levels of reporting. It represents measures with 6 to 23 states reporting. The number of states reporting these measures increased, of course, in 2013 to 2014, with the exception of the PC-01, the Elective Delivery. The number of states reporting PC-01 decreased from 13 states for 2013 to 11 states in 2014. Do we know why? That's a good question.

MS. LASH: We don't know exactly why, but we do know that some states rotate the measures that they report on in any given year. So that might be contributing.

MS. GORHAM: Right. And then also, the one pager gives a good list of reasons why they didn't report and so forth, so I can pull that up.

CHAIR PINCUS: Just another sort of question related to the previous one that looked at the measures that increased reporting. It looked like all of the ones that increased

reporting were largely claims-based measures, except for BMI. Is that correct, BMI is not a claims-based measure?

MS. LASH: I think it's HEDIS.

CHAIR PINCUS: It is a claims-based? How many people actually put in a claim for a BMI assessment?

MS. LILLIE-BLANTON: It's just the assessment. Whether it's --

CHAIR PINCUS: Yes.

MS. LILLIE-BLANTON: But I'm not sure, I'd need to check --

MS. COURT: Yes. It's whether --

MS. LILLIE-BLANTON: -- my figures.

MS. COURT: -- or not the doc did it in the office visit. Included a BMI check in the office visit, it's a code. It's --

CHAIR PINCUS: Oh, there's a code for --

MS. COURT: Yes, it's a code. And it's not widely used.

CHAIR PINCUS: Okay. So the question

about the consistency with which it's actually being coded?

MS. LASH: The measure is in HEDIS, so.

CHAIR PINCUS: Okay.

MS. GORHAM: Thanks, Sarah. These are good questions. I'm going to pull up my one pager so I can --

MR. SLABACH: I'm new to the Medicaid Work Group, so forgive me for some of my educational efforts here at my own understanding. I guess I'm shocked to know that this is optional for states to participate in. Is that historic? I mean, this has always been --

CHAIR PINCUS: It's the law.

MR. SLABACH: It's the law? Okay. So I guess there's no question about that then. I'm just curious, are there any correlation between the states that are reporting and those that are or are not expanding Medicaid? I mean, is there some trend that we notice? Or is it just random and --

CHAIR PINCUS: We may be able to get to

that later.

MR. SLABACH: Oh, okay.

CHAIR PINCUS: We can sort of look at that. Because I think, aren't there some things like which states report and which states don't? Oh, George?

DR. ANDREWS: Yes. In the earlier slides that we looked at in terms of the measures, BMI was not NQF-endorsed. And yet, when you look at what we just saw, not only in '13, but in '14, almost -- the states that are reporting the BMI almost doubled.

Additionally, we know obesity is a major issue in this population. And so, my question is, why isn't BMI endorsed by NQF?

MS. LASH: It hasn't been submitted by NCQA for endorsement review to my knowledge. And because --

DR. ANDREWS: It is a CMS Star Measure.

MS. LASH: It is in HEDIS. It's a --

DR. ANDREWS: And so it --

MS. LASH: -- widely used Measure.

DR. ANDREWS: -- is utilized for the duals. It is utilized across the board by health plans. The states obviously like it. So in our effort to try to simplify and make it easy and -- I think it behooves us to question that.

MS. PATTON: Yes. We have the recently endorsed NQF BMI assessment for an SMI population. So it is a chart-based measure though, but it is NQF-endorsed to look at BMI in people with schizophrenia and bipolar diagnoses.

MS. LASH: We'll be doing that this afternoon.

MS. COHEN: I'm just curious to go back to the slide with all the states reporting. The ones that -- so towards the bottom, the ones with fewer states reporting. I'm particularly curious about the HIV Viral Load. Is there any thoughts? Oh, it's new.

MS. GORHAM: The one thing that is important about that is it was first collected in 2014.

MS. COHEN: Oh, okay.

CHAIR PINCUS: Ann?

DR. SULLIVAN: And just on the Screening for Clinic Depression and Follow-Up Plan, is that just a chart measure or is that involves follow-up plan?

CHAIR PINCUS: Yes.

DR. SULLIVAN: So it's not -- we can't pull that off claims data?

CHAIR PINCUS: Right.

DR. SULLIVAN: Right. So, that's why it's probably low.

CHAIR PINCUS: I mean, that's obviously the pattern that you see. Is those that are easily accessible through claims are much more likely to be reported than things that require some additional effort. Marsha?

MS. LILLIE-BLANTON: I just want to mention on the HIV measure, my understanding: it is very complex. But it is an important measure because it's an outcome, it's viral load.

So we only had, I think it's three states, it says two. Does that say two or three?

I think we now have three states that we have the data in on. But it's also states that we know recognize this as an important measure. I think it's Louisiana, Delaware and New York.

So I think states will put in the extra effort if they realize they have a problem that they need to better track. But it is complicated.

CHAIR PINCUS: Alvia?

DR. SIDDIQI: I was just going to add that I know some themes are recurring possibly from the last couple of days, but elective deliveries and antenatal steroids I know we discussed sensibly yesterday about whether or not they should belong in the PEDS core set and obviously they were new measures, so they still had some low reporting.

But, again, the folks that are looking at those child core set, those CHIPRA folks or those quality folks that deal with the child core set, I think it would help for them to see these two measures on their reporting plan. And so I

was just going to throw it out there again that maybe those two go on the PEDS core set.

CHAIR PINCUS: Dan?

DR. LESSLER: I had a question and then a comment. And actually, Bev, you might know this. In terms of hypertension reporting -- I'm just noting here a lot -- is that a code as well? In terms of provider checking? So a lot of -- okay, so that is distinct from BMI where you can check a code that you actually measured BMI, comes in with the claim, and then you know.

So the comment I would just make about the BMI measure, and more generically based on my experience, is that to the extent that you're collecting data like was BMI checked at a visit and that that's done through a mechanism of coding, typically you find that those are very low initially, I would say, as a general principle because if you're busy and it's something else to do, you don't do it. But -- right. I mean --

CHAIR PINCUS: BMI assessment or you --

DR. LESSLER: No, you do the BMI assessment, but you don't if you're --

CHAIR PINCUS: Right.

DR. LESSLER: -- in Epic or whatever electronic health record or --

CHAIR PINCUS: Right.

DR. LESSLER: -- these days they're on paper, you don't do that. And to the extent that anyone feels that such a measure is worth collecting, and it can be something other than BMI, I'm just using that as an example.

Again, and in my experience, actually this is more sort of working within a big health system, is that if you begin reporting on it and then tie some sort of incentive, depending -- it doesn't have to be financial and in this case could be at the plan level because if you really feel this a valuable metric that you want to get, then you can encourage people to report it and it takes time.

The first step is getting the data and seeing that only four percent of people are

measuring BMI or something like that. Which you know is not the case. And then the quality improvement efforts are actually initially around getting at the clinician level somebody to actually be capturing the data.

And then you get to a point where you can actually use the data, presumably, to truly improve the quality of care. So it's just, I think, it's an important point that you have the question Brock, about BMI that -- around metrics that begin to get at, might begin to get to some degree more toward outcome, although that is a process metric, but which are collected through coding and how that might work if one really wanted to use that to drive quality improvement.

CHAIR PINCUS: Nancy?

DR. HANRAHAN: Daniel, that was an interesting thought because -- bear with me on this. In the science or the field, BMI is now not being used as much as calculating the amount of activity that, say, a child has. So benchmarking activity levels is what is trending

into the future.

And is an outcome and not so much a point of process, like an objective measure, BMI. It is objective too, and I've had conversations with Harold and our behavioral health field that where thoughts of quality are going is more towards a wellness perspective, a recovery perspective, a place where we've moved away from focusing on the disease into a more hopeful conceptualization of what kind of outcomes we want.

So this is an example of how we would trend away from something like BMI, which is just loaded with all kinds of body image problems and et cetera, et cetera, into a place that is more positive, more wellness-oriented.

MS. PELLEGRINI: Thank you. Just looking of course at a couple of the maternal and child health measures here and the chart that we have here, excellent chart, thank you, it's really helpful. And it's always so helpful when we hear directly from the state program managers

and I have so many questions about choices that just don't seem to make sense to me.

And just an example, California isn't doing the elective delivery measure. The California Department of Health was one of the three partners that developed the early elective deliveries toolkit with the March of Dimes, right? And there's so much going on in California, the private payers were on board, the Department of Health is on board, everybody's pulling in the same direction on this issue. And yet, it is not one of their Medicaid measures.

So what is going on in situations like that, what's driving some of those choices? And I know that some of it is, for example with antenatal steroids, an incredibly important measure because it has a direct impact on premature infant health, they actually went down last year, but I would hypothesize that's because it's a hard measure to collect.

We know it's chart reviews, right? But, some of these other ones, it would be

wonderful to be able to dig deeper.

MS. COURT: That is a chart review measure. So I think what would've augmented this representation --

MS. PELLEGRINI: It is, but it's one that everybody's doing.

MS. COURT: But not --

MS. PELLEGRINI: But the data's practically sitting there.

MS. COURT: No, it's not practically sitting there. If you want to do a robust method of collecting the data, then it has to be complete. You have to have funding for it.

There's no state funding, for example, for collecting these measures. We glean this out of our own resources. I'm thinking of having a bake sale, frankly, to meet some of the unfunded mandates that we have to collect hybrid measures and medical record based measures for other health homes, the dual-eligible project. None of that is funded.

So, again, I think what would help

this portrayal is showing which are administrative based, which are in the purview of a state to be able to collect, and which require either CAHPS survey or medical record extraction.

MS. LILLIE-BLANTON: Can I just speak to that measure as well? The exclusions in that measure is what makes it so problematic to collect. And you really do need charts to make sure that you're excluding all the conditions which there's not --

MS. PELLEGRINI: But I mean, this is in the Medicare IQR right now, right?

MS. LILLIE-BLANTON: Right, yes it is --

MS. PELLEGRINI: So --

MS. LILLIE-BLANTON: It is.

MS. PELLEGRINI: -- this is not an --

MS. LILLIE-BLANTON: And hospitals --

MS. PELLEGRINI: -- exotic measures.

MS. LILLIE-BLANTON: Hospitals are reporting it. Hospitals are reporting it because --

MS. PELLEGRINI: Right.

MS. LILLIE-BLANTON: -- they're required through IQR. But that doesn't mean that Medicaid has access to what a hospital reports to the IQR.

CHAIR PINCUS: So, Anne?

MS. COHEN: So I kind wanted to echo Beverly's comment a little bit that, and I have a couple measures that I want to potentially point out for adding, so I'm going to be as guilty as anybody today.

But on things like what you just said about the hospital data, depending on what state you're in, that could be in a different agency that does hospital accreditation. And it seems like no big deal, right, it's within the state. Well, the hospital accreditation unit within the Health and Human Services at a state level, may be on a separate floor and may not even talk to the other unit.

And then just to share the data, they need data sharing agreements. They need access

to the data, which is how MMIS maintains theirs, so it seems as easy as this stuff seems, it can be a two-year project just to sign off on a data share agreement because the state's IRB review committee has to review the IRB data release.

I mean, that's as weedy as you get about this stuff. So I think that there's a lot of unintended consequences of measures that we don't think about. And so it's -- to be fair to state folks, that's why things can be so complicated.

And it does take money, I mean, so to add -- I was in a public health department for a while on a committee that was part of the public health department and our committee person sat next to the person responsible for the BRFSS, the Behavioral Risk Factor Surveillance System survey that are done by every state, huge, big response rate. And we wanted to add a question on disability.

It took our committee six years to get a question added and it was something like

$400,000 per fielding of one question. And that was only the cost of the regular fielding the question, let alone all the development and all the other stuff.

So, I'm just trying to help people, as ridiculous as it is, how Beverly and the people that are doing the quality, folks at the state level are really soldiers for us in this game.

CHAIR PINCUS: I think it also puts pressure on us to think about when we wanted to add a measure, what's the real value in it? And also, to get as much information as possible when we consider measures about what are the real costs in implementing the measure? And that's why getting feedback from the states is so important.

So, Dan and Nancy? Dan?

DR. LESSLER: Actually Marsha had a question for you. Which has to do with PQRS. So on the Medicare side, a lot of quality information is actually administratively collected through PQRS. It's the same as with

BMI.

There are all sorts of additional codes that get used and some of which begin to get more toward outcome measures. They're being recorded by the clinician at the point of service.

And just wondering -- and again to Harold's point and everybody's point. I mean, to the extent that better data can be collected administratively, it makes it more efficient, more possible. And I'm just wondering, and I haven't done the crosswalk between, for example -- --- it's been two years since I've been working in electronic health records and PQRS.

But between these measures and the Medicare measures and whether or not there's some way to -- as with BMI and looking at PQRS, where there's some way to more efficiently collect this data in that kind of a way?

MS. LILLIE-BLANTON: Let me just say, I would say that we are trying to work a lot more closely with our Center for Clinical Standards

and Qualities, CCSQ, which manages the IQRS, the Inpatient Quality Reporting System and the Physician Quality Reporting Systems, and we definitely recognize that getting information on duals, those who are both Medicare and Medicaid, will come better or more efficiently through those systems.

What we have not been very successful at doing is getting information segmented from those systems for Medicare only and the duals. I think there's a broader issue, and that is whether or not we can get Medicaid someway added to those systems, which are now almost on automatic pilot.

What I have been told is that those systems are also defined by law to be linked to Medicare. So that, for example, when we had early elective delivery added to the IQR, Inpatient Quality Reporting System, we had to identify the number of Medicare beneficiaries who give birth.

(Laughter.)

MS. LILLIE-BLANTON: And that was the responsibility I had. So that's how I know that was what we did to document. And there are not a lot, but they are and many of them are individuals with disabilities as opposed to seniors, which makes sense to all of you here in this room. But that's what we had to do.

And it was largely because there was enough push from the top, meaning from our CMS overall for the Partnership for Patients initiative, that we were able to make the case, make the point, and get our -- because the Office of General Counsel has to sign off on any changes to those reporting systems because they are defined by law.

So I do think that's the next generation and as we talk about what more this entity can do, it could be that one of the things -- I mean, it's in CMS, we do what's called, and I hate to give acronyms, but A19. I don't know what A19 stands for, but that is what we do when we want a change in the law.

And we could initiate a request for a change in the law so that Medicaid could be included in those systems. How much effort it would take to get HHS to advance that to Congress because there's so many smaller changes in the law that the agency's trying to move through the system that I'm not sure that a change in the law about public reporting or collecting data would make it to the top.

But that is -- I do think that's something that we should add to the potential discussion of this group and you all should decide at some point if you want to make a recommendation. Because anything -- if it comes from NQF MAP, it helps us in moving it up our chain.

DR. LESSLER: I would just say that -- I mean, in my own personal opinion, I would think this would be an extraordinarily high priority. I mean, it should go to the top of the list.

CHAIR PINCUS: And maybe at one of the breaks, we can maybe talk about how we might

formulate a recommendation around this. Okay. Maybe a subgroup might offline go and --

MS. PELLEGRINI: Because Marsha, you have lots of partners who would love to help you with this. And I think, perhaps, drawing up a bill or drawing up a proposal and sending it up through CMS for clearance may not be the most efficient path. And there may be others available to us.

CHAIR PINCUS: Brock?

MR. SLABACH: The physician -- I'm going to have to think about -- I got sidetracked in my thoughts on that last point. But I think that's an important one and I do agree with that. Let me come back to my question later, I'm sorry.

DR. SIDDIQI: That just reminded me of what I was going to say real quick. But we know about the Sunshine Act and now provider data is all being more and more transparent. What physicians are doing in terms of their payments and things like that.

So, I think definitely we need to

formulate in our NQF report specific guidelines or recommendations saying that public reporting needs to mandatory or required as part of participation. And we talk about how Medicaid is a federal and state partnership, and so I think that's the huge difference between Medicare and saying that's completely federal and now we're trying to talk about Medicaid, which every state does a little bit different.

But if you can somewhat incentivize it, obviously but also kind of require some of these reportings it would help. And, again, states are looking to measure their own Medicaid plans against certain measures and HEDIS measures. And so as much alignment as we have, I think will make this whole process just flow better, but also more meaningful in terms of that vertical integration piece.

CHAIR PINCUS: Okay. Brock?

MR. SLABACH: Thank you. In the SGR legislation that was just passed in April, there was the provision to merge the three physician

reporting systems into one. What impact, if any, will that have on any of these discussions? And how will that be changing going forward, the timeline?

MS. LILLIE-BLANTON: Well, we just completed an analysis of the provisions related to measurement. And the question you asked is a question that I'm asking. And I'm sending to our Office of Legislation and to ASPE to help us. But, yes, we do think that there's provisions that could potentially impact us, but it's not precisely clear at this point.

CHAIR PINCUS: Okay. Shaconna?

MS. GORHAM: Okay. I believe that we stopped at the levels of low reporting. We talked about the HIV Viral Load Suppression being first collected and reported in 2014. We spoke about the antenatal steroids measures. They had less states reporting in 2014 compared to 2013.

However, the Care Transition and the Screening for Clinical Depression and Follow-Up Plan actually remained the same over 2013 and

2014. Okay.

I think, Cindy, you asked the question about do we know why states did not report. So the most common reason for states not reporting was data not available, and there are typically zero to five TA requests received per measure. Additional support was provided to the states by CMS's TA team.

For example, the TA team developed additional guidance to assist states in reporting measures. They developed a Data Quality Checklist, among other things, and so those are just some examples. Again, the one pagers gave very good summary and detail of why states did not report and the number of states not reporting.

While a few measures were pointed out as having relatively low levels of reporting, the staff did not identify any potential removals from the core set. Instead, we believe that more experience and data points are needed for the particular measures.

So with that being said, we had really good discussion and I've pulled up my nifty Excel sheet that was also in your bundle of materials. So if you have any particular questions about any more of the measures, then we can answer those.

So if no more questions about the particular measures, then do we have any potential proposal for measure removal? Oh, I have questions.

CHAIR PINCUS: Okay. We've got some people.

DR. LESSLER: I'm trying to figure out how to formulate a question about this, but I guess it's more of an observation at this point. It's just interesting to me the number of states that did report on hypertension, which is chart level data.

And I'm wondering, is that -- well, from a clinical perspective, I think that's extraordinarily important. I mean, if I were just to say from population based standpoint, I think I can understand why they would want to and

its importance.

But I'm wondering if there's something about that? It'd be -- and Bev, I don't know if you have any comment or anybody else has any comment. I mean, I find that encouraging.

And actually what it gets me thinking about is whether it'd be worthwhile trying to -- since the chart level data is hard to get and whether or not there's value in prioritizing and saying, you know, if you're going to go after one chart level data, go after this.

I personally I would vote, I think at this moment, for hypertension. Particularly given how much success we're having there. And Bev I don't know if you have -- or anybody --

CHAIR PINCUS: But I think this is part of a more general issue. Are there certain counterintuitive kinds of information that we have? Where there's something that seems like it would be hard to collect is highly reported? Or, on the other hand, things that seem to be easy to collect have a very low reporting rate?

MS. COURT: This is Bev. I think you also have to look at whether there's complete reporting or there's partial reporting. So for those states that may have integrated EHRs, where they can pull that, then it's achievable.

If they're getting reports, for example they've embedded that into certain managed care plans. Maybe they have three managed care plans, they had one that reported it. They reported the one managed care plan.

So I think when you see that the state reported on it, it doesn't mean that they reported on it for their entire Medicaid population because there's so much partial reporting. I think you take that with a grain of salt.

CHAIR PINCUS: Well, the useful thing I think to see if there's some way the next time around to get the information about what's the level of reporting by state.

MS. LASH: That actually is in --

MS. GORHAM: It's in the one pager.

MS. LASH: -- the one pager packet --

MS. GORHAM: Yes.

MS. LASH: -- that looks like this. There's a lot here, so it's easy to miss.

MS. GORHAM: Right.

MS. LASH: But I'm trying to page that measure right now.

CHAIR PINCUS: Yes. Or some way to condense that data so it's easily accessible.

MS. LILLIE-BLANTON: And in the reports for the child report, because you don't have any detailed state reporting yet on the adult measures. That won't happen until this year.

But in the child report, the notes at the end of every table give you the specifics on whether it was complete or partial reporting and what the state said that was reported. So there was correct on --

CHAIR PINCUS: Anne?

MS. COHEN: I'd kind of like a conversation about a specific measure. And

discussing what ---- A, it's highly reported, so it may not be worth switching for another measure. And this measure was taken up by the Duals Committee and I believe that this measure that we took up was switched from the other measure.

So it's the 2371, Annual Monitoring for Patients on Persistent Medication is the one that we have now. And reported highly, that's why I'd love to hear from states why it's working. With -- give me one second, 2456, Medication Reconciliation: Number of Unintentional Medication Discrepancies Per Patient.

So it's a little different. It's getting at a little different issue, but the Duals Committee felt like this was important because of medication errors and all kinds of other stuff. So it is --

MS. LASH: It's a facility level measure.

MS. COHEN: It's a facility level

measure.

MS. LASH: And it would involve chart review, to my knowledge. I can pull up the specifications.

DR. SIDDIQI: Do we have access to the one pagers for the adult? I have the child core set.

MS. GORHAM: Yes. You have ---- it should be on your SharePoint page. Alvia, you're on both task force --

DR. SIDDIQI: Yes.

MS. GORHAM: -- so you would have to go to your committee homepage for adults.

MS. COHEN: And NQF staff please feel free to shut me down if this an absolutely terrible idea, but I mostly just kind of wanted to discuss the --

MS. LASH: Yes. Let's discuss --

MS. COHEN: -- intention of this measure and whether it's what we want to get at and whether there's another medication kind of errors that might be more valuable.

MS. LASH: So, the measure Anne is suggesting is number 2456. It was developed by the Brigham and it's a rather complex but really important measure of safety as results of medication use.

So the description, which I'll read aloud from our QPS system, is that it is intended to measure the quality of the reconciliation process by identifying errors in admission and discharge medication orders due to problems with the medication reconciliation process. So the target population is any hospitalized adult patient and the time frame for measurement is the hospitalization period.

So at the time of admission, the orders are compared to the pre-admission medication list compiled by a trained pharmacist to look for discrepancies and identify which discrepancies were unintentional using brief medical record review. This process is repeated at the time of discharge where the discharge medication list is compared to the preadmission

medication list and the medications ordered during the hospitalization.

This is a rather newly endorsed Measure from our care coordination project. And it was one of ---- might have been the only new measure endorsed in the care coordination project. I do recall the steward making the case at the time that it is rather labor intensive. It works much better in a facility that has electronic health records.

But we know medication errors are rampant. So there was an important quality improvement opportunity there. The question I guess to this group would be if this is a quality improvement opportunity the Medicaid agency could influence or --

DR. LESSLER: What's the number again Sarah? I just want to --

MS. LASH: Sure. It's 2456.

DR. LESSLER: 2456.

MS. LASH: Yes.

MS. COHEN: And let me be clear, this

is an example that I had readily at my fingertips. My real question is whether the existing measure, the Annual Monitoring for Patients on Persistent Medication gets at the quality issue we're capturing.

So are we wanting to know, okay, if these patients are on persistent medication, why are they on them? And do they need to be reviewed? Is it that we want to deal with polypharmacy issues? Or is it that we want to deal with medication errors? And that's really kind of what I want to get at.

And this measure, the annual monitoring of medications, really to me gets into play for people with disabilities who may be on multiple medications and I want to make sure that this particular measure is the correct one. And whether or not there needs to be others that look at that.

Now, granted, it's highly reported, so let me be clear, this may not be something that needs to even be messed with. But it's just

something that I kind of wanted us to consider while we're here.

CHAIR PINCUS: Marissa?

MS. SCHLAIFER: I'm still looking at the current measure, but I think on the 2456 measure, I think it's a great aspirational measure and a great -- but, I mean, as far as realistically what's going on today and what the state Medicaid programs can influence, I think it's definitely something maybe that hospitals should be measured on, I don't know that it's something that state Medicaid programs should be measured on. Because I don't think they have the ability to influence it.

But as far as an aspirational measure and a measure that should be used to measure the quality of hospitals, I would totally agree with it. I'm still looking at the -- I mean, I think, for what you're saying and obviously if the current measure is specific to certain medications and so that I think misses what you're looking for.

Conceptually I think it's probably where you want to be, but you're right, it doesn't hit the disease states and the medications that --

CHAIR PINCUS: Yes. I mean, the reality is when one has to focus on claims data, you're really identifying sort of opportunities for doing something, but you don't know whether something was actually done.

MS. SCHLAIFER: Yes.

CHAIR PINCUS: So there's a -- and so that's one of the problems. That's another problem with sort of screening measures. That even if you know somebody got screened, did somebody do anything about a positive screen?

And so that is limited information and a more distal connection to the outcomes. And that's one of the problems we face. And one of the questions I had is are there -- not just looking at also sort of the incongruities of sort of why is hypertension so well represented and maybe it is because it's mostly only partially

reported, and that may be the case.

But also, and I don't know if Mathematica has this data, but what are the measures that states complain the most about?

MS. LILLIE-BLANTON: Of course --

CHAIR PINCUS: And is that --

MS. LILLIE-BLANTON: But let me -- I'm not sure if anyone from our contractor for Mathematica is on the phone now? Can you answer that question? Is anyone there? I know Margo said she might have a conflict in timing, but is anyone else there? The phone lines are open, right? Or are they open?

MS. LASH: If there's a member of the Mathematica team, you can signal the operator by pressing Star 6? One?

OPERATOR: Star, one.

MS. LASH: Star, one, and your line can be opened.

OPERATOR: Ann Rosemary Bort (phonetic).

MS. LILLIE-BLANTON: Oh, great.

OPERATOR: One second.

MS. LILLIE-BLANTON: Can you answer that question?

MS. BORT: I'm sorry. We were trying to figure out how to get on and I didn't -- it was the question about the measure that the states had the most concerns about?

CHAIR PINCUS: Well, the measures, not the single measure. But what are the measures that the states complain the most about?

MS. BORT: Well, I think we do have that information. I don't have it at my fingertips, but we do have kind of -- we certainly have TA requests. I don't know that we group them by complaints or questions, but we could get that information.

CHAIR PINCUS: It would be useful to hear that and just get a sense of what is the most aggravating.

MS. COURT: States can certainly provide that in the semi-annual reports. So if you can hear directly from the states as to how

they would list those and the reasons why, I think then you would actually get representative feedback.

CHAIR PINCUS: Can we also get some more -- in terms of data not available. It's --

MS. COURT: There's more breakdown than that, but I don't know --

MS. LILLIE-BLANTON: So, it is. And we've said in the future, we will provide more granularity about that one because within that other, we break down some of the categories. We just have not provided that to the MAP, but we can do that in the future.

CHAIR PINCUS: Okay. It could be helpful. And then to look at what are the characteristics of measures that are more acceptable or less acceptable.

And particularly, again, these sort of incongruities that Dan mentioned. Where there are things that seem like they would be harder, but they're still highly reported. What's behind that?

MS. LILLIE-BLANTON: So can I just say though, generally measures ---- and I think we've said this before, so I feel like I'm being redundant, but measures that require chart review are problematic. Or that are hybrid, that require a sampling from the population, are problematic.

MS. BORT: And Marsha, also I think measures that require linking to another data source --

MS. LILLIE-BLANTON: Yes.

MS. BORT: -- such as vital records.

MS. LILLIE-BLANTON: Yes. So right --

MS. BORT: Those are challenging.

MS. LILLIE-BLANTON: So chart linkage are the two areas that are most problematic. So, for example, the high blood pressure is something that you need the medical record and that's something that a state typically would have to either hire or use their external quality review organization to do the chart reviews.

And that's one of the reasons I asked

the question yesterday about could we make more effective use of the external quality reviews for both managed care but also otherwise. It just means the state would have to cover some of those costs. But anything that's an extra cost to the state becomes a burden.

MS. BORT: I think one more challenge is things that states pay a global fee for and so you can't always disaggregate down to figure out what actual service was provided or number of visits or specific content of visits if it's a global fee. And this comes out most commonly in the maternity measures.

DR. LESSLER: So I just want to really endorse what you just said in terms of trying to leverage the external quality review to a greater degree in terms of collecting these measures since the states who have managed care have to do that and we're collecting a lot of this data anyway.

To the extent that it can be coordinated and states could be provided with

technical assistance in terms of particularly how to aggregate up to a state level and so forth. I think that would be another opportunity for efficiency.

MS. PELLEGRINI: I think it's worth repeating something that we've said in past meetings, which I imagine some of you all were in as well. Which is that the future of quality measurement is not claims data. Right?

Claims data is becoming less and less granular as we're getting into more things like bundled episodes and ACO-type measurement, things like that. That data is becoming less and less useful all the time.

And meanwhile, the EHRs that are coming online, their primary function is clinical care and billing and quality measurement or research or things like that are much farther down the development list.

So maybe what we could do as a group as part of this report is urge HHS to work more closely with EHR developers to kind of raise the

priority of structuring the EHRs so that they're more amenable to the data extraction that we're talking about here. Because right now, that seems like it is not a priority and that is going to hamstring this process more and more as time goes by.

CHAIR PINCUS: George?

DR. ANDREWS: Yes. A comment and a question. As it relates to the blood pressure under control, recognizing that this requires chart review, there are still codes that are used.

So, again, I don't know to what extent -- because I know physicians, providers have gotten better in terms of using those codes to report blood pressure under control, even the different degrees of where the blood pressure range is. And so, again, I'm throwing that out.

DR. LESSLER: And that's the whole PQRS piece because Medicare does that.

DR. ANDREWS: Right. And then, my question ---- and I'm really surprised, is of the

states that are reporting, Florida is not shown. And Florida has a large Medicaid population. And I know they capture data. And I know they stay on top of their providers in terms of -- whether it be penalties or whatever. So do we know why Florida isn't reporting?

MS. LILLIE-BLANTON: Florida does report for the children's measures and have been very consistent over the years. We try to incentivize the reporting for the adult measures with our grantees and that certainly, I think, happened because there were 27 grantees and we had 27 grants to report and three other states that were not grantees that reported. So there's a resource challenge.

But the key thing I think you're saying is that Florida has the data. I actually talk a lot about Florida because Florida has one of the most accessible quality reporting systems online for their health plans. There's several states that are already moving forward. And so Florida is one of the states that I use as an

example of the model of a state that is already doing the quality reporting system.

But we've not been able to get them to report on the adult measures. We will work on that, but I want to say, sometimes I'm trying to think of the priorities. I really like the idea about trying to prioritize measures that we can improve reporting on.

And then we also have to prioritize states we want to bring into the system. And we have limited resources as well. So, we'll have to think about which of these priorities we're going to prioritize.

Because all of them are on our list. You know we talked about goals, so the goal is to increase states reporting and increase measures reporting. And the question is just how can we do all of those at the same time. But, yes, to go back to your original question, Florida has lots of data, we just have to get them to report that for the adults.

CHAIR PINCUS: Marissa? Oh --

MS. LASH: But to quickly make a related point. In response to Brock's earlier question about the correlation between states participating in this measurement and those expanding, there are nine states not currently expanding Medicaid who are submitting adult core set data. So I don't know that, that's as a powerful of a pattern as I would've expected.

CHAIR PINCUS: Marissa, then Anne. Then we'll take a break.

MS. SCHLAIFER: So since we've gone around the room a little bit since, and this may be a little late of a comment or answer. But I really like where Anne is trying to go and I just wanted to -- yes, no, I think we definitely want to get something in there that says, are we doing an overall assessment of people's medications. And I think your question was, we seem to be focusing on some of the hypertension measures within this measure.

What I think what's most interesting about measure 2371 -- and it does serve a

purpose, I just don't think it serves our purpose. I mean, it serves a purpose to be in there, but not the conversation we're having now.

It's interesting, it is not in any way a measure of should this person even be on this medication? What it's measuring is, are you doing the blood test to make sure that their dose of that medication is appropriate? But it in no way looks at, should this person be on this medication at all?

CHAIR PINCUS: Anne?

MS. COHEN: Which, I mean, thank you for looping back to that --

MS. SCHLAIFER: Yes.

MS. COHEN: -- because I would've lost --

MS. SCHLAIFER: I don't know if it should go away, but --

MS. COHEN: But, so --

MS. SCHLAIFER: -- it doesn't serve the purpose that we're talking about.

MS. COHEN: Two things. One is, do we

need a different hypertension measure since this is, I think -- no, there's a high blood pressure measure also on here. But, so that's one question. And then I see the polypharmacy issue is on this.

MS. SCHLAIFER: I know. She told me to put that --

MS. COHEN: So, yay, Sarah, thank you. But I agree, I take down my measure suggestion because clearly it's not an effective one, but thank you for capturing the spirit.

But I wanted to comment on the idea of how to creatively get at getting data. Or doing incentivizing about data. There's two thoughts. Even though NCQA -- not all plans are NCQA certified by any means, but increasingly a large number are. Why couldn't NCQA encourage plans to do a quality improvement project around a specific area that we all know is important? That's part of this set. That's maybe part of other sets.

And then kind of -- well, no, but NCQA

could provide some financial support maybe. I don't know. That's a big huge stretch, sorry for anybody NCQA in the room.

But at minimum, they have to do a QIP, they have to do recertifying every few years. It's at the plan level. It's just something to kind of think about.

The other thing is that the EHR question that you brought up about pressuring EHR vendors, I actually think the opportunity is not necessarily in the EHR vendors because there's a whole data fight with them right now. But it is with the care management software vendors at the plan level.

Because there's a lot of data that's collected in that care management software that never trickles out of the internal plan care management. Yes. So there's a large number of vendors that offer that software. Plans use it. They have all kinds of data changes they make to it. They use it for quality improvement project internally, and by a large extent, that world is

all managed and run by the plans and the vendors.

So you could put tickles in the care management software that when care managers talk to a patient, ask them about polypharmacy for instance. And then using that as a reporting out tool for the plan to then report out to the state on a quality improvement project.

So it's kind of an out of the box, creative thing and it would be challenging, but it's something that maybe CMS hasn't thought about.

CHAIR PINCUS: So, I think we've had a very rich discussion. And it sounds like we're going to be making recommendations about specific measures, but there were some more generic kinds of things that we can make recommendations about that go to the issue of reducing disincentives and increasing incentives.

So thinking about how to break down some of the barriers. So to think about recommendations around facilitating linkage among different data sources, things like that.

Facilitating ways by which vendors, whether it's care management or whether it's EHR vendors, can facilitate access to data relevant to quality reporting that are collected in the course of providing care.

To think about how one could make use of registries in this. How one could link to the approach that the PQRS is using. So that -- and to think about ways by which one could also induce incentives.

So for recommendations around NCQA accreditation, for example. Around some kinds of more formalized and specific elements of quality improvement projects that would want to be incorporated. So these are the kind of things that we can think about and can make recommendations that are not measure specific, but really look at the broader set of issues.

Okay, so let's take a ten minute break. And reconvene at 20 of. And we'll hear from states.

(Whereupon, the above-entitled matter

went off the record at 10:23 a.m. and resumed at 10:36 a.m.)

MS. LASH: When you arrive back at your seats, you'll have handouts about some additional measures we'll be taking up later this afternoon that weren't in your initial materials.

So you can set those aside for now and we'll be explaining them after we hear from our state panelists.

CHAIR PINCUS: So, David, are you on the phone?

DR. KELLEY: Yes, good morning. I am here.

CHAIR PINCUS: Okay. So, we're going to hear from David and Beverly. We want to try to move through this briskly because we'd like to start a discussion of the measure by measure reviews before lunch. And so, Dave do you want to start?

DR. KELLEY: Sure. Thank you. Hopefully everyone can hear me okay. Let me know if --

CHAIR PINCUS: You're coming through loud and clear.

DR. KELLEY: Okay, great. So again, from our standpoint within Pennsylvania, to give you a bit of the lay of the land, we are primarily managed care across all of our counties.

We've been in managed care for 17, 18 years. We do have a carve-out model of physical health, behavioral health. And we do not include at this point in time dual eligibles, except for duals under 21.

So when it comes to measuring, we have about 1.6 million and growing numbers of individuals in what we call our HealthChoices Program. And we are undergoing currently traditional Medicaid expansion. So we expect those numbers to grow significantly over the next three to four months.

So what are some of our challenges? Again, I think, having consistency in the adult measures across all states so that everybody's

doing the measure exactly the same way. Which for us is not that big of a problem.

Our plans are NCQA accredited. They do the HEDIS measure set. And for many years we've required them to do what we call Pennsylvania Performance Measures, which are measures that are not NCQA, but we have either developed or, in this case, we're actually using the adult core measures that are not HEDIS and asking our plans to report on those measures.

So, I think that just from our standpoint, consistency across all states. And then alignment with both Medicare, but especially with meaningful use of quality metrics. And then, I think earlier there were some comments again about moving away from claims and getting more into electronic extraction.

I can't make that point enough times that electronic extraction of quality metrics, whether it's through the meaningful use, the QRDA1, that's patient specific. And I would say that we definitely need to make the vendors hear

loud and clearly that they need to be working with our eligible providers to really push out that more robust data set electronically.

I would also highly encourage that all of the adult quality measures be converted into e-measures and be reported using the QRDA standardized format. I think that would take away many of the barriers around reporting and extraction.

One of the measures that tend to be reportable on the least are those that require the more robust chart audits. So, for instance, with us, antenatal steroid reporting has been difficult. And that's one that I believe we do not report on because of a whole host of barriers. So from our standpoint, we really want to see consistency alignment and then really a push on electronic extraction.

I there were some comments earlier about care management software, and our managed care plans have care management software. We make them rigorously report on a whole host of

things. I don't know if there's consistency in how those things are actually reported in various care management softwares.

So I would have some concerns about consistency. How those end up being reported. And I would have concerns that plans would be all over the place in the consistency aspect.

Again, I think in partnership with NCQA, and NQF, we really need to be pushing for the acceptance of electronic databases for both HEDIS and adult measures. So that from a health plan standpoint, if ---- for instance, we have some projects where we're working with some major health systems to actually electronically extract right out of their EHR and then we've been working with NCQA to make sure that those extractions are acceptable for quality metric reporting.

And then I think the other thing that, I've heard this on some of the comments, that we leverage our EQRO considerably in -- we have eight managed care plans and we use them to

really do weighted averages across all of our health plans so that we can report a HealthChoices weighted average measure for all of the HEDIS as well as the adult core measures.

We also use them -- because we have a carve-out, there's certain measures like the initiation and engagement measure where we actually give them our data set, a validated encounter data set, and they help us measure that because of the carve-out situation. We also use the EQRO to look at, I believe, it's live births under 2,500 grams and the C-section measures as well.

So in some instance we use the EQRO to actually do the measurement for us because it's just easier than working with all of the plans. So, as you're thinking about new measures ---- or adding or subtracting measures, think about what can be electronically extracted now or hopefully in the near future.

Think about alignment with meaningful use. Think about ways that there are some states

that have a behavioral health, physical health carve-out. Think about sometimes those challenges that states may have in reporting those particular measures.

And then I think I'm probably redundant, but again, those measures that do require actual chart audit, especially like in the hospital setting or settings that health plans typically don't have to go into as part of HEDIS, there are a whole host of barriers to getting and reporting those particular measures.

So those are my comments and I think we were supposed to talk about some of our notable successes related to quality measurement. Again, I think, looking at our initiation and engagement project that we did with the Adult Quality Grants, we've been able to measure initiation and engagement. We've actually been able to pilot some programs around quality improvement because we've been able to measure that across physical health and behavioral health.

So, again, we also have had some notable successes in electronic extraction of certain measures with some of our larger health systems around OB care.

And, again, as you're thinking about what measures to add and subtract, think about ways in which large providers can actually extract, or large health systems can actually extract, these measures and report to our health plans or to us, the state.

I'm going to end my comments there and certainly can entertain questions if that's appropriate.

CHAIR PINCUS: Thank you, David. Let's hear from Beverly.

MS. COURT: Thank you very much. And I've got some slides here. And I will go through these quickly because I think I'll reiterate a lot of points that states have already made.

CHAIR PINCUS: Maybe move the mic a little bit closer.

MS. COURT: Certainly. So first of

all, I want to thank CMS for the opportunity to take part in the grant program, the Adult Quality Measure Grant Program, which really enabled us to do things in Washington state we wouldn't have been able to do. Such as build our staff capacity and in particular have multi-agency, cross-agency, collaborative quality improvement projects.

So I'm going to go through these quickly. I think Washington state, as you can see, we're siloed in our medical and our mental health delivery systems. They're in separate capitated programs. Long-term care services is outside of managed care. Duals is mainly fee-for-service.

When we started with the AQM project, our particular interest, because we were also entering into a duals project, was looking at those areas that really fell through the cracks. Those intersections between long-term care and the medical. Between medical and behavioral health. And so we focused our projects on -- we

broke down rehospitalization, I'll get to that in a minute.

So in terms of selecting measures for reporting, of course you've already heard administrative based measures are the easiest to implement.

If we're going to suggest dropping a measure, care transitions is a bear. And I think it would move states further if there was an intermediate measure that could be introduced that would -- care transitions is such a huge, very complex array of transactions that have to happen in order to capture that.

I think keeping it on there for a long period of time won't necessarily move the needle. So I would encourage you to look at some interim, even process measures to start getting movement with states on that area.

Another opportunity that the adult measures folks have is in our reporting why we didn't report on a measure, what isn't shown there ---- we don't have the opportunity to

explain is what we are doing. So care transitions is a huge effort in Washington state. We're not reporting it. But to develop the infrastructure, to create that, a huge investment.

So if there was an open text field, that would be really advantageous in the reporting, and then being able to understand what's happening in states for those measures that aren't reported.

So what are some of the data collection barriers? I think we've talked about this already. One of my pet peeves, you may have noticed this already, but CAHPS survey. We know that when we do program evaluation, we get 80 to 85 percent response rates.

When we get such a low response rate in CAHPS surveys done at the plan level, you can't tell if those results are spurious or not. So you can pray that there's going to be random variation the next time you measure that. That point estimate that you get from the CAHPS

survey, I don't think is very reliable.

The other is that it's not actionable. Because the way it's currently structured, you can't narrow down to the practice level in order to make effective changes. Or geographically.

So there are ways and, for example, Oregon piloted this in the AQM project, ways of modifying CAHPS surveys so that you can actually do something with those results. So I would encourage that there be a recommendation from this group that the CAHPS survey methodology be enhanced so that it adds the elements of being able to draw down to the practice level.

And just beneficiary survey fatigue. Earlier this year we did our QIO, our EQRO did a CAHPS survey, we had the National CAHPS survey that's being fielded now, we're going to have another CAHPS survey shortly for the duals project, so we have the potential of having one Medicaid beneficiary asked or responding to three CAHPS surveys.

None of that is shared with the state,

so the state can't use that in order to meet AQM reporting. And so another -- I think, another thought is if you're going to be-- even CMS, if they're going to be fielding these surveys, think of the utility of only hitting that client once with the same question. And being able to share that information with the state so that we're not creating this survey fatigue situation.

Reporting from MMIS systems certainly have their limits. I think we've talked about that. Medical record hybrid, again, people know that those are challenging.

So, I won't go through this -- I've got some references here, but the two projects we focused on was reducing psych rehospitalizations. We found that this was an outcome type based measure, much preferred than follow-up after mental health hospitalization.

In fielding this ---- in putting this as a performance measure for the capitated mental health plans, we found that there was a lot of argument. Okay, what qualifies as a follow-up?

That you could do follow-up, but it had no bearing on the rehospitalization.

When we did these projects and we provided provider feedback, we found that 40 percent of those that had repeat psych rehospitalizations were not engaged in the mental health system. They don't just walk through your door. If you take a public health policy approach, we'd have to go search them out. And they're findable.

We know from the data that we were already supplying them, for example, they're showing up in the ER repeatedly. So, there's some major system -- different ways of thinking about how we approach these problems and this has been a big one in Washington state. And so we have actually adopted this psych rehospitalization measure as a statewide measure.

CHAIR PINCUS: Is that an all-cause rehospitalization or specifically a psychiatric?

MS. COURT: Psychiatric rehospitalization is now one of our outcome

measures that was adopted by the governor.

MS. COHEN: It's 0576. Follow-Up After Hospitalization for Mental Illness.

CHAIR PINCUS: No that's not the -- this is --

MS. COHEN: It's not the same?

CHAIR PINCUS: -- actual rehospitalization.

MS. COURT: No. Psychiatric rehospitalization, I don't know that, that's a Measures.

CHAIR PINCUS: Yes. I don't think that's --

MS. COHEN: But weren't you saying that rather than --

MS. COURT: Yes.

MS. COHEN: -- sort of after mental health hospitalization that this was more valuable?

MS. COURT: Right. It's far more impactful and that's what we want people to focus on, reducing rehospitalization. So there's the

Follow-Up After Hospitalization for Mental Illness is one of the AQM Measures.

CHAIR PINCUS: Right. Yes. I'm not asking about the follow-up one, I'm asking about the rehospitalization one. Why you chose the measure for rehospitalization to be a psychiatric rehospitalization after the index one as compared to a rehospitalization for any reason?

MS. COURT: So if you look at any reason, that's so broad. How can you impact that? How can you put together -- and really, the question is what was failing? What was failing in our system?

What was failing in our system was contact between the hospitals and the mental health capitation plans. Between mental health capitation plans and the medical capitation plans. We knew that those were system problems. These are where the systems are supposed to engage, they're not.

And we can show that, that is -- if we drilled down for a rehospitalization, these were

our problem areas. The psych rehospitalizations, if we could get a handle on that, a huge impact on our rehospitalization overall rate.

Same with reducing rehospitalizations from nursing homes. I mean, 22 percent of people who were discharged from the hospital to a nursing home are going to be rehospitalized within 30 days. So it was -- you really want to focus on those areas where you think you can, and especially in a quality improvement project, make a difference.

And, in fact, in that one we did. That pilot looked at increasing communication within the nursing home, documentation, and it pays off. That's something that now we're looking at --

CHAIR PINCUS: Just, Ann and Nancy, this is relevant to this specific issue?

DR. SULLIVAN: Yes.

CHAIR PINCUS: Okay.

DR. SULLIVAN: On the psych rehospitalization, do you think it was because

you were kind of honing down on a particular -- when you do the measure of after mental health -- after hospitalization follow-up, you have a whole panoply of people who have been in the hospitals and come out. But when you're talking about psych rehospitalization, you're often talking about a high risk group that kind of comes back.

So do you think that's what helped in terms of narrowing the group and the focus between the plans and the -- or what do you think worked when you started to use the psych rehospitalization measure versus the other one?

MS. COURT: So the other one, you asked the capitated mental health plans, please count the follow-up that you did from people --

DR. SULLIVAN: Right.

MS. COURT: -- who got discharged. Okay, so it doesn't have -- they count things that aren't necessarily that effective.

DR. SULLIVAN: Okay.

MS. COURT: So this is a good process measure -- this is one of the process measures

where really the outcome is, did you reduce hospitalizations overall for psych for the population and then, particularly, the psych rehospitalization. I mean, this was like 17 percent overall rehospitalization of those who were admitted for psych. And that's pretty high.

And so, I think that we've talked about gradating and having a tier of measures to get to a certain outcome. And this is a good example where maybe these are paired. You have follow-up after mental health hospitalization and then -- but your final outcome is ---- I think, psych rehospitalization is where you want to focus your attention on that outcome.

Because if you do the -- you say, hi guy, and you make a phone call or whatever, that may not be good enough. And obviously, it hasn't been. We've used that as a quality measure in contracting and it just is not panning out well.

CHAIR PINCUS: Nancy?

DR. HANRAHAN: Thank you, Beverly. I think it's really interesting the work you're

doing. It's great. One of the groups that -- I think it was the Behavioral Health Steering Committee, and I think you were on that too Harold, but we reviewed readmissions for psych hospitalization and there was a myriad of reasons why that, that measure really wasn't that useful.

In the research that we did on looking at the outcome of psychiatric rehospitalization, and we studied transitions in care. So we studied an intervention to try to decrease readmissions to psychiatric hospitalizations and what we found was that the various places that admit for a psychiatric condition, a psych unit in general hospitals or a free-standing psychiatric hospital, each of them had various interpretations of the HIPAA regulations, making it almost impossible to break through the barrier to communicate with the providers that were in those settings. Which I think really confounds this study of this variable significantly.

So what we did was we shifted to the all-cause medical or surgical readmission to

general hospitals, and find that to be a much more -- that the medical side, sector, is much easier to communicate with. Their interpretation of HIPAA regulations is much looser than it is in the behavioral health field.

And then also they are so desperate for help with these clients that they don't know what to do with, the behavioral issues, that they were more than willing for us to come in and try to solve this problem and really -- so there was a willingness to participate.

And we found that for adolescents, obstetric, maternal age childbearing women, and surgical and medical conditions that all of these people had significantly higher rates of readmission than those without serious mental illness. And we defined serious mental illness major depression, bipolar, and schizophrenia. So we really drilled down to that very specific definition.

And so, I think that it's a cleaner way to go about looking at readmissions for the

population that generally have a huge burden of comorbidity medical, as well as psychiatric. But, just some thoughts.

MS. COURT: Right.

CHAIR PINCUS: Lisa?

MS. PATTON: Yes. I was just going to make a couple of points. And Nancy made it better than I could. But one of the -- at SAMHSA, we really support the use of the all-cause readmissions.

Because we know that a large number of our SMI population don't really get great medical care. Or if they entered the hospital for a behavioral health issue, the underlying physical health concerns may not be addressed during that hospitalization.

And so we really look at that follow-up after mental health care as getting at some of that. And also addressing the need for better care coordination and the community networking that goes with that.

And I think that's part of the intent

of that Measure, is to see how does that care coordination happen and who's involved in that process. But, again, looking at all-cause readmissions seems to capture more of some of what's happening with that population.

DR. SIDDIQI: I was just going to say, I'm glad we have the all plan readmission rate as a Measure. But when we're getting at what Beverly's talking about, it sounds like the Measure of follow-up for mental illness is basically checking to see if the patient was seen in an outpatient office visit after their hospitalization.

But does that really impact the outcome of do they come back to the hospital? And there are a lot of points that you just made, Lisa, for example community partners, phone interventions, group therapy. There's a lot of different ways that you can tackle this issue that can be even primary care focused that doesn't involve an actual follow-up visit within a certain set time period that could actually

impact the outcome in terms of is this patient getting better care coordination across the board.

So, I think we should try and see if there is a Measure that is on readmission specifically for mental health. Whether or not we want to substitute it with the one from follow-up mental health illness or maybe just to add to the set.

Because the all plan readmission rate is looking at everything and it's for all-cause, so it's not the same focus that Beverly's talking about. So I'm trying to look at the Measures that relate to a readmission for mental health or psychiatry, there's like, actually I'm not really seeing on in the Excel.

So I'm not sure if there's any that are out there in the pipeline or about to go through NQF endorsement. Or was this a measure that specifically, Beverly, you had formulated for your work?

MS. COURT: Right. We dreamed this up

as part of our quality improvement project and it didn't include all psych diagnoses. We did limit it and target it. I agree that all plan readmission is important because psych is an underlying issue on such a high proportion of our Medicaid population.

In this case, we were trying to hold some entities accountable for those things that they were paying for, that we were paying for. And this was an outcome that they could control. So, I think it differs -- when we moved to merge medical and behavioral health contracts, I think then that would be the way to go there.

But, again, if you're trying to -- they can say, well, I have no control over what the medical managed care plan, who they admitted. Great. But you do have control over who you admitted.

So this got down to -- it really opened the arena, I think, of, you're responsible for a population, not just who showed up to your door. And I think the 40 percent of those who

had no contact with the mental health system, but were repeat rehospitalizations for some extreme psych issues, that pointed out a huge gap in how we contract and how we hold plans responsible.

DR. SIDDIQI: Right. Just to follow-up, I was just going to ask and encourage if you would be able to try and work through the NQF process to perhaps submit a Measure that you've already worked on. I know that's a huge ask, but I'm just going to through it out there.

CHAIR PINCUS: So, Dan, and then I want to call on myself.

DR. LESSLER: Okay. Thanks. So actually -- so this is a siloed measure for a siloed system? I think that's --

MS. COURT: At this point.

DR. LESSLER: -- the point. And the -- which given the system today, it probably makes sense and certainly has been helpful in this context.

But some of the ideas that are on the table, I think, are just really important ideas.

Because one of the things going forward as -- at least in Washington, as we look at 2020, full integration and so forth and I think everybody is, New York and others are pursuing this idea of integration of behavioral health and physical health. Is this idea -- it begs the question of what are good measures of systems that are integrated? And I don't have the answer to that.

I actually was thinking a lot about this just yesterday and overnight in anticipation of this meeting. But I think some of the comments might begin to get at that and I think it is something that we really need to ask NQF and Measure developers to be working on.

But one idea, for example, is for people, and I'm putting aside all the difficulties in doing this and so forth, so I'm just trying to -- but for people with SMI, what is their hospitalization rate and across psych and medical, what is their rehospitalization rate?

In this case, if we had a really

integrated system, I sort of agree with, I think, what others are saying. That in a fully integrated system, coming out of psych hospital, you would want to look at readmissions regardless of whether it's to a medical admission or psych admission.

So, I just think it's a really good conversation. I think we need measures that speak to the integration that we're all trying to achieve.

CHAIR PINCUS: Let me just comment. First off, I agree with you. And in fact, actually last week, we published in JAMA a viewpoint exactly on this issue that we can circulate. And we just recently got a grant from the Commonwealth Fund actually to develop an agenda for quality measurement at the interface of behavioral health and general health care.

And so that's -- and partly because if you look at the data, actually the majority of healthcare costs for people with severe mental illness are not on the mental health side, but

it's on the general health side.

MS. COURT: Right.

CHAIR PINCUS: Now, the other point I wanted to make is that these two issues are not mutually exclusive. So that one can have a measure that sort of has the same denominator, but two different numerators.

So that it's people that are having initial index admission for a mental health condition and then looking at their rehospitalizations both with regard to psychiatric rehospitalization and for a general medical or for any.

We do know that among the rehospitalization rates across all of Medicaid, that four out of the top ten conditions for rehospitalization are behavioral health conditions. Two of which are substance abuse and two of which are mental health. So that is clearly an issue.

And you can see -- and the incremental cost of doing it two ways is actually very low in

terms of the analysis. So that -- and it may be useful in terms of what -- in directing quality improvement records to look at the discrepancies and differences.

So I think that, that's valuable. And we'll get to later today about sort of thinking about how one can do this kind of segmentation. Particularly in the behavioral health side at this interface between behavioral health and general health.

Looking, for example, at performance on general health Measures for this segment of people with severe mental illness as like a disparities population kind of thing. So that there -- again, these are approaches that we can talk about.

MS. COURT: So, are we on --

CHAIR PINCUS: Ann?

MS. COURT: Oh, sorry.

DR. KELLEY: This is Dave Kelley. I'd like to weigh in if possible.

CHAIR PINCUS: Okay.

DR. KELLEY: There's been a lot of work on readmissions in the Medicaid. Medical directors actually published last year in Health Affairs a multi-state project on readmissions.

Different states have challenges around looking across physical and behavioral health. And I'll just start with that statement. I'll also agree that if you're not paying attention to individuals with behavioral health conditions and SUD, that you're not going to get the entire picture.

I would advocate staying with an all-cause readmissions measure, but then looking at that initial index admission and then looking at what happens subsequently. It gets very difficult because some states do not have the ability to look across both sets of information.

And integrated managed care, even though it's supposed to save the world, I can tell you it will not. Because even when you do sub-contracts, a lot of those entities still don't want to share some of the information. And

we've done a lot of self-analysis.

We report -- and this is back to my initial comment about having consistency in how states report -- the readmission measure, as I understand it, there is not a NCQA and Medicaid readmission measure. This is one of those measures where I think there was flexibility in how states reported this.

We reported an all-cause readmission in our physical health. We do that externally. We use our EQRO to develop that spec, we've been measuring now for several years, it's actually part of our MCO-paid performance.

Our EQRO also independently looks at behavioral health readmission rates independent. And then we also have had them look at -- and again I mentioned earlier the beauty of having an EQRO look across those sides of the carve-out, and they actually have dug a lot of analysis for us around looking at the effects of people with behavioral health conditions and then specifically the effects of individuals with SUD.

And if you don't pay attention to behavioral health conditions and also SUD, you're really going to miss a huge opportunity. So, my comment to the committee is that I would stay with an all-cause readmission with some sub-analysis.

And then I also would like to advocate that there are increasing number of measures, NCQA has several measures, again, that are looking at integrated care. And I think looking at medication adherence for schizophrenics -- at individuals with schizophrenia. Looking at blood pressure control.

I really want to advocate that there are more and more measures that actually get to more integrated care. And again, the initiation and engagement is another example of where we need to be paying attention from a quality metrics standpoint in integrating care.

CHAIR PINCUS: Anne?

MS. COHEN: So, I mean, I think there's a couple problems that we can sort of outline

along this. Mental health is so carved out in most states, at the county level, and the bed day availability is so limited, that I think you're really missing a huge percent of the population in the rehospitalization measures.

And I would echo the comments from the gentleman from Pennsylvania and I think we have a number of measures before us here that we can take a look at. And one that I think could be really valuable is 2605, which is Follow-Up After the Emergency Department Use for Mental Health Conditions or Alcohol.

Because that's when a lot of the mental health patients end up in the ER and the primary reason for rehospitalization is medication management issues that have gotten so severe and they can't get appointments and the only way the psych doctor can rebalance them is say to get admitted. So, I think that, that captures a large percent of the population.

I also like the idea of some of the measures that deal with diabetes, A1c 3, and

blood pressure management for folks that are schizophrenia or bipolar disorder because I think that, that's a huge secondary condition component that we're not tracking that could really avoid some of the hospitalization issues.

CHAIR PINCUS: Nancy and then Beverly.

DR. HANRAHAN: I want to ask Sarah if she would put all-cause readmissions up there for the dual eligible and the Medicaid population. Because I think we're all agreeing that there's something to that, that will add substance to -- particularly the dual eligible or the SMI population that's so costly and so burdened with disease in our society.

But I also want David to talk a little bit more about engagement and activation. Because I know we started speaking about this among the MAP groups that I've been on as a Measure that we really need to explore.

It's a dimension of quality improvement that we have not hardly touched. And it really accesses the patient's perspective and

the patient's accountability and responsibility in that linkage with quality. So can you just talk a little bit more about how in fact you did tackle that, David?

DR. KELLEY: Sure. Using our quality grant, we, again, had our EQRO actually report on initiation and engagement measure across our carve-out. And as they did, because we had behavioral health at the county level that then gets rolled up into five behavioral health MCOs, we also had a to do a county by county sub-analysis.

And for our quality improvement project that we did in our grant, we actually took the large county Allegheny County and the Pittsburgh area out because we really noticed that our results were, shall we say, far from optimal. And so we were able to overcome kind of the confidentiality issues.

Officially, we have fairly robust encounter data sets from both our physical and behavioral health plans. So we were able to

measure initiation and engagement and what we found was that many of these individuals were landing in the emergency room, were not really getting appropriate follow-up care.

So they really weren't getting even initiated. And then those that were being initiated really did not stay actively engaged. And so we used those in Allegheny county to really start to build a better care model that we're really just getting off the ground.

Actually, we have all of our MCOs in that area participating and actually, even though the grant is over, they've offered to sustain this model of care coordination and navigation for two years. So we're in the process of putting in actually an intervention where individuals are seen either in the emergency room and/or if they get admitted to the acute care physical health side of the fence, in one health system there are social workers that have been trained in Esper and have been linked to our managed care plans.

And then in another large health system, there are actually peer -- they call them peer recovery specialists, that are again working with those consumers. So we've been able to measure it. We're not happy with the results. And now we're trying to build kind of these interventions around better navigation and helping these consumers actually initiate and get engaged.

But we've done a fair amount of work in looking at individuals with SUD, how they get admitted to the ED over and over again, and how they have been readmitted to hospitals, both on the physical and behavioral health side of the fence, repeatedly.

And it's part of -- if you look at your claims data, some of these individuals will come up as dizziness and giddiness or metabolic poisoning or whatever. There are unique ways that hospitals have of coding these incidents.

But when you do a drill down, it really drives a lot of our medical costs on the

physical and behavioral health side. But again, being able to measure it really is helping us to identify where are the issues.

CHAIR PINCUS: Beverly.

MS. COURT: Okay. Well, I'm glad I got to stir up some discussion. So just to go forward then to look at some of the findings that we had.

Our other focus of rehospitalizations were those that were emanating from nursing homes. We did do a paper looking at our dual population where we merged Medicare and Medicaid data, specifically looking at the issue of rehospitalization from nursing homes. A number of -- there's a citation to the paper, it's online. So you can read about it.

But one of the things that we -- so this addresses how do you take these Measures and operationalize them? How do you make them into performance Measures and what's effective and what's not effective?

And this gets back to the point, I

think, that was made either, the need for risk adjustment. And this just an example. On the vertical axis, we have 90 day inpatient readmission rate. On the horizontal axis, we have a risk score, which is a case mix index of the duals in the nursing homes. This is using CDPS, Medicaid Rx, just diagnosis, pharmacy, age, gender.

But we found it very effective in -- especially when we used this against the Medicare and Medicaid information together on these duals, to portray a case mix of the nursing homes. And then each of these dots is a nursing facility that had received at least 25 dual eligible hospital inpatient discharges in this time period.

So if we were to look at the performance of these nursing homes and we were to set, let's say, the average as our performance measure, that would be 36 percent. That's huge. That means that these folks are cycling between the nursing home and the hospital.

However, there is a relationship between the admission rate and the severity of the patients that the nursing homes are serving. They're not equally distributed. So if we take that into account, then we have a case mix adjusted expected performance.

If you lay a -- you relate the expected performance to the severity of the people that they have in their facility. So what does this do? In terms -- if we don't case mix adjust results in our expectations for performance, what happens is that, for example, we have this one facility that gets penalized.

It has quite a severe risk adjusted weight for the clients in their nursing home. Yet they're under what we would expect to be their 90 day readmission rate. If we had just identified the 36 percent, we would have penalized this facility.

But if we do risk adjustment, we find in fact that they're probably one of the best performers and we would want to learn from this.

Likewise, we would be rewarding mediocrity if in fact we didn't risk adjust those that are below 36 percent, but they really could do better given what other nursing homes can do with a similarly severe patient population.

So I just wanted to -- when we say, okay, well how do we make movement on these measures? It's one thing to measure it. It's another, totally different, set of activities to say, we're going to make improvements in this measure. And so this is an example of what you have to do and how you have to be very careful when you try to implement improvements in these measures.

Gaps, I was just going to throw out, because Washington does a great job of it, we do a lot of long-term care services delivered in the home or community. And so one of the things that hasn't been reflected in the measures is measures of home and community based long-term care use. Just for your consideration.

Lots of barriers that we talked about

before, but I'm really glad that we've had the opportunity to address it. And Marsha and I are going to be talking later with her folks.

Again, the issue of mathematical competency in a sense, that the measure definition not include the partial Medicaid coverage in the denominator. And this isn't an issue -- when you look at the NCQA or the HEDIS measures, that's for people who are enrolled in plans. They don't have partial Medicaid. They have full Medicaid. They don't have third party liability. They're fully Medicaid. Or else they wouldn't be enrolled in those programs.

So it's not an issue if you're basing your measures off of the performance of those managed care plans. However, if you are using administrative based, you're looking across the state, if you're generating them that way, you get very skewed results. So, again, we have an opportunity to make that refinement in the measure, technical specs.

Again, things that will encourage

states to continue to -- when you do a state to state comparison, there's always going to be winners and there's going to be losers. If you can reformat how you report these measures as a quality improvement, that is you follow a state over time and you also capture what they're doing for those measures that they're not being able to capture at this point. What is their process to building that infrastructure?

I think then you build a reporting atmosphere that's conducive to states reporting. But it would be very, very easy at this point to slide into something that's immediately considered unfair, immediately considered winners and losers. So I think it need to be handled very carefully about how the data is released and what kind of incentives, disincentives it would create.

So I think I've made all my points. And I really appreciate the opportunity to address you.

CHAIR PINCUS: This has been really

terrific. I think it really helps to influence our thinking in terms of what we add, what we don't add going forward. And I think rather than have more a sense of -- we've already discussed a lot of these issues, why don't we move to having public comment on states' experience.

And then we can move much more directly right to discussion of measure by Measure kinds of issues. Anybody online that would like to comment in the public comment period about states' experience in reporting measures?

OPERATOR: To request a public comment, please press Star then the number 1 on your telephone keypad. And there are no public comments at this time.

CHAIR PINCUS: Thank you. What about in the room?

DR. LIU: Hi. This is Junqing Liu from NCQA. I would like to use this opportunity to give the Task Force a review of the NCQA's behavioral health measures that will be discussed

this afternoon. I think it would be helpful to --

CHAIR PINCUS: Actually, we're going to discuss it right after this public comment period. So right now.

DR. LIU: Yes. Great. So, two of the measures will be discussed are metabolic screening Measures for people with schizophrenia and who are on antipsychotics. Those were are developed and endorsed by NQF three years ago.

And that project led us to this recent project that we developed 11 measures, that's a set of measures for people with serious mental illness and substance abuse issues. So thanks for the committee to consider these measures.

So for the recent measures, we heard stakeholders encourage us to develop outcome measures for people with behavioral health conditions. So that's led to this work. So we have seven of the measures that are diabetes indicators for people with SMI. And one of them is controlling high blood pressure for people

with serious mental illness.

We developed these measures because there is evidence to support that there's higher prevalence and disparities in care for people with serious mental illness for these conditions. And evidence support that people with SMI die 25 years earlier than the general population because of their chronic medical conditions.

So we developed these measures to address the medical care and also address an integration of behavioral health and the primary care for this population. So the measures are aligned with the general population diabetes and hypertension control measures. But we specified them for the SMI population to really emphasize disparities in care and offer us an opportunity to monitor the care for this population.

And the reporting of this measure could require over sampling of the general population measures so we can have enough sample of people with SMI to look at the quality of care for that population. And it --

CHAIR PINCUS: By the way, you have this paper before you, so hopefully you don't anything ---

DR. LIU: Yes. So the material that has an overview of this set of measures and high level specification for these measures.

And we also have a screening and follow-up measures for people with serious mental illness or alcohol and other drug dependence problems. Those were the BMI screening and follow-up, tobacco screening and follow-up, and alcohol screening and follow-up.

So we developed these measures, again, because of the higher prevalence and the comorbid behavioral health conditions for this population as well as disparities in care. And we adapted existing general population measures and reporting measures for the serious mental health population and the substance abuse population.

And also, we stressed into the numerators of these measures to require two events of services, could be counseling or

pharmacotherapy, to really meet the needs of this high-risk population. And the stakeholders encourage us and supported us to specify the measures this way.

And we tested these measures, the diabetes measures as well as the screening measures, and the results really demonstrate large disparities focused across measures. The performance rates for the SMI and substance abuse populations were 10 to 40 percentage points lower than the performance rates for the general Medicaid populations.

So there's clearly disparity and room for improvement. And the last of the measures is the follow-up after ED discharge for mental health or substance abuse problems. That measure really captures the continuity of care as we know that as evidence support those with follow-up care are much less likely to be readmitted into an ED. And also we know that behavioral health conditions are among the ten top conditions of ED readmits for Medicaid beneficiaries.

So that's our overview of the measure set. And I'm happy to answer any questions you may have during discussion. Thank you.

CHAIR PINCUS: Thank you. Are there other public comments?

DR. EISENBERG: Hi. My name is Woody Eisenberg. I represent the Pharmacy Quality Alliance. I'd like to introduce three new measures that are not part of your packet, but that I hope that you'll consider this afternoon.

These are measures of the use of narcotic overuse. And they were developed to directly address the epidemic of narcotic morbidity and mortality that besets the nation currently.

The three measures are the use of narcotics over a certain dose, in this case 120 morphine equivalent dose milligrams over a certain period of time. The second measure is the proportion of individuals without cancer receiving prescriptions from opioids from four or more prescribers and getting them from four or

more pharmacies. And the third measure is a combination of the two, it's the proportion of individuals receiving greater than 120 milligram morphine equivalent dose from four or more prescribers and four or more pharmacies.

The description and the specifications, although you may not have them, are over on the side table. We've done testing of these measures and what we've shown is that there is great variation amongst different health plans in the commercial and in Medicare.

We don't yet have specific Medicaid testing, although we are pursuing that right now. And we hope that you'll consider these Measures during this session because we think it fills a gap in the Medicaid Core Set. Thank you.

CHAIR PINCUS: Any other public comment?

DR. SIDDIQI: Just a follow-up question to the speaker from PQA. Are any of these going to be going through an NQF endorsement process? Or has it been applied? Going to be --

DR. LIU: They are all endorsed by NQF.

DR. SIDDIQI: Sure. I meant the opioid --

CHAIR PINCUS: From the PQA, I'm sorry.

DR. EISENBERG: The PQA measures were just endorsed by PQA two weeks ago. We're in the process of preparing them for NQF submission right now. Thank you.

DR. SIDDIQI: That's great.

CHAIR PINCUS: So can we move ahead then? So we're skipping over lunch.

(Laughter.)

CHAIR PINCUS: No, we're going to come back to lunch later. We're going to come back to lunch later.

But we want to start the conversation for the measure by measure review. And not focusing right now on measures to remove, but focusing more on measures to fill gaps.

MS. LILLIE-BLANTON: Before we go to that section, I just want to suggest we add something from Beverly's presentation to the

board, where she said gaps were home and community based services measurement. Just so we don't forget it. I just don't want to lose it.

CHAIR PINCUS: Lisa, was there something you wanted to --

MS. PATTON: We can come back to it when we talk about the behavioral health condition Measures. So, I can hold off.

CHAIR PINCUS: Okay.

MS. LASH: Okay. So, when this body last met, there were a list of high priority gaps developed. You can see them on your screen here. There was an interest in having more Measures to look at concepts related to access, to both primary and specialty care. More outcomes reported directly by the Medicaid enrollees. Care coordination. Cultural competency. Efficiency.

Long-term supports and services, not specifically home and community based services. Maternal health. Promotion of overall wellness. Treatment outcomes for behavioral health

conditions and substance use disorders. And the workforce. So many of these are sort of stubborn measure gaps that have persisted like this for some time. Although there are always new measures in development.

And so we're very pleased to be able to bring you potential measures for addition in some, but relatively few of these gap areas. Because that was such a long list, we actually did a prioritization of the gaps at the last meeting and there was a stronger request about action in three gap areas.

So first, maternal health relating to risk for poor birth outcomes. I think we really had a lot of that discussion yesterday. And the MAP did vote to support measures relating to that topic.

Second, behavioral health and substance abuse treatment to prevent readmission. Very germane to what we had just been discussion. And then finally, access to primary care.

As I just said, we've been over the

perinatal and maternity topic with some good success. And right now, we'll dive into measures that we found in behavioral health and access to primary care. Essentially, the rest of the gap areas didn't have strong enough measures for addition at this time or the properties of the measures would not make them suitable for this type of state-wide reporting program.

For example, there are newly endorsed measures of readmission to long term care hospitals and home health, but they only include Medicare claims. And so you could look at them for dual eligibles, but that wouldn't be accessible by the Medicaid agencies.

So I want to remind everyone about the voting procedure quickly. We have it looks like 12 of you voting members currently in the room. Our federal partners are non-voting as are the states. Harold will plan to recuse himself from some of the voting and I'll ask him to describe that in just a second.

But either way, whether there are --

I think Brock was probably coming back, whether there are 12 or 13 voting members present, the consensus threshold would be eight people needing to support a particular motion to move forward. And so the options available to you are to fully support a measure for immediate use by CMS.

To conditionally support use of a measure with some additional requirements that the measure potentially achieving NQF endorsement, that there would be a specific change you would request to be made by the measure steward, or if you think CMS needs to do further work on confirming the feasibility or potential burden to states before you want to throw the whole weight behind that recommendation.

I don't think we'll use do not support, rather we would probably not vote on a measure that doesn't seem to have the interest of the group.

CHAIR PINCUS: And let me just say that with regard to the behavioral health measures

that are stewarded by NCQA, I served as a advisor to that process and sit on their Behavioral Health Measurement Advisory Panel. So that's why I'm recusing myself from the NCQA measures.

MS. LASH: Any questions about the voting? Okay.

So, in the preparation, in the original bundle of materials, we had pulled out some but not all of the newly endorsed NCQA measures on behavioral health. So you'll have to do a little bit of toggling between the Excel sheet, which does contain Measures 2599, 2600, and 2605, and the handout that has eight additional measures.

There are, in this particular topic area, quite a few potential measures available to the group. In the staff review prior to the meeting, the one that emerged as our front runner, which we would propose for discussion, is the measure on Follow-Up After Discharge from the ED for a Mental Health or Alcohol or Drug Dependence Condition. It's the bolded one. It's

number 2605 and it comes last, it's on the back page of the NCQA handout.

MS. GORHAM: Now, just a bit of clarification. On the screen, it's bolded, but if you're actually looking at your Excel sheet, then it's highlighted in yellow.

MS. LASH: Yes. Thank you. And so, the other measures could be worthy, but given the way MAP had articulated the particular gap they were interested in filling about care coordination and outcome-oriented measure and so on, and that there are already other measures in the Adult Core Set related to cardiovascular disease and diabetes, that is the rationale for the staff pick and we would be looking forward to discussion about whether there would be an alternative proposal for one of the other available measures. So, this is the spec in --

CHAIR PINCUS: Okay. Just one --

MS. LASH: Sure.

CHAIR PINCUS: -- other, just a process question. So we have these measures that are up

here, plus the additional measures that are on the handout --

MS. LASH: Right.

CHAIR PINCUS: -- from NCQA. What about the measure that came up in the recent discussion? Are we going to get to those?

MS. LASH: The opioid measures? Sorry.

CHAIR PINCUS: Well, the opioid measures also. But also the rehospitalization measure, for example.

MS. LASH: There is not -- as Beverly described, the psychiatric rehospitalization measure that they're using in Washington is homegrown and we don't think we could scale that right now to this national program.

We could talk, but this might be sort of a separate issue, about the use of the plan all-cause readmission that is already, right now in the Adult Core Set and how use of that might be strengthened to stratify --

CHAIR PINCUS: Right. It could be so --

MS. LASH: -- and identify different populations.

CHAIR PINCUS: -- could be segmented and stratified in some way.

MS. LASH: All right. So, I will quickly review Measure 2605 and we can discuss that. And after we have reached a conclusion about the group's feelings on that, sort of ask any of you to call out one of the other specific Measures for additional discussion.

So, this Measure 2605 looks at the percentage of discharges for patients 18 and up who visited the emergency department with a primary diagnosis of a mental health, alcohol, or other drug dependence condition and who had a follow-up visit with any provider with a corresponding primary diagnosis of mental health, alcohol, or drug dependence within seven and also within 30 days of discharge.

So there are two rates within the Measure. It's a claims-based process Measure and I will actually defer to our NCQA colleagues in

the room to further explain any questions you might have about the tech specs. Thoughts? Beverly?

MS. COURT: So follow-up wouldn't include audiology, correct? I mean, I'm always fairly shocked when audiology is considered a follow-up after hospitalization or other Measures. So when you say any provider, I think there is reason to put some parameters around that.

MS. LASH: There are some exclusions. It's fairly detailed.

DR. LIU: Okay. I think I'm on now, thank you. So for the provider, we did not specify the provider type. Rather, we require primary diagnosis of mental illness or substance abuse problem to indicate that the visit is for the behavioral health condition.

We understand that each state have different regulations in terms of who is qualified behavioral health providers. So that's the way to get around that.

The measure does have exclusions. Those were mainly for people who are directly transferred from the ED to another inpatient setting. The rationale was that those folks are getting the needed care when they are going to another level of care. So this measure is focused on people who are discharged to the community.

DR. HANRAHAN: Just a clarification. A primary diagnosis of mental health, and I know somewhere you detail this out, is that any mental health diagnosis? Does that include, I mean, I'm assuming it does, any alcohol or drug ICD-9 codes? Is it ICD-9 codes that you're using?

DR. LIU: Yes. So we use the diagnosis codes of these conditions. The mental health diagnosis are very inclusive. Include all the common mental health conditions such as schizophrenia, bipolar, major depression, anxiety, et cetera.

And to maybe clarify that, this Measure has four indicators. Two of them are for

mental health indicators. The other two are for substance abuse indicators.

So, for those people that visit the ED with a primary mental health condition, then the measure looks to see if they get follow-up visit for the primary mental health diagnosis. And the same logic for the other two indicators for the substance abuse.

DR. HANRAHAN: So it's a primary diagnosis of a mental health condition is what I'm understanding. And is it any mental health condition? I guess what I'm driving at here is that, that's a very, very broad categorization.

A primary diagnosis really helps because it narrows the focus a bit because you're not going to get a primary diagnosis unless it's a mental health or drug or alcohol condition. But I think that it's far better to carve away at some of the hot spots or the high users rather than do that kind of a broad sweep. And that's just from my experience doing research. Beverly's shaking her head too.

MS. COURT: That's why we refined our psychiatric rehospitalization to really select set of diagnoses.

DR. SIDDIQI: Just a follow-up about the primary diagnoses. So if a provider sees this patient and it's a primary care provider and is addressing, let's say, hypertension, diabetes, and some other diagnoses, as long as they put in the mental health diagnosis, that would meet this? Or it has to be the first diagnosis that they list?

Because that is going to be a huge challenge. Because primary care providers generally like to put the primary diagnoses, even if it is a mental health follow-up visit, they often times are going to not primarily put this as their first diagnosis. They would put the comorbidities often. So then, would that not capture that follow-up visit?

DR. LIU: Yes. These are all very valid concerns and questions. We actually heard those and discussed with our measurement expert

panels and technical expert panels. They really encouraged us to open the mental health indicator to people with any mental illness, not to limit it to say a subset of mental illness.

Because they think this is a high risk population. If they have an ED visit with a primary mental health diagnosis, they ought to get follow-up care.

DR. SIDDIQI: So I agree --

DR. LIU: And --

DR. SIDDIQI: I agree with you, but I guess what I'm questioning is when you say primary diagnoses, that's first of all going to limit even your search for administrative claims. If you just say any diagnosis of mental health for that follow-up visit, in other words, it doesn't have to be primary --

CHAIR PINCUS: Just to clarify your question.

DR. SIDDIQI: I'm just clarifying.

CHAIR PINCUS: Are you talking about for the denominator or for the numerator?

DR. SIDDIQI: For --

CHAIR PINCUS: Because I think --

DR. SIDDIQI: In the description, so I'm thinking it's the denominator.

CHAIR PINCUS: Yes. Because for the denominator, it's in the ED, not for primary care provider.

DR. SIDDIQI: Then it's the numerator then. It's the numerator --

CHAIR PINCUS: Okay.

DR. SIDDIQI: -- in terms of -- we should be able to capture any patient that follows up in seven or 30 days, that's what it says, seven or 30 days who has a mental health diagnosis that was initially seen in the emergency room, it sounds like.

And you're not going to capture that if you just say primary because the majority of -- first of all, the administrative claims hassle is going to be that much more challenging. In administrative claims, to be able to just capture whether or not that diagnosis was collected is

very different from saying it's the primary diagnosis that was collected in the way that providers bill. So that's where I'm confused.

And that technical question that I'm asking about is when you say primary diagnosis, do you really mean to say any diagnosis in that visit as long as it was a mental health diagnosis? Because when you're saying primary, that's not administrative claims data source.

I mean, that goes into much further discussion of how challenging that's going to be in terms of the first diagnosis that a provider bills for as number one.

DR. LIU: Yes. Let me help to -- that's a good question about sometimes providers may not necessarily code their behavioral health conditions as a primary diagnosis. However, we discussed that with our expert panels.

They recommend us to really require the primary diagnosis for the numerators because they think that, that's really to ensure the face validity of this measure. Because that's the way

to ensure that their follow-up visit is for mental health conditions or substance abuse conditions.

And also in our testing, we really tested different options of the numerator by requiring or not requiring primary diagnosis. We actually get very similar results. So we are seeing the same population who are getting follow-up care.

DR. SIDDIQI: But again, you're looking at claims data, so in your testing, are you testing chart reviews? Because if you're doing claims data --

CHAIR PINCUS: It's different.

DR. SIDDIQI: -- and you're trying to pull, you're going to pull all the claims with that diagnosis.

CHAIR PINCUS: So just to clarify terms here. Obviously with your claims data, it's not necessarily primary diagnosis. It's the billing diagnosis.

DR. LIU: Yes. We use the -- we test

this measure in Medicaid claims and it's using claims that are -- we were able to use that to identify the primary diagnosis.

CHAIR PINCUS: So on this specific issue, about the numerator definitions, Marc?

DR. LEIB: If we -- restricting the definitions to primary diagnosis on claims data for physician billing, hospitals have very specific rules on what they list first, second, third. Physicians can list their diagnoses in --

CHAIR PINCUS: Right.

DR. LEIB: -- any order they want and most often just do cut and paste from their previous visit. So if they see a patient for hypertension commonly, that's going to be the first listed diagnosis.

And they'll never see in this measure the fact that they were there for their depression, their anxiety, or anything else, because it will not be the primary or first listed. And the term primary by the way is only used on a hospital claim.

CHAIR PINCUS: Right.

DR. LEIB: First listed is used on physician claim. And it's --

CHAIR PINCUS: So it's --

DR. LEIB: -- doing it this way is irrelevant.

CHAIR PINCUS: So it's a billed diagnosis. So, Anne and then Dan, on this specific issue. And oh --

MS. COHEN: So --

CHAIR PINCUS: -- Ann too.

MS. COHEN: So I would echo that. And it gets a little more complicated than that for mental health for this reason. If you're a primary care physician, you can only treat somebody for their depression for their first 30 days. If it's considered a serious mental illness, it then is kicked to the county if it's county carved-out, which it is in most states.

So therefore, their physician when a person comes in, even if they have a serious mental illness, is probably unlikely to code for

mental illness because they won't get paid. At all for the visit.

CHAIR PINCUS: Ann?

DR. SULLIVAN: The issue here is though, this is an ED visit. An -- oh, the follow-up.

MS. COHEN: Thanks. Let me give you an example, okay. Somebody with schizophrenia has multiple trips to the ER. Maybe an encounter for a mental health facility. Gets triggered by the plan to go in for a primary care visit. Goes in primary care visit, decides that he has some wounds, decides that he has pneumonia, whatever. He won't code for that.

He's not going to even think about coding for I'm following up with this person because they have a primary diagnosis of schizophrenia because he's already carved down to mental health. So then, maybe he will go see county mental health. But probably it will take three months.

DR. SULLIVAN: Permission of their

provider --

CHAIR PINCUS: I'm not sure why that's a problem.

DR. SULLIVAN: -- their after care provider?

MS. COHEN: So the problem is, is that when you pull the data, they're going to see -- well, it would take at the health plan level, let's say, how many of the mental health patients have gone to the ER A, and then did they see the doctor? So it just depends on how they pull the claims. That's the issue.

CHAIR PINCUS: I think it's, I mean, the way I understand it is, how many -- what patients have been to the ED and had a --

MS. COHEN: A mental health diagnosis.

CHAIR PINCUS: -- mental health diagnosis.

MS. COHEN: Maybe that's what it is.

CHAIR PINCUS: Yes. That's it. And then say of those, what proportion of them within 30 days had any encounter that had a --

MS. COHEN: Then it's --

CHAIR PINCUS: -- billing diagnosis?

MS. COHEN: Then it's --

DR. SIDDIQI: Referring to what the steward is saying that the primary diagnosis --

MS. COHEN: No, no, no --

DR. SIDDIQI: -- has to be --

MS. COHEN: Wait, we're wrong. We're wrong. So this is why, okay. Sorry, forgive me, I think finally like the light went on.

I'm a health plan administrator, a care manager. I'm going to pull all my ER visits in the last 30 days. Of those, because I've had quality project related mental health, I'm going to stratify the mental health patients out. Did they go to the doctor, yes or no.

DR. SIDDIQI: If that's the way --

MS. COHEN: That's the issue.

DR. SIDDIQI: If that's the way it is, that's different from --

MS. COHEN: That's what it is.

DR. SIDDIQI: -- what she's saying

though in terms of their testing was only if it was a primary diagnosis. That it counted in the numerator.

MS. COHEN: No, no, no, no. The primary diagnosis is only for stratification purposes only. It's not a numerator factor. So if someone with schizophrenia went to the doctor and got a wound check, that counted. Which is okay.

DR. LEIB: It has to be the primary diagnosis.

DR. SIDDIQI: That's where I'm concerned.

MS. COHEN: The encounter of the ER --

DR. SIDDIQI: The follow-up visit --

CHAIR PINCUS: No, the encounter follow-up visit, if you read this.

MS. COHEN: Oh. Then you're --

CHAIR PINCUS: But for the outpatient, it would be a -- it's not a primary diagnosis, it would be a billing diagnosis.

DR. LEIB: Well, that's not what it

says though.

CHAIR PINCUS: Right.

DR. LEIB: It says the primary diagnosis.

CHAIR PINCUS: So I'm --

DR. LEIB: So how is this operational?

DR. LIU: In the claims, I believe there's a field that says primary diagnosis. So that's how we capture that.

DR. SIDDIQI: You'd have to be able to capture the number one billing diagnosis of the provider. Which makes the administrative claims data source that much more complicated.

If you had just captured it as a diagnosis, in other words, that the provider billed for hypertension, diabetes, and then added wound care, and then added the diagnosis of schizophrenia or the diagnosis of depression or a mental health diagnosis, that would be fine with me. But I think the fact that you're saying it's a primary diagnosis, you're not going to capture all those primary care provider office visits in

the claims data.

CHAIR PINCUS: But I think the --

DR. SIDDIQI: Because it's primary.

CHAIR PINCUS: Let me just -- I think the thinking is that if they were doing wound care and all these other things, they probably were not following up on the fact that the person actually attempted suicide and --

DR. SIDDIQI: No, we do follow -- primary care physicians --

CHAIR PINCUS: -- the lacerations --

DR. SIDDIQI: -- do follow those things up, but mental health diagnoses typically are not billed first by primary care providers. It's the chronic medical conditions that allow your payment, so those are the ones that you're going to primarily bill for.

And still secondary, maybe third, fourth diagnosis will be the mental health condition, but it's not typically primary. Because you will not get paid as a primary care provide often.

And it's not just in the carve-out states. I'm not just talking about the carve-out states. Typically mental health conditions primarily diagnosed -- if you put it as a primary diagnosis, the patient will come back to you frustrated because there was an issue with co-payments, there's an issue with payments from the health plans.

So primary diagnoses typically are not mental health conditions in primary care provider offices. Again, you're talking about follow-up in a county mental health facility and mental health facilities, certainly that would be the primary diagnosis and you would capture --

CHAIR PINCUS: Anne?

DR. SIDDIQI: -- that. But not in the primary care provider office.

MS. COHEN: Okay. So, there's -- this is my primary question. What is the purpose of the metric at the end of the day? And the purpose of the measure, right, is do we want them seen at all? So that we make sure that they're

okay. Okay. So that would mean no problem, wound check or whatever, that's fine. We saw them.

Or do we want to have a mental health discussion with this individual? Or alcohol, drug dependency? If it's an alcohol, drug, whatever, then we have to know that data. If it's we just want them seen, then it doesn't matter. Because in theory, we'll pull the hospital data first, stratify, and then look for the --

DR. SIDDIQI: But the primary care provider's role is always very challenging and there's multiple conditions being addressed. So you're actually addressing both the primary physical --

MS. COHEN: Then that's fine.

DR. SIDDIQI: -- and the mental health.

MS. COHEN: So I'm asking what is the purpose of the measure? What is the intent of the measure? What is the follow-up intent? And then what are you trying to capture? Do you see

where I'm going Harold?

CHAIR PINCUS: Yes, I do. Nancy?

DR. HANRAHAN: So I think the problem would get solved. If we eliminated after any provider with a corresponding primary diagnosis of mental health or alcohol or other drug dependence and left within seven or 30 days. Because what that would say is simply we have a percentage of people that went to the ED that had a primary mental disorder diagnosis that then were followed up. That's it.

DR. SIDDIQI: Yes.

DR. HANRAHAN: And that's all the information we're going to get from this. And is that adequate?

MS. LASH: I want to just clarify. This Measure is NQF endorsed, newly endorsed, so we don't want to relitigate that. And so therefore, it's pretty baked. So we will need to make a decision as a group about whether this exact Measure as it is currently specified is something we want in the Adult Core Set or not.

I'll just sort of leave there.

DR. LESSLER: I just had a process question then. Because we're considering this, but there are a number of other mental health measures. And I'm just wondering, are we going to decide on this measure and then move to the next.

CHAIR PINCUS: Yes.

DR. LESSLER: So there isn't the ability to sort of think about these in their totality and sort of say, of these, this probably would be --

CHAIR PINCUS: No, we will. Actually we will have an opportunity to prioritize.

DR. LESSLER: Okay.

CHAIR PINCUS: Yes. But I think this one, I think, was qualitatively different than the bulk of the others. This one is more of a coordination of care one.

DR. LESSLER: I understand.

CHAIR PINCUS: The others are more related to dealing with issues of comorbidity and

wellness.

DR. LESSLER: Right. So it's -- I just was going as long as --

CHAIR PINCUS: But we can table this until after we look the other ones.

MS. SCHLAIFER: To see if there's a better one.

MS. LASH: You like better?

MS. SCHLAIFER: Yes.

CHAIR PINCUS: Okay.

MS. LASH: Okay. Other questions, specifically on this measure before we move on. Ann?

DR. SULLIVAN: I would just the developers -- the question for people who tested this. What their opinion is of what they found when they actually ran the data? Did they get a significant number of people? Did they get people with this primary diagnosis? Did it come out? I mean, did they get an extremely small percentage? Did they get a significant percentage?

DR. LIU: That's a good question. We actually rounded the claims that using the different primary versus secondary diagnosis of substance abuse and mental health conditions.

We were able to find a sufficient number of people for the measures and we compared the prevalence of the condition using primary diagnosis to the prevalence of this condition in the population. We actually find very similar prevalence rate. So that also adds to our confidence of our definition of this measure.

DR. SULLIVAN: You said you ran primary and secondary? What do --

DR. LIU: Yes.

DR. SULLIVAN: For comparison? And you found out that basically you got a good number on the primary?

DR. LIU: Yes. We used the primary diagnosis that you find the prevalence rate is very similar to the population prevalence rate that --

DR. SULLIVAN: Yes.

DR. LIU: -- is shown in the literature.

DR. SULLIVAN: Because I just want to say that I understand all the problems about billing and primary care, but when someone's leaving an ED and goes to see somebody particularly for that ED problem, it still might bump up somewhere in what you see. A lot of them end up not going necessarily, some go to primary care, some don't.

But that's your real reason and you're really paying attention to it, and if they found that the secondary primary wasn't that distinguished, maybe the measure's okay the way it's written. That's all I'm saying.

DR. SIDDIQI: I just wanted to give feedback that I'm not sure what the sample size of your testing was. But, again, if you're looking at the top three diagnoses, that would make more sense. Recognizing that within Medicaid populations, access to behavioral health providers is an extremely big problem.

And so the majority of follow-ups that are happening for these behavioral health patients that are in Medicaid are actually in the primary care provider's office. And many of those are family physicians, pediatricians, internists that are seeing Medicaid patients. So I just think that --

CHAIR PINCUS: But I think you want to be sensitive to access, actually it's better to have the more restrictive diagnosis.

DR. SIDDIQI: But no, not necessarily. Because access to a primary care provider is still very meaningful and very valuable. It doesn't have to be with a behavioral health provider who would only bill that top diagnosis for that primary diagnosis that is a mental health condition. That can be a very meaningful visit.

In fact, many patients that primary care providers see have mental health conditions. It's, again, just the issue of -- and they are addressing the mental health needs of that

patient and trying to do care coordination for that patient and work with the health plan.

But the point is that you're going to miss those providers who aren't going to, again, put that as the primary diagnosis because of this specific issue with this measure. So I would just hope that in our report, that we can put, even though it has gone through NQF endorsement and has been fully baked, essentially if we can give that feedback to the measure steward that this is an issue.

And especially when you talk about, again, implementing this measure across the board for states to be able to do this. They're going to want to be able to just report on any follow-up visit that happened for that patient that had a mental health diagnosis condition for that claim code to have been billed. Not that it was only primary. You're going to select out a huge number of primary care office visits --

DR. LEIB: I agree.

DR. SIDDIQI: -- in follow-up.

CHAIR PINCUS: Marc?

DR. LEIB: In a number of states, behavioral health is carved out from physical health. And we make this dichotomy like there's two different parts to the human being.

And a primary care provider, whether it be family practice, internal medicine, or whatever, while they can sit there and evaluate the patient and write a prescription and keep them going, if they list that as their primary diagnosis, they will not be paid for the visit. So they put that as a third or fourth thing so they capture the fact they did something, it's in the record.

But they list their hypertension, their diabetes, their whatever as their main purpose for being there. And that way their office visit is paid for and the patient got their needs met until they get to see the behavioral health specialist in three, four, five months down the road. And that's the reality of the access to behavioral health out in the real

world.

CHAIR PINCUS: I think we've hammered this. Does anybody want to say anything that's different than what's been said? Marissa?

MS. SCHLAIFER: I have a question. This is as a non-behavioral health specialist or person. Is part of having the measure, if we can't get people in to see a behavioral health specialist, is that some of the purpose of the measure that we're capturing that people aren't getting the care they need?

I mean, I realize you don't want to -- it shouldn't be Medicaid, Medicaid programs shouldn't be dinged for it. But it seems like this is important information that I personally didn't know. And I'm just wondering if there is a purpose for the measure, if not the purpose that we're --

CHAIR PINCUS: Marsha?

MS. LILLIE-BLANTON: I'm going to respond to her question. My concern would be if -- yes, that's right. Because what we're saying

is that, that individual who needs mental health care isn't getting it.

And what I hear is, people might be getting it, it's just not being coded as if they got it. And so the performance looks poor, but in fact the person is getting the care.

MS. SCHLAIFER: So I agree, it's not --

CHAIR PINCUS: Lisa, and then we'll move on to the next one.

MS. PATTON: Yes. I was going to say, just based on the feedback that we're hearing today, clearly this is an imperfect measure. And I think Anne might've been getting at some of this earlier, but it's kind of like well, what is the intent and what do we hope to see?

And so, not necessarily that this should now be taken up, but if it were then some work could be done simultaneously in the background perhaps to address some of these concerns. But with the clear indication going out that this is something important to ensure that, that follow-up care happens regardless of

the setting.

CHAIR PINCUS: Yes. And I think it would also be useful to maybe recommend that actually your hypothesis about this could be tested. And to see if there's data to test that hypothesis.

Just to point out, some years ago I directed a national program on depression and primary care for the Arthur E. Johnson Foundation and we worked with the Midwest Business Group on Health to actually test the hypothesis that primary care providers would not be billed if they had a depression diagnosis. Because they were getting a lot of feedback about that. And so they sent out 100 bills to test it and 99 of them were paid.

Now, things may have changed, but that's -- so I guess my point is that, and let's end this discussion just to say that if we're going to send this back, we should ask that the assumptions that we made are tested.

DR. SIDDIQI: I think, just one last

point I was going to make, is that these primary care providers do see a certain percentage of Medicaid, but certainly they're seeing the commercial patients, they're certainly seeing the patients in Medicare.

And so traditionally, commercial payers and sometimes when you bill for a primary diagnosis as a primary care provider, you do get rejected claims. Patients are upset, providers are upset. And so we've been trained as primary care providers not to bill primarily for that diagnosis for mental health.

So certainly if that's going to change and we are starting to reimburse that better across the spectrum, that's fantastic. But it's going to take years before we're going to see that change for primary diagnosis.

CHAIR PINCUS: Move to the next one?

MS. LASH: Let's see. So at this point, I would ask if there are other of the behavioral health measures, either what you see on the slide or the additional measures in the

handout. Not the opioids yet, we'll probably come back to those after lunch. But, NCQA specifically, we can have further discussion.

CHAIR PINCUS: Cindy?

MS. PELLEGRINI: So a question for the developer. Why were each of these items separated out into an individual measure instead of making a composite or something like that?

CHAIR PINCUS: I could answer that.

MS. PELLEGRINI: Oh, thank you.

CHAIR PINCUS: That actually came up in the -- and basically according to the rules of NQF, they need to be distinguished as separate measures. Initially there was a thought that you could simply stratify within an existing measure. But they wanted to put it through the separate endorsement process.

MS. LASH: I think Cindy's question's a little different actually.

CHAIR PINCUS: Oh.

MS. LASH: Not that -- your answer is why we have an SMI specific measure of diabetes

care, for example. But I thought Cindy might've been asking why don't we just have a composite measure of chronic condition management for people with mental illness? It would be a different way to lump. Was that -- I don't know, you can clarify, Cindy, what you were getting at.

MS. PELLEGRINI: Right. That's it. Because I think if you put one of these in and not the others, you're giving much greater emphasis to one condition that's going to be relevant for some people and not relevant for other people. Right?

MS. LASH: Yes. So that's why NCQA developed them as a suite. They, I think, don't want to speak for them too much, but I think that they all really do go together to give the full picture. And it wasn't possible to gain that full picture with the use of just one very complex composite measure.

CHAIR PINCUS: And I think part of it was also to anchor it with the, I guess, the principle measure that's a chronic -- the

diabetes measure. And so to anchor it with that so that it simply is another stratification within that measure. Which has marginal additional cost to do.

MS. PATTON: Yes. And Hal, this is what I was going to mention at the beginning of this discussion. This work originated -- Richard Frank, the current Assistant Secretary for Planning and Evaluation, he really pushed this work forward in 2010-2011. And so it's been led out of ASPE and funded by SAMHSA.

To really try to get at proxies for care coordination, as well as really developing a broad suite of measures that would look at the health disparities experienced by the SMI population.

And so that was really the intent of it, was to get at some of these perhaps metabolic conditions that come out of medication issues and that sort of thing. So that was really the underlying reason for the work.

CHAIR PINCUS: Ann and then Anne and

Nancy.

DR. SULLIVAN: Yes. Just to get back to that point. I think in the field, most people when they look at trying to follow what they call the metabolic syndrome patients with serious mental illness, they look at diabetes screening and diabetes care, they look at hypertension, high blood pressure, and they look at cholesterol.

And if you look at those as a bundle, which is kind of what you're talking about, like the cholesterol one jumps up here, somehow I don't see the cholesterol one here. But I think those are the things that people are looking at and saying these are the key things we need to follow in these patients, things we need to screen for and the things we need to treat relative to them being underserved and having disparities.

So I think most of these would fit in with that. How you form them, whether you bumped them all together. The only other one I would

say is I'm just curious why you didn't include, unless I'm reading this wrong in this one, the cardiovascular, the LDL?

MS. LASH: The handout is the newly endorsed measures that came under review in the most recent --

DR. SULLIVAN: Oh, okay.

MS. LASH: -- behavioral health endorsement. These ones that start with 19 instead of 25 --

DR. SULLIVAN: Okay.

MS. LASH: -- or 26, those are older Measures. But they are still --

DR. SULLIVAN: And then --

MS. LASH: -- NQF endorsed.

DR. SULLIVAN: -- just one other question, for state purposes. If you're already pulling most of this data for the general population, I'm kind of assuming that to segregate out into the SMI -- now it may vary depending upon whether your SMIs are fee-for-service or in managed care plans.

But I think it really gets to that whole question of disparities. I mean, if you're going to really deal with disparities, you have to start segmenting your data, and you have to look at whether or not a subgroup, because your whole data might look good and your subgroup might look really, really, awful and I think that, that's where this could be very, very helpful.

And we just know that the seriously mentally health are a subgroup that every piece of data shows have all kinds of problems. So to do this would also be a good experiment, I think, at looking at disparities at the same time very clearly that you're also looking at trying to get to this whole issue of treating serious mentally ill better. So I think some combination of all of these on the medical side I think are critical for the population.

CHAIR PINCUS: Anne and Nancy?

MS. COHEN: I'm the other Anne. I'm Anne Cohen. My counterpart. My distinguished

counterpart from New York.

CHAIR PINCUS: Anne with an E.

MS. COHEN: Anne with an E, yes. So knowing we can only vote for so many, I was kind of thinking the one that I thought could be most valuable. And I had thought the 1932, the diabetes screening, would be quite useful and here's why.

If you could figure out a way to get the -- one way obviously is blood draw. So when they're drawing for their medication, if they drew for diabetes at the same time, then you would be able to capture that population fairly easily.

Here's my only concern. We have on our current list under behavioral health, Adherence to Antipsychotics for People with Schizophrenia. So that would make sure you cover one of the populations on the list. But we don't have the other.

We actually would need 1880, Adherence to Mood Stabilizers for Individuals with Bipolar.

So we don't have both on the list, whereas both are on the list there. Do you see where I'm going with that?

MS. SCHLAIFER: You're not saying you couldn't --

MS. COHEN: I'm not saying that you couldn't. I'm saying that in order for the suite to be fully effective, ideally you would have the bipolar adherence medication one, too.

If we're monitoring for schizophrenia and we're not monitoring for bipolar but then we have other ones in system that are for both groups, you can't -- it's more of a balancing thing. Does that make sense? I could be off-base.

CHAIR PINCUS: It's -- I think what you're saying is that it's sort of logical to have both an adherence measure and a sort of balance, kind of risk-related measure. But it's not essential; it's just logical. But it's not essential. Yes.

I think there are more issues with the

bipolar measure, because it's a more heterogeneous condition. And so the issue in which you think about adherence may be different than the way you think about it for schizophrenia.

MS. COHEN: I see where you're going. That makes more sense.

DR. HANRAHAN: So just for perspective and build on what Lisa said, is that there -- up until a few years ago there were no behavioral health measures.

So this is the beginning of building that core set. And a lot of work went into this, I know. And they're not perfect. So just keep that in mind as you go forward that we need these measures and they're not perfect. And they've got a ways to go, but we need these measures.

MS. LASH: So, Anne has made a case for, was it 1932? Nancy or Ann Sullivan, do you have other specific measures you'd like the group to take up?

DR. SULLIVAN: I think you want to go

beyond just the screening, you'd want to include the comprehensive care for diabetes as well. Now, I don't know how many measures you can add.

But if you're going to really try to help these key issues, then I personally think comprehensive care for diabetes, the hypertension, and the LDL are the things that are really what you should be looking at. The other one which is up there --

CHAIR PINCUS: Just to say, I mean, right now, we can, I think we can -- there's not a limit to how much we can add. But then at the end, we're going to have --

DR. SULLIVAN: Oh, okay.

CHAIR PINCUS: -- a prioritization process.

DR. SULLIVAN: Okay. So I would propose the comprehensive care for diabetes and the hypertension and the -- can I take one from the other? I think the cardiovascular. I would propose those three. So the cardiovascular health screening is --

MS. LASH: Can you give us the numbers?

DR. SULLIVAN: -- 1927.

CHAIR PINCUS: Ann, can you give us the numbers?

DR. SULLIVAN: Yes. Cardiovascular health screening is 1927. The comprehensive care, blood pressure, comprehensive care for diabetes, they have a bunch of things under that, but the comprehensive series that mentions hemoglobin A1c is -- it doesn't have a --

CHAIR PINCUS: 2603?

DR. SULLIVAN: Yes. And then the controlling high blood pressure.

CHAIR PINCUS: 2602?

DR. SULLIVAN: Right.

CHAIR PINCUS: So 1927, 2603, and 2602?

DR. SULLIVAN: Right.

DR. HANRAHAN: I agree with Ann completely. But I also want to add to the list engagement and activation. I think it's an area, it's a gap that we can --

CHAIR PINCUS: Is there a specific

measure? Or is --

DR. HANRAHAN: No, unfortunately. I thought Sarah was asking where the gaps were and --

CHAIR PINCUS: Yes. Okay. So we're going to get to gaps a little bit later. But I guess the question I would have is engagement and activation in what? Treatment for --

DR. HANRAHAN: In health care. In treatment --

CHAIR PINCUS: Okay.

DR. HANRAHAN: -- for people --

CHAIR PINCUS: You may want to think about -- when we get to the gaps thing, get more specific.

DR. HANRAHAN: You want me to get more specific?

CHAIR PINCUS: Yes.

DR. HANRAHAN: All right.

CHAIR PINCUS: Okay. So Ann, Dan, and Anne.

DR. SULLIVAN: I would just like to

throw one more into the mix which is --

CHAIR PINCUS: And Lisa.

DR. SULLIVAN: -- which is the factor use screening.

CHAIR PINCUS: And 2605?

DR. SULLIVAN: Right. That's it.

CHAIR PINCUS: Okay. Dan?

DR. LESSLER: So first, just a question about 2603 versus, and maybe I'm just not -- 1932. So both of these are looking at getting an A1c done in slightly different contexts. Is that right?

Or am I -- I'm just wondering the extent to which these sort of potentially comprehensive diabetes care for people with serious mental illness. So hemoglobin A1c testing, that's 2603. And then 1932 is diabetes screening for people with schizophrenia or bipolar disorder who are using an antipsychotic medication.

So it's a little bit different in one case. I'm just thinking possibly we want to

think about one or the other if we're thinking along diabetes screening. So I just want to call that out.

But I guess from an epidemiologic standpoint in looking at some of the data we've seen, I mean, what's most important in these people, actually is hypertension control. Because that's what really kills people --

CHAIR PINCUS: It's 2606.

DR. LESSLER: -- kills people with diabetes. And the other I would say is the tobacco measurement.

So, and with respect to hypertension, again, I would note that there are -- it seems like there are a lot of states, and I know they're partial reporting and with all those caveats, I think maybe there's some opportunity here to build on the fact that states have demonstrated some ability to report on an actual outcome measure, which is blood pressure control.

Which is what ultimately, particularly with people with diabetes, probably contributes

in large part to the fact that this population dies in its 50s of cardiovascular disease. So I just want to make a strong case, and I know this is pushing on an outcome measure for that hypertension control, and I think it's the same for tobacco.

I mean, those are -- if there are two things, and a lot of this is important, but I think those are the ones that I would really advocate for.

CHAIR PINCUS: Okay. So Anne and then Sue. Okay, Sue? And then Marsha. Okay

MS. KENDIG: No. I just wanted to bring up, in listening to this conversation, I would definitely agree with Ann's recommendation around diabetes, hypertension, and so forth.

But what strikes me is what we're talking about is very similar to some of the measures that were used in the health homes in some states with the SPA amendments. And I actually have pulled up the reports from the early adopters and I think New York was one of

the early adopters that has reports in here.

And those measures seem to be useful. So my question is number one -- and I guess you're the only one here, Ann, from the early adopter states. I mean, I had worked this in our state, so I know what our experience was. But I think one of the questions is, when you are collecting on all of those Measures, how much of an additional burden was that?

And then the other thing I would say is one of the reports I'm looking at does have some questions that were, and I wish Nancy were in here, that actually was getting to some of the patient engagement and activation information. So, that might be something that is helpful. Maybe at lunch if anyone wants to take a look at this, I'll keep it up.

CHAIR PINCUS: Okay.

MS. KENDIG: But that might something that's helpful. Because we do have some experience with exactly what we're talking about. So, Ann, I'm going to defer to you if you can --

DR. SULLIVAN: I would've deferred to Foster Gesten if he was here because he's the guy who does all our data on the Department of Health side, but I don't know that New York can be as comparable to some other states because they have a pretty robust way that they can look at all this data.

But my understanding was while it became a little cumbersome, that they were able to get it without too much difficulty. But, again, I can't speak for other states. But, I mean, we could ask into the future exactly how much it added to try to get this out of the health home.

But I know we're very strong on making sure that we get the right data out of the health homes and that we're really trying to do it. He could probably -- he would've been able to speak much better to how much it added to the burden --

MS. KENDIG: Yes.

DR. SULLIVAN: -- to the state.

MS. KENDIG: I know we spent a

significant amount of time aligning the measures so that we weren't asking our providers to report in three or four different ways. But I know that took a significant amount up front and I just haven't had a chance to go through the report while I was sitting here listening to you all. But, again, I think it gives us at least some experience.

CHAIR PINCUS: Anne and then Cindy.

MS. COHEN: I just wanted to kind of talk to what Lessler said that the tobacco use I think is really critical. It's historically been used as behavioral modification tool or behavioral control tool for that population, just like the DD population. And the DD population, the rates have dropped dramatically and that's been the focus and that hasn't been the case for mental health.

So that being said, can I throw before I forget two measures that aren't related to these out on table? Just to add to the list? So, since we have all-cause readmission measures,

I would be neglectful to my community if I didn't bring up the all-cause rehab and all-cause LTC admissions.

So those Measures are 2502, so All-Cause Follow-Up after Rehabilitation Admissions. And then 2512, All-Cause Follow-Up after Readmission for Long-Term Care Facilities.

CHAIR PINCUS: And are you suggesting a stratified version of that measure?

MS. COHEN: Yes.

CHAIR PINCUS: Okay.

MS. LASH: I think we had found and eliminated those measures from consideration because they're based on Medicare claims.

MS. COHEN: Oh, see, I thought they weren't. Okay. Never mind. Because I looked at them and I thought that was one --

CHAIR PINCUS: There is no --

MS. COHEN: -- of the exclusions.

CHAIR PINCUS: There is no Medicaid --

MS. COHEN: No, there is no Medicare for those, so it would have to be on Medicaid.

Right?

MS. LASH: Sorry, Anne, you said --

MS. COHEN: 2502 and 2512. And it might not be stratification. I mean, maybe you want to know who's in the rehab facility and the long-term care facility. Anyway, I don't know. I'm just throwing them out there. They can totally be eliminated, but they were just ones that I'm thinking of --

CHAIR PINCUS: No, I was just thinking about it from a point of behavioral, we're looking at behavioral measures.

MS. COHEN: Oh, no, no, no, no. Well, yes, you could, but I was thinking --

CHAIR PINCUS: Yes.

MS. COHEN: -- about this for the whole population.

CHAIR PINCUS: Okay.

MS. COHEN: But for behavioral health, it would be more interesting.

CHAIR PINCUS: For this batch, we're batching the behavioral health Measures. Because

--

MS. COHEN: Okay. Never mind then.

CHAIR PINCUS: But it's --

MS. COHEN: But for behavioral health, it could be interesting, too, actually.

CHAIR PINCUS: While they're looking, Cindy?

MS. PELLEGRINI: So I'm going to state up front that I know my blood sugar's getting a little low. So I might be a little cranky.

But I appreciate Daniel's comment about the fact that people with these conditions tend to die right around or not long after age 50 because of heart disease and tobacco related illnesses, right? And I think that's compelling.

But in general, as a lay person on these issues, I'm really struggling to figure out why we should add one more than another out of this half a dozen or so. And if it's hard to pick among them, do you just put in all of them?

At which point we're adding a huge

number of measures. We're basically almost 50 percent of the core set. I mean, the core set's only 25 measures right now, 26? Sorry, I miscounted. And then if you add none of them, then you're still left with the gaps that you had before.

So if there are people who have views about this to help me figure out why, like Daniel did, some of these are more important than others in general, I would appreciate that. Because I think some of them are going to be very important to certain people and not others. And so --

CHAIR PINCUS: So let me --

MS. PELLEGRINI: -- choosing among them is difficult.

CHAIR PINCUS: -- maybe suggest something that might help you. One is that these are all sort of stratified measures, so the incremental effort to collect the data is small. Because they're basically off of already existing measures. So that's part of the argument why that is simply looking at it from a stratified

point of view.

From my perspective, I think Dan's right on track. I mean, it's cardiovascular disease and tobacco use that's underlying it. And then all of which is sort of undergirded by a failure of coordination of care. So I don't know if that helps you, but that's -- so any other nominations?

MS. COHEN: This isn't, I know this isn't a specific measure, but I have to add the concept to the list. So we talked a lot yesterday about trauma-driven care and I think for this group that's pretty critical, so I think that needs to be captured somewhere. And then the idea of quality of life also.

I do have a measure, but it's not very well loved, so I'll throw it up there anyway just so you have a number. But it's the 0260. It's the quality of life measurement tool, instrument, whatever. Actually this will go for behavioral health. For that subpopulation.

CHAIR PINCUS: So just -- what exactly

is that Measure? What's the --

MS. COHEN: So it's -- let me pull it up.

MS. SHAHAB: So 0260 is Assessment of Health-Related Quality of Life Physical and Mental Functioning. And it's by the RAND Corporation. The description is percentage of dialysis patients who receive a quality of life assessment during the KDQOL-36 question survey that assesses patient's functioning and well being at least once per year. Yes.

MS. COHEN: 0260. Now, we use this for this group because we wanted to look at social deterrents of health as like sort of the pacer. But we kind of eliminate the concept of diabetes care.

And it's the idea that you're trying to get at -- we're a little rebellious in the duals group. Yes. But we wanted some way in the report to capture that you need to look at certain determinants of the health other than the specific health stuff.

CHAIR PINCUS: Let me just take my Chairman's hat just to speak against that. Because I think it's -- number one, it's kind of distal to actually improving quality of life. And it may be particularly burdensome both at a clinician level and at a health plan level. So I would put it lower on my priority --

MS. COHEN: Yes. Now, I would agree that it's not necessarily something that we're going to add today. But I think that we need to put somewhere in the report that there needs to be consideration for other things other than pure health-related quality.

CHAIR PINCUS: Right. And I think that's something that when we get to gaps, that's something you can --

MS. COHEN: Okay.

CHAIR PINCUS: -- sort of --

MS. COHEN: Maybe that's a gap.

CHAIR PINCUS: -- maybe rather than having it -- so really what we're putting up here are measures that we would actually vote on.

MS. COHEN: Okay. So then I would agree; eliminate it from the list and Sarah can add it to gaps.

CHAIR PINCUS: Okay.

MS. COHEN: And also the trauma care would be helpful. Thanks.

CHAIR PINCUS: And Zehra, did we find the Measure about rehospitalization?

MS. SHAHAB: Were you talking about the readmissions ones? The two readmissions ones that Anne had mentioned? Yes, they're for Medicare beneficiaries.

CHAIR PINCUS: So is that -- would the specifications be different for Medicaid? Because there is -- AHRQ puts out these reports on Medicaid readmission rates, so it must be available.

MS. LASH: So the measure 2502 about inpatient rehab, the denominator and the data source was constructed around Medicare fee-for-service. I think it's probably too much of a stretch.

CHAIR PINCUS: Okay. So this would also go in as an example in the gap area? Of looking at rehospitalization rates both overall as well as with these different numerators? And denominators actually.

MS. LASH: I also think that the type of facility is not a mental health facility in general.

CHAIR PINCUS: Yes. But that was, I think there were two.

MS. LASH: Okay.

CHAIR PINCUS: One was the general hospital, one was --

MS. LASH: Got it.

CHAIR PINCUS: -- the sub-acute one. So we'll put that in the gaps as something that, again, looking at overall readmission rates and readmission rates for people with a mental disorder, both within a -- both for a mental disorder as well as for other conditions. Okay?

So we have how many measures? One, two, three, four, five, six, seven measures to

vote on. Should we vote on these before or after lunch?

DR. SIDDIQI: I was just going to propose -- but can we do a work through lunch to just kind of go through the voting? So we grab our food --

CHAIR PINCUS: Okay. So --

DR. SIDDIQI: -- and then -- just in the interest of traveling today and --

CHAIR PINCUS: I think that's a great idea.

DR. SIDDIQI: -- getting out on time.

CHAIR PINCUS: Okay.

MS. SCHLAIFER: (Off mic comment) -- help us to prioritize? I mean, otherwise we could just vote yes on everything. And I think, I don't know, it seems like --

MS. LASH: Let me put out some parameters --

MS. SCHLAIFER: Yes.

MS. LASH: -- around what CMS has been able to do in the past in terms of a level of

change. The most recent annual update had one measure removed and one measure added. Although MAP had recommended we elect three measures. We already, yesterday, picked out two that we liked related to the maternal and perinatal care. And --

MS. SCHLAIFER: And we've got more going on besides mental health.

MS. LASH: -- we still have the access to primary and specialty care subject area to go through after this. And we also haven't discussed the opiate measures from PQA. So it would probably behoove the group to pick out no more than two, three at the very most of these behavioral health measures.

CHAIR PINCUS: Beverly?

MS. COURT: It would be helpful to states to know of these other emerging measures, that if they can tie them into, for example, existing quality improvement projects or if they feel that there's a particular issue in their state. Because when we look at -- when people

say, okay, well what do you want to measure? Well, we kind of, let's just grapple around and see what's out there.

I mean, there's usually 170, I think we, I forget how large our list was, but it was excruciatingly long. But if it looks like these are emerging, then we can start building that infrastructure.

CHAIR PINCUS: So I -- as much as I hate to disagree with my colleague, Sarah, I agree with you, Beverly. I think that we're supposed to give our opinions, so we might as well give our opinion. And CMS doesn't have to listen to us.

But I think alerting people that these measures exist, that they may be useful, and CMS could look at the priority -- we will then later prioritize these and CMS can look at our priorities and decide whether they agree or not.

MS. LASH: Right. We describe these --

CHAIR PINCUS: Yes. And I don't see a need --

MS. LASH: -- all 11 of these measures --

CHAIR PINCUS: -- to pre-censor ourselves before we prioritize. Okay. So why don't we get lunch. Is it out there?

MS. LASH: Yes.

CHAIR PINCUS: Why don't we get lunch and come back in ten minutes? Okay. Yes.

(Whereupon, the above-entitled matter went off the record at 12:39 p.m. and resumed at 12:49 p.m.)

CHAIR PINCUS: If everybody could please be seated. We want to go through the voting process before we lose a quorum. And people will be pardoned if they speak with their mouths full.

MS. LASH: Yes. Okay. So we will take a vote on each of these Measures individually. And if they gain the support of eight or more of you, they will be --

CHAIR PINCUS: We're missing somebody.

MS. LASH: Yes. George has left for

the day, I believe. Kirstin I just saw, so she must be in the ladies. So we'll give her a moment. And then --

CHAIR PINCUS: If George has left for the day, does that change the voting?

MS. LASH: Yes.

CHAIR PINCUS: No, we're going to prioritize later.

MS. LASH: So, we've heard a lot of discussion about the importance of this body of measures broadly and notifying state partners that there are these additional things they might want to look at above and beyond core set requirements. I think that would be part of the discussion.

And yet, the final product that we deliver to CMS will involve a one, two, three, four, and so on ranked list of measures. The vote right now is about whether you want these indicators behind me to make it onto that ranked list.

And the last thing we will do today,

hopefully in the next hour, is to give you all stickers and you can do what you saw the Child Task Force doing yesterday, where you can indicate what priority order you would like CMS to address the measures in.

The list can be fairly long, but the bottom of that list is rather unrealistic for action within the next year. Does that make sense? Can you use your mic Marissa?

MS. SCHLAIFER: I asked before in a different way. I mean, is there a point -- CMS is having us do this because they need advice on what we -- if the list gets too long, does it become like, why did we even bring you together because you like everything? I just, I mean, I just feel like that's --

MS. LASH: No. I think, I will speak for CMS in saying they find the whole discussion very valuable. There are some short-term and long-term actions that they will be taking to strengthen the measure set.

The most immediate and short-term is

the addition of some small number of measures. And that determination of the number is up to them. But just as last year we discussed asthma medication and another care transition measure that didn't make it, MAP still signaled the emphasis for those two measures.

CHAIR PINCUS: So Sue and then Beverly, and then we'll begin voting.

MS. KENDIG: I just have a clarifying question. So some of these Measures are available without the behavioral health or the mental health qualifier, like diabetes screening and so forth, right? So if those are already available, is there anything to -- I guess that would be reported as discrete indicators, so a state would have to run both those Measures and then overlay them and look at them. Correct?

CHAIR PINCUS: Correct.

MS. KENDIG: Okay.

CHAIR PINCUS: Beverly?

MS. COURT: There's already -- in the AQM reporting, there is reporting for

subpopulations. It's looking at disparity analysis. So for example, disabled non-disabled by ethnicity group, by race. So just that may be where you could implant a stratification of SMI/ non-SMI that might be helpful. And, again, for those states that can do that kind of bifurcation, that may get you --

CHAIR PINCUS: I mean --

MS. COURT: -- a long ways to what you're looking for.

CHAIR PINCUS: That's basically what these are or some of them are. And that was the intention was to actually to not necessarily have them be separate measures. But apparently by NQF rules, they had to go through and be separate measures.

MS. COURT: Oh.

MS. LASH: I think some of them are slightly different from the original.

CHAIR PINCUS: Yes. A couple are slightly -- most of them. So, okay. Why don't we get started and --

MS. COHEN: Wait, wait, wait. One more quick thing.

CHAIR PINCUS: Okay.

MS. COHEN: So, sorry, Beverly, but I have a little challenge with that. So in most states, they have display aid codes, but they don't have any more information other than the aid code. And in many states, they're not even able to talk to the mental health carve-out to find out who actually is in mental health. So I don't know how that would work without a separate measure that triggers them to actually do it.

MS. COURT: So the stratification is voluntary reporting. Breakdown, for example, between disabled non-disabled populations. I'm just suggesting that where states are capable of doing it, and we are, in Washington state for example, that, that might be an easy win, rather than imposing a new measure is use the stratification which is already voluntary. There's already a place, and dear God, I love entering all that information into CARTS, but

that is one more that I could do. So, I'm just offering that as an option.

MS. COHEN: I totally get where you're coming from. I totally agree. That would be my only caveat is that I don't know how for a particular sub-disability group that stratification could happen. Only because there's no indicator. Do you see where I'm going?

MS. LASH: So we need now seven votes, with the Chair being recused, to pass the measure.

CHAIR PINCUS: So let's move through these quickly. First one up is 1932, which is the Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications. How many voting to support this measure? It's up there, it's on the screen. Okay. Nine. Okay. Bev?

MS. COURT: All I ever hear is the numerator, not the denominator, so I don't know what nine means.

MS. LASH: We need seven or more.

MS. COURT: Okay. Thank you.

CHAIR PINCUS: Okay. 1927, Cardiovascular Health Screening for People with Schizophrenia or Bipolar Disorder who are Prescribed Antipsychotic Medication. What?

MS. DAWSON: Can we give recommendations to the measure steward on this as well? Or is this just as is for the measure?

CHAIR PINCUS: This is an already endorsed measure.

MS. DAWSON: Right. I think our question would be, because of the age range, it's 25 to 64, to making sure that it aligns with the other age ranges for the other HEDIS measures. For the 1932, that's the age range of 18 to 64. That would just be my only caveat.

DR. LIU: If I could help with that. We actually intentionally did not align that during the development process because expert panels advised us to raise the age range for the cardiovascular screening measure because they

think the health risk for that condition needs to be at the older populations. And that's the recommendation, the rationale for that.

CHAIR PINCUS: So I'm voting on 1927. All in support, raise your hand.

MS. LASH: Seven.

CHAIR PINCUS: Okay. Next is 2602, which is Blood Pressure Control for the Seriously Mentally Ill, which is actually on the handout from NCQA. Okay. All in favor of that one?

MS. SHAHAB: 2602 is seven votes, so it passes.

CHAIR PINCUS: Okay. The next one is 2603, which is A1c testing, which is also on your handout.

MS. COHEN: So, can you -- forgive me because now I'm getting them all confused. Between 1932, 2603, what's the difference? And what's the -- and I assume 2603 and 2608, they're obviously very different, right?

CHAIR PINCUS: 2608 is A1c control.

MS. COHEN: Yes. I understand that.

So that's newly diagnosed, and that's already diagnosed? The 2603?

DR. SULLIVAN: One's for testing and the other is controlled.

MS. COHEN: Okay.

MS. LASH: The top measure looks to see if someone needs to be diagnosed with diabetes. The next measure of A1c testing, once you are identified to have diabetes, is your A1c tested? And the control is an intermediate outcome measure of how well it's being managed.

MS. COURT: Do we want to quickly identify which are admin, which are survey, and which are hybrid?

CHAIR PINCUS: No, I don't think so. It's a lab testing. It is a survey?

MS. LILLIE-BLANTON: Unfortunately it is. It's from the CAHPS survey.

DR. LIU: It's not a -- this is Junqing Liu from NCQA. The 2603 measure is a hybrid measure, so it's not using survey.

CHAIR PINCUS: In the current data set.

1932?

DR. LIU: That one is a claims-based measure. The test are -- it has codes for the tests.

CHAIR PINCUS: So we were on -- so we're just going back to where we were on the voting. So A1c testing for people with comorbid diabetes and serious mental illness. Yes. So we're taking a vote. So all in support of that measure?

No, this is 2603. Yes. Yes. It's not on antipsychotics; it's -- and mental illness. So what was the number? Okay. We're voting now on 2603. Everybody raise your hand high.

MS. SHAHAB: So 2603, there were six votes. It does not pass.

CHAIR PINCUS: The next one is Follow-Up After Emergency Department. That's 2605, as it is currently defined. All in favor of that, in support of that, raise your hand.

MS. SHAHAB: 2605, three votes, does

not pass.

CHAIR PINCUS: Okay. 2600, which is Tobacco Use Screening and Follow-Up for People with Serious Mental Illness or Alcohol or Other Drug Dependence.

DR. SIDDIQI: Can I get clarification from the measure steward? What is the follow-up that is counted in this measure? How do you capture that with the claims? For follow-up for tobacco screening? I understand the tobacco screening part, but it's the follow-up that's unclear.

DR. LIU: The follow-up requires two events of services. That could be two events of counseling or psychotherapy. So this is also a hybrid measure. You can meet the numerator by claims codes or medical record review.

DR. SIDDIQI: Right. So it would require hybrid? It can't be just all claims?

DR. LIU: Right.

CHAIR PINCUS: Okay. All in support of that measure?

MS. SHAHAB: 2600, four votes, does not pass.

CHAIR PINCUS: Okay. Next one is 2608, A1c control. All in favor of that?

MS. SHAHAB: 2608, six votes, does not pass.

CHAIR PINCUS: Actually, I'm just curious as to why this more outcomes measure did not pass as compared to the one that was more of a process measure?

(Laughter.)

CHAIR PINCUS: I was just wondering what the difference was. Okay.

MS. LASH: Okay. Let's move on. All right. The next measure for your consideration was to address the previously identified gap area of access to primary and/or specialty care. There is an NCQA stewarded, but not NQF endorsed measure titled Adults' Access to Preventative/Ambulatory Health Services: Percentage of Members 20 Years and Older Who had an Ambulatory or Preventative Care Visit.

So it's a fairly straightforward indicator of utilization as a proxy for access. And the details of the Measure are in your Excel file.

MS. SCHLAIFER: It's not endorsed?

MS. LASH: It is not endorsed or under consideration. I don't believe NCQA has submitted it. They're -- I'm not positive. You might know.

DR. LIU: That's correct. We haven't submitted this measure yet.

MS. LASH: Do you think you're going to?

DR. LIU: It's in HEDIS. It's reported by health plans.

CHAIR PINCUS: Do you plan to submit it?

DR. LIU: I think that's a good question. This measure's in a different domain, that's utilization domain. We may consider that, but we also have to weigh all the other measures to go through the process.

MS. LASH: There might be a potential for it not to pass because it is more of a utilization indicator than a performance or outcome indicator. Alvia?

DR. SIDDIQI: I was just going to state that I do think states are looking at this. Illinois definitely looks at this one in particular as a HEDIS measure. And I think pending NQF endorsement and saying that I think to NCQA and giving that feedback may help move things along on this one.

When we're talking about ACA expansion, access to care is going to be a huge issue and already is an issue. I think this is one that states can hold plans accountable to and I think it's something that could be useful to the state, in terms of trying to address care coordination and access issues. So I do support this one.

CHAIR PINCUS: Other comments on this? Marissa?

MS. SCHLAIFER: I was just going to

say, I think based on the conversation rather than just having the discussion to support or not support it, it sounds like we might want to throw the conditional support into this.

CHAIR PINCUS: Okay. Dan?

DR. LESSLER: Yes. I just, I mean, it is sort of a useful utilization measure. It's hard to --- as a quality measure or process measure, it's harder to wrap my head around.

I wonder though if -- one of the things with respect to access and not to dig up our earlier conversation here, but the idea that certain people coming out of an emergency room visit should be seen in follow-up, I mean, people with chronic illness and so forth and in a timely manner.

And that strikes me, I mean, I know that's something we're struggling with, with our ED utilization work in Washington right now. And that strikes me as the kind of measure of access that would be helpful and that might be more reflective of quality.

And I don't know if there is such a, and I didn't have a chance to really go searching around, such a, either NCQA or NQF. But it just strikes me as a bit more helpful in this access realm.

CHAIR PINCUS: Cindy?

MS. PELLEGRINI: Maybe it's just because I had lunch and I'm perking up now. But I'm really kind of liking this measure. And for two main reasons.

The first is that with Medicaid expansion, I think we could potentially have a different profile of people going into preventive care. And seeing how those rates change over time could be very useful.

The second is, coincidentally, today the White House launched a new campaign called Healthy Self where they're trying to encourage people who have health care to utilize the preventive health benefits available. So this is sort of consistent with some of those concepts where we're really trying hard to promote

preventive care and this would give us a way to track that over time.

So it's kind of -- it's a little bit crude. It's not terribly granular, but it would give us some basic information to point us in the right direction I think.

CHAIR PINCUS: Beverly?

MS. COURT: I would encourage people to look at the specs for this if this is the ambulatory care in the current -- HEDIS 2015. For example, exclusions of principle diagnosis of mental health or chemical dependency, that's excluded. There's also the actual reporting of the Measure is extensively -- there's all sorts of breakdowns, age, by member months, outpatient visits, ED visits.

So anyways, I think it would be useful to look and I believe this one also includes audiology. That's my pet peeve. Can you tell? Thinking that audiology is somehow indicative that someone has preventative care.

MS. PELLEGRINI: Where can we --

MS. COURT: So I guess I would look at this -- it would be helpful to look at the specs. Because it's more limited than you may think.

MS. PELLEGRINI: Where can we see those? Because the grid that I'm looking at here that we got says there are no exclusions in the denominator.

MS. LASH: We have incomplete information because this isn't endorsed. So that's an error.

CHAIR PINCUS: Alvia?

DR. SIDDIQI: I was just going to add that we already look at this measure through the Illinois health care program on our profiles that we send to primary care providers. And the wellness visit is essentially what this is getting at. Your preventative annual physical maintenance visit.

And, again, when we're talking about access to care, this is a really big one because it's an issue about your general Medicaid adult population, are they getting in to actually see

the doc once a year, the provider office for the preventive visit? And that's where you address all the other preventive screening issues. Your mammograms, your breast cancer screening, cervical cancer, et cetera, et cetera.

So, just wanted to clarify that the claims data -- this is one that can be done through claims. It's pretty easy to do and report on. So I just wanted to echo that again.

CHAIR PINCUS: I just wanted to call on myself on this one. I guess I'm generally not disposed towards utilization measures per se, unless they're useful from the point of view of being kind of a balance measure.

So for example, one of the problems I have with our initiation and engagement measures for substance abuse is that it's highly dependent upon utilization of substance abuse. So that -- and whether there's a screening program in place. So that if you are screening, you're going to identify people that are less highly motivated to follow-up as compared to just taking people who

come in without any screening.

And so, in some studies we've done, we've shown that places that actually screen, like the VA, does much more poorly on those Measures as compared to private plans that don't screen at all. And so having a utilization measure of looking at utilization of substance abuse services would make sense as kind of a balancing thing. What would this be balancing?

DR. SIDDIQI: I think you're balancing -- well, you're also talking about alignment with the Pediatric Core Set, so the adolescent well visit, the well-child visits. Again, the emphasis on preventative visits where you can address, as a primary care provider, all of the preventative screening measures that are needed for preventative health care maintenance. And then the other part about this one, is this is an access measure, so if we're talking about a gap area in the Adult Core Set right now, there isn't really a good access measure.

CHAIR PINCUS: But is there a

recommendation that there should be an annual health care visit? For everybody?

MS. COHEN: I'm almost positive, and I could be wrong, but there's --

CHAIR PINCUS: I can't hear, you got to put on your --

MS. COHEN: I'm almost positive that it's required under the conduct standard for the plans --

DR. LEIB: For children, but not for adults.

MS. COHEN: I think it is for adults.

DR. LEIB: Well, maybe in your state. I don't think it's required in ours.

MS. COHEN: I thought that there was a federal requirement, but maybe I'm wrong. Maybe it's just a well-child visit then.

CHAIR PINCUS: Okay. Ann and then Marc.

DR. SULLIVAN: That was also my question, that there is a requirement in those younger years for an annual health visit that

people are supposed to -- in their early 20s? That was my first question. My second is, what's being excluded in mental health? Is it a mental health visit that you're excluding? Or what was the --

DR. LIU: Let me help here. This measure does not have exclusion as it's shown on the screen. So the mental health population is included.

DR. SULLIVAN: So when you say ambulatory, you're not -- if someone had a mental health visit, but not a visit to a primary care doctor, that would be counted? Or that wouldn't be counted?

DR. LIU: It's a wellness visit.

DR. SULLIVAN: It doesn't say that, though.

DR. LEIB: But that's not what it says.

DR. SULLIVAN: That's not what it says. So that's why I'm just asking. It says ambulatory or preventative care visit. It doesn't just say a wellness visit.

DR. LEIB: The way this is worded, going to your orthopod for knee pain would satisfy this without ever having anyone listen to your heart, your lungs, do a lab, basic lab tests or anything else. This is not going to get the equivalent of a child wellness, a well-child exam that we have specifically in the Child Core Set. This is not the same.

CHAIR PINCUS: Well, I mean, first of all, you guys got to use the microphones, number one.

(Laughter.)

CHAIR PINCUS: Number two, we actually have the steward here.

DR. LIU: The question of whether screening and well care visit are included in the measure, is that the --

CHAIR PINCUS: Are specialist visits and any kind of ambulatory visit included in the measure?

DR. LIU: Yes.

CHAIR PINCUS: So it's not purely a

wellness visit? That's -- so, any more comments? Do we want to vote on this? Oh, Marsha?

MS. LILLIE-BLANTON: I know I can't vote on this, but, to me, this measure is similar to what we get with MEPS, Medical Expenditure Panel Survey. And so, to me, there are trade-offs in our core set.

And so while I think this will give us some measure of the proportion who made any visit, I'm not quite sure what else you get from that. Because, like, with children, we do have requirements -- not requirements, excuse me -- guidance that encourages pediatricians to use the AAP Bright Futures Guidelines for visits per year, or at least for the first maybe five or six years of life. And then there's guidance. And then after six years, it's maybe once a year. But before then, it's more than once a year.

So I'm not quite sure what we get from this other than proportion with a visit. And that's not bad to have. But we do have, in the CAHPS, measures that talk about unmet needs. I

mean, whether or not you needed care and didn't get it.

And the problem, of course, with CAHPS is that it's a survey data. But at least you have a sense of was there a need and was your need fulfilled. So, this one I'm on the fence, but I'll defer to the MAP, of course.

CHAIR PINCUS: Marc, do you still want to comment?

DR. LEIB: For me, maybe it's the lawyer hat on me sometimes, that words matter in how I interpret these things. And I look at what it actually says when I try and figure out if it's the kind of measure we want. And I just don't think this one gets to the data we'd want to have or need.

CHAIR PINCUS: Okay. Alvia?

DR. SIDDIQI: Just in the record, if we could give feedback to the measure steward about this one. Really we're trying to get at the preventative care visit and I think that would be more meaningful for access.

CHAIR PINCUS: So is there a motion to support with or without conditions for this? Okay. Let's move on.

MS. LASH: I think that brings us to opioids, where we do not have any slides.

CHAIR PINCUS: So then we refer you to --

MS. LASH: So we are -- yes, looking at our PQA handouts.

CHAIR PINCUS: Actually there are two handouts that everybody got?

MS. LASH: They have two. They're about the same measure set. One is a little bit more detailed than the other. It was most helpful to look at the section in the middle of the page where there are numerators described for Measures 1, 2, and 3.

CHAIR PINCUS: Alvia?

DR. SIDDIQI: So, I just wanted to clarify. But since this hasn't even been submitted for NQF endorsement, we're talking at least a year-long process. So I'm thinking these

are measures that may be able to come back to the MAP next year rather than this year for our purview.

MS. LASH: That would be possible.

CHAIR PINCUS: Right. But we can also -- one of the options is to support conditional upon NQF endorsement, is one of the options.

DR. SIDDIQI: But if it's not ready before the next MAP meeting, then it wouldn't be submitted. Correct? Like, it's not going to go through the process and be ready before the next MAP meeting, I would assume.

MS. LASH: It would likely not be endorsed by the time CMS is issuing their update for 2016 reporting. But that recommendation could stand into the following year. Additionally, this group could decide you would not like to take a vote on it at this time and that we would like to re-review it at a later date.

CHAIR PINCUS: So is there a motion on the floor to either support this measure, or to

support it conditionally pending NQF endorsement, or support it conditionally pending other issues?

MS. SCHLAIFER: I would say that this is a measure that I think is very needed and does need to move forward. I get the sense from both the questions and the kind of look on some people's -- that I think the guidance of the NQF -- I think there's certain measures where we just look at it and go, even though it hasn't been NQF endorsed, we want -- just the reactions, I feel like there is a sense that we want to see the NQF process.

This is a measure that is very important in the Medicaid population, as well as the Medicare population and the commercial population. But that from a pharmacy benefit management point of view, it is a measure that is definitely needed. Whether I get the sense that --

CHAIR PINCUS: There's no harm in nominating --

MS. SCHLAIFER: Well, I think, at least

the sense I'm getting, and maybe I'm not getting the sense, is that whether you need a measure and whether this measure is perfect, is what the question seems to be. But I would advocate that we definitely need a measure in this area.

I mean, in concept, I think we all would endorse it -- I cannot speak for anyone else -- that we'd want to endorse it. We talked several years ago about getting away from endorsing in concept. I think that's something that if that was still an option, I'd want to do.

But I think that conditional support with saying that as soon as it's NQF endorsed -- I think your question is, you want more information about how it does in the NQF. I'm just trying to translate what I think you're trying to say.

DR. SIDDIQI: Right. Yeah, I think that if it's still going to go through NQF submission, it's going to go through a whole review process, it's going to be tweaked, it may look very different from what it's being

presented today. And I think, for the record, we should state that we do think that this is a very important topic. This is a topic where there is a gap that we do need measures for this topic.

But I just think that, looking at timing, I think next year's MAP will be able to actually address whether or not to include some of these measures. And then, of course, staff would review them at that time and then it would've gone through the whole NQF endorsement process.

Whereas some of the other measures were actually on track and through the NQF process, they were just closer, at least on path. This one's a little too premature, I think, for us.

MS. LASH: And I think this is in a similar place as some of the measures not endorsed that were recommended in the Child Core Set. So, the development is complete, but there has not yet been an opportunity to have a matching endorsement project. Although there

might be in the coming year.

DR. LESSLER: So, if I could comment. Actually it's interesting, tomorrow I'm in an all day meeting in Washington state where we have the updated Agency Medical Directors' guideline for opiate prescribing that is being released and presented in a CMA that has gotten very wide recognition and utilization.

I think this is an extraordinarily important area to have measurement in and especially in the Medicaid population. And I think the idea of going through NQF endorsement is important.

I'm a little bit concerned about these particular measures. I mean, I think they're trying to get at the right thing. But, for example, the 120 milligram equivalent of morphine -- you know, I think increasingly people are very unclear what sort of that high dose limit should be. And it's the kind of thing where I think people are realizing that it's sort of like unsafe at any speed. And there are a lot of

people who -- I mean, it's not just the people on 120 mil equivalents that are at risk and so forth.

So I really, I mean, I endorse the concept, I guess, as somebody was saying. But I do have concerns that these measures are getting at what really needs to be -- the best way of getting at what we need to be able to measure with respect to opiate use.

CHAIR PINCUS: So, a couple of points, maybe to summarize. So, on the one hand, there's a concern about, are these the ideal measures? Do we wait for NQF endorsement?

The other side of it is that it's kind of at the same level as some of the child measures, which were supported, but conditional. One of the issues that comes up is the process by which such a measure would be taken up for NQF endorsement.

And it's unclear to me what the -- because NQF starts these endorsement processes based upon some kind of, I guess, contract from

HHS, and so I don't know if -- are any of those trains going to be running over the next year?

MS. LASH: We are expecting to start a variety of projects. I couldn't say for sure which would be the best opportunity to review this measure.

CHAIR PINCUS: But I guess one question is -- Marissa if you want to recommend it --

MS. SCHLAIFER: Well, based on -- that the child first did this yesterday or the day before yesterday --

MS. LASH: Could you use your microphone?

MS. SCHLAIFER: I'm sorry. Based on the other comment that the other task group did do this yesterday, then I would recommend that these move forward. I think I'm reflecting on some of the conversations that have gone on in the Coordinating Committee and the discomfort with the Coordinating Committee by doing that.

So, if I don't have to subject that on top of it, I would recommend that they move

forward. I just think --

CHAIR PINCUS: So you're --

MS. SCHLAIFER: I'm making the recommendation. I'm changing --

CHAIR PINCUS: You're making the motion?

MS. SCHLAIFER: Yes. Based on the fact that --

CHAIR PINCUS: So you're making the motion. Okay. Is there a second?

MS. LASH: Actually, can I pause? There's actually three measures here. Are you suggesting conditional support of all three measures?

MS. SCHLAIFER: I've lost it in all my papers.

MS. PATTON: Sarah, can I just ask a quick question? Sorry. Are there other already NQF-endorsed measures that get at elements of this?

MS. LASH: I've been searching through and there's nothing that says opioid or drug

abuse.

MS. PATTON: Yes. Okay. Thanks.

CHAIR PINCUS: There's nothing that's come up that I know of.

MS. PATTON: Okay.

MS. LASH: Yeah, I did just search.

DR. SIDDIQI: Just to clarify, Sarah. The pediatric concurrent antipsychotic multiple medication one, wasn't that at least being submitted through NQF though? It's just starting? Or is it -- so when it's complete, it doesn't even mean that it's submitted? I see.

So even though we may make the recommendation, the likeliness of CMS accepting that one, I think, would be pretty low then, perhaps. That's just -- okay.

CHAIR PINCUS: So, is there a second?

DR. SULLIVAN: Second.

CHAIR PINCUS: Okay. Any further discussion? Okay. So do we want to vote on each of these separately?

MS. LASH: I think we should vote on

them separately.

CHAIR PINCUS: Okay.

MS. LASH: Could you use your microphone, Marc?

DR. LEIB: I'd like to make an amendment to the motion. I have no problem if it gets NQF endorsement substantially as it's written, that's one thing. If it's modified significantly, I think we'd want to re-see the new measure, or the modified measure, to determine whether it still answers the questions we want to know.

MS. LASH: So, we will take individual votes to conditionally support the measure if it gains NQF endorsement in its current form without material changes.

DR. LEIB: Essentially its current form, yes.

MS. LASH: Yes.

DR. LEIB: If you modify a few words --

MS. LASH: Yeah, I don't mean a few codes here and there.

DR. LEIB: Yes.

MS. LASH: Okay. So there are three measures here. I'll quickly name them. First is a measure of high dosage opioid use, the proportion of individuals without cancer who are on a daily dose of opioids greater than 120 milligram morphine equivalent dose for 90 days or longer.

The second measure will be the proportion of individuals without cancer receiving prescriptions for opioids from four or more prescribers and four or more pharmacies.

And the third is the proportion of individuals without cancer receiving prescriptions for opioids greater than the equivalent dose of 120 milligrams and for 90 consecutive days or longer and who are going to four prescribers and four pharmacies. So it's a composite of the first two.

Show of hands, please, for members in favor of conditional support for Measure Number 1 of high dosage? That's nine votes, so it passes.

Did you vote for it? Then that's ten. Okay.

Second measure, multiple prescribers and multiple pharmacies. Show of hands? Eleven, Nancy raised hers up at the last minute. That also passes.

And the composite measure of multi-providers and high dosage. Show of hands? That's ten. That also passes.

CHAIR PINCUS: Are there any other nominations?

MS. LASH: Yes, are there additional measures on any topic the Task Force members would like to consider at this time? Anne?

MS. COHEN: Two I previously brought up --

CHAIR PINCUS: Mic?

MS. LASH: Marc, you'll need to turn yours off. Marc, off, so Anne can turn on.

MS. COHEN: The two I previously brought up, the all new admissions, readmissions measures for long-term care and rehab facilities. I mean, if we're going to consider all admission

ones, can we like cover those as a group? I don't know if we are. I have them if you need it.

CHAIR PINCUS: For Medicaid?

MS. COHEN: Oh, never mind. I forgot. It's the end of the afternoon. Forgive me. Strike that.

MS. LASH: It's unfortunate that they're not that flexible. Sorry, I'm editorializing.

Any other additional measures?

CHAIR PINCUS: But we will include those in the gap area. Medicaid all-cause readmission.

MS. LASH: Okay, I think we're now at the point of prioritization. And to finish defining the universe of the measures supported that we want to prioritize.

Last year, there were two that were supported: 1799, Medication Management for People with Asthma, and 0647, Transition Record With Specified Elements Received by Discharged

Patients. Which is very similar to a care transition measure currently --

CHAIR PINCUS: Which was the most annoying one.

MS. LASH: Which we got some negative feedback on. Especially for that reason, I think we need to take a vote on whether these should continue to carry over on the list of measures to CMS for this annual update.

The information on these two is in your Excel file in the tab titled 2014 Recommendations by MAP. Beverly said it was difficult to report.

CHAIR PINCUS: It was among the least reported measures and the one that caused the most consternation amongst state officials reporting.

MS. LASH: Yeah, she recommended a different type of care transition measure for which we could not find an appropriate substitute. Alvia?

DR. SIDDIQI: I was just going to say

that it looks like, at least if we look in the past, that CMS, when they added a measure, they took out a measure. And it's possible that we're making all these recommendations, that measures may have to go as well.

And I just think that the care transition measure is one that I would still kind of recommend that, if CMS was to consider removing one, that would be one to consider removing. Because it is such a challenging one to do, even with hybrid chart reviews and claims units. It could be very challenging. And not to add another measure that would be like that, that would be really challenging to do, again, for Medicaid patients.

The Medication Management for People with Asthma, I remember serving on this MAP Task Force last year and really supporting it, but I do think there's some concerns again about unintended consequences of picking a measure. And for this one, some of the literature suggests that providers may then overly prescribe

controlled medications for patients that may even not have chronic asthma to try and meet this measure.

They're concerned that it was capturing data that the patient had asthma and now needs the medication, actually causing increases in morbidity and sometimes mortality from improper medication use. So I just think it is important to think about our measures and what we're selecting and what we're recommending. So, I would not recommend either one to be added.

MS. LASH: We can take a vote on the removal of the care transition measure once we're finished with this aspect of the discussion. Any other questions or comments on last year's recommended measures?

I will also note that the Medication Management for People with Asthma is also in the Child Core Set. So this would be an area of alignment. And I think that was one of the reasons the prior group favored it. It's, essentially, I think --

CHAIR PINCUS: If we fail to resupport it, it just goes away.

MS. LASH: It goes away.

CHAIR PINCUS: Marissa?

MS. SCHLAIFER: I will make a motion that we resupport the medication management measure.

MS. LASH: All in favor, raise your hands.

CHAIR PINCUS: I'd like to actually see the --

MS. LASH: This is 1799. I'll read the description since I know not everyone has this file open. This measures the percentage of patients 5 to 64 years -- so, in the Adult Core Set it would be some subset of that -- who are identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period.

There are two subrates, the percentage of patients who remained on a controller medication for at least 50 percent of their

treatment period and the percentage of patients who remained on the controller for 75 percent of the treatment period.

CHAIR PINCUS: Given the fact that it's undergoing annual update, that's what it says here, Marissa, would you consider changing the recommendation to be conditionally support pending renewal of this annual update?

MS. SCHLAIFER: Definitely.

CHAIR PINCUS: Okay.

MS. LASH: Are we ready for the vote? All in favor of conditional support pending completion of the annual update and no significant changes, please raise your hand. That's ten and it passes.

Now for Measure 0647, Transition Record with Specified Elements Received by Discharged Patients. Any discussion? Is there a motion to renominate the measure?

CHAIR PINCUS: I think this is a chart review.

MS. LASH: This requires chart review.

And has only three to five states reporting at this time. Or the similar measure. Okay. I'm not hearing a motion. We will remove 0647 from the list of support.

MS. SHAHAB: So, just because we voted on a lot of measures, I just wanted to say the numbers, the measure number, and then the votes for the people who aren't in the room as well. So today we voted on 1932, with nine votes, it passes. 1927 --

CHAIR PINCUS: Can you give the title also?

MS. SHAHAB: I don't have all those.

CHAIR PINCUS: Aren't they on there?

MS. SHAHAB: So, 1932 is diabetes screening antipsychotics. 1927, cardiovascular screening and antipsychotics. And that's seven votes, so it does pass. 2602, blood pressure control for persons with serious mental illness. And seven votes, it does pass. Those are all the ones that passed. And then the three opiate ones. But there's a few that did not pass.

1799, there was ten votes, which made it pass with conditional support pending NQF update from annual review.

(Pause.)

MS. SHAHAB: So we're all still here. We're just writing the list of measures to prioritize in the room. And then the Task Force will prioritize those accordingly.

MS. SCHLAIFER: We haven't talked about the gap list, about if we have measures to hit the gap list. Is that going to happen before we vote? Or is that --

MS. LASH: We had planned to take the prioritization vote and then talk about gaps, but --

CHAIR PINCUS: Do we want people to go and --

MS. LASH: In a moment. We're still compiling. There was, I believe, a total of nine measures supported.

CHAIR PINCUS: Are you including the ones from yesterday?

MS. LASH: Including yesterday's. And so we will give folks five votes, six?

CHAIR PINCUS: That many?

MS. LASH: Four?

CHAIR PINCUS: Yeah, four.

MS. LASH: Four. Each of you will get four stickers to indicate your preferences.

CHAIR PINCUS: Maybe five. We should give five out. When you vote, you can use your five dots for a single measure or spread it around to five. Or whatever combination in between. Okay. Everybody let's get up, and then sit right down to talk about gaps. Okay.

(Whereupon, the above-entitled matter went off the record at 1:46 p.m. and resumed at 1:52 p.m.)

CHAIR PINCUS: So, Avlia, we're now going to take any motions on removing any measures from the existing set.

DR. SIDDIQI: So, I would make a motion to remove the transition of care record measure from the Adult Core Set.

CHAIR PINCUS: So is there discussion on that? Dan, did you want to?

DR. LESSLER: I would second it.

CHAIR PINCUS: You were going to second it? And can you maybe state more explicitly what the problem is?

DR. SIDDIQI: Sure. So, I think the problem with that one is, although it's very, very important, it's extremely challenging to do in terms of linkages of data. We've talked about even getting vitals data to link with claims data is so challenging.

So this one really requires multiple different sites and facilities that you have to check in with to see if the transition of care record has actually been received throughout the process of care coordination. And although it is important and it is something that I think states and plans and providers are all striving towards, and I think maybe even certain health systems even measure it on their own or they have their own ways of looking at it, I think from a state

perspective, reporting this for Medicaid across the board for the Adult Core Set is really challenging.

And I think we have so many other measures that we've recommended, I think it's time to actually give CMS some feedback about a measure that we could potentially remove as well.

MS. GORHAM: So, Alvia, just for the record, you're referring to Measure 0648?

DR. SIDDIQI: That's correct.

MS. LASH: 0647 was recommended last year, is not in the core set.

CHAIR PINCUS: Right.

MS. LASH: It's a vote to remove a similar measure entitled Timely Transmission of Transition Record, and that is, I believe, 0648.

MS. GORHAM: 0648.

MS. LASH: So the slide is somewhat confusing. Just listen to, yes, what Alvia has just said. Are we ready for the vote?

CHAIR PINCUS: All in favor?

MS. LASH: Show of hands? That's 11,

the motion passes.

CHAIR PINCUS: So now we can go on to gaps. Or do you want to have public comment first?

MS. LASH: It's been a while since we took comments. It might be prudent to stop here for a public comment.

Operator, could you give the instructions for anyone on the phone while people in the room go to the microphone?

OPERATOR: And at this time if you would like to make a public comment, please press star then the number 1 on your telephone keypad. And there are no public comments at this time.

MS. LASH: Thank you. No one in the room? Great, we'll move on to prioritizing or in general refining remaining gap areas in the core set. Zehra?

MS. SHAHAB: So, obviously, MAP has identified gaps in the measure set so that NQF and CMS can search for measures in those topic areas. And this year's recommendations may have

changed the landscape of which gaps remain.

So, others will need to be carried over to the next annual review because we don't have measures on certain topics, such as the Medicaid funded long-term support services. And so, from your perspective, you can see this list of the gap areas here.

Access to primary and specialty care. Beneficiary reported outcomes. Care coordination. Cultural competency of private providers. Efficiency. Long-term supports and services. Maternal health. Promotion of wellness. Treatment outcomes for behavioral health conditions and substance abuse disorders. And workforce.

So, those are from last year's gap list, but we have additional ones that we noted from this year. And those are the new chronic opiate use. Polypharmacy. Psychiatric rehospitalization. All-cause readmission. Home- and community-based services. Engagement activation in healthcare. Trauma-informed care.

And health-related QOL.

So, from your perspective, have any of the gap areas been satisfied? Are there others that need to be added? And I'll turn it over the Harold to lead the discussion of the Task Force.

CHAIR PINCUS: So are there any other -- actually, exactly what Zehra said, anything that we can remove off the previous list? Anything that we need to add to either list? And thirdly, anything that we need to refine to be more specific about? Anne?

MS. COHEN: I would just say, and it sounds like some of the states are already doing this, but stratification for at-risk populations to look for health disparities.

CHAIR PINCUS: Okay. Any comments, thoughts about that? I actually have two refinements and sort of -- actually, three refinements to make. Sue, do you want to go?

MS. KENDIG: I don't know quite how to phrase this, but when I look at this list, I think they're all important. But there are some

-- we've talked a lot about the burden on the states in terms of collecting data.

What we haven't talked about is the burden on the provider in implementing processes that would actually support appropriate outcomes in the care coordination piece, the cultural competency pieces, and so forth. And those are very important issues.

I wonder if there would be a way in the report to just sort of recognize that when measures -- that to get the outcomes we want, we need to recognize that there may be a burden on providers also and figure out how we are going to address that. So if that concept could somehow be included, I think that would be important to get us all going down the same path. Thank you.

CHAIR PINCUS: Other suggestions, comments, refinements? So I have a couple of things just in terms of refinements. One is I think there's a specific issue in terms of the access issue with regard to access to specialty behavioral health care. And I think some

creative thinking about how to deal with that.

We published a paper last year in JAMA Psychiatry showing that 40 percent of psychiatrists take no form of insurance. And it's much more so with regard to Medicaid. And there are pockets of the country where, more than half the counties in the country, have no behavioral health providers. And so I would suggest that refinement to that one.

I think, around care coordination, I think another refinement there is, again, what I mentioned earlier today, care coordination between and among mental health, substance abuse, and general healthcare as a specific area of focus for care coordination.

And number three is, I might refine the psychiatric rehospitalization and all-cause readmission. I think the psychiatric rehospitalization one is, in a sense, a subsidiary of all-cause readmission, but also is different, and we talked about looking at it from two points of view.

One is for people with psychiatric conditions who are hospitalized, people who are hospitalized with a psychiatric condition or a behavioral health condition, to what extent are they rehospitalized within 30 days for that condition or for a behavioral health condition? And to what extent are they rehospitalized for any condition? So it needs to be a bit more refined about that. Any comments or --

DR. SIDDIQI: And this will be my last comment as I go to catch a cab to the airport. So thank you so much for this experience and this opportunity.

But I was just going to refine that first one. I agree, Harold, that we need to say access to primary care, specialty care, and behavioral health services or providers. Because what's happening is, for example, the opioid measure, that looks promising. But the challenge with that for providers and plans is, where do you want us to send these patients to that have these issues with chronic opioid dependence and

substance abuse issues?

The networks aren't there. A lot of the plans are being held accountable now to improve those networks. And so, again, we've talked about CMS's proposed rules on Medicaid managed care and trying to improve oversight of some of the care coordination that takes place.

But I do think that's where we need to find some measures that can actually talk about access to the network in terms of specialty network adequacy, but also behavioral health services and network adequacy there. Because primary care providers are really struggling with seeing Medicaid patients with these issues. And they want to do the right thing, but they're really struggling. Thank you. Thank you for this experience.

CHAIR PINCUS: And I think we have to get beyond the carve-out situation and really sort of instantiate this within the contracts on both sides of the issue.

Other suggestions for additions or

refinements? Do you have enough to write this up?

MS. LASH: I think so. The next question is, are there gaps you want to emphasize on the very long list of gaps at this point? Perhaps not, but always being more precise in this feedback is of benefit to CMS. Marsha?

MS. LILLIE-BLANTON: Before we move on to how to fill it --

MS. LASH: Could you get a little closer to the microphone?

MS. LILLIE-BLANTON: Oh, I'm sorry. Before we move on, I just want to make sure that that list gets added to that? Okay. It does.

CHAIR PINCUS: Any bright ideas?

MS. SCHLAIFER: Can I ask a question? The new chronic opioid use, what exactly was that?

MS. LASH: That's a good reminder for us. It was a suggestion that came out of a state presentation on the first day of the meeting during the Child Task Force that there's sort of

a critical period right around 45 days where someone might have had an orthopedic injury, gets a short term prescription, and then a 30-day refill on top of that. And Jeff Schiff from Minnesota described that they have, I think, between 30,000 and 40,000 people a year in their Medicaid program who sort of hit this 45-day window where they could very easily become long-term addicted and at risk for later heroin use.

So I think that the opioid measures that PQA brought forward maybe partially address this issue. But also perhaps not. So it would be more an early intervention for people who could go on to have long-term, chronic painkiller --

CHAIR PINCUS: So, anything else that people want to add? Any other comments? I think we're done.

MS. LASH: We should share, for the record and for everyone's information, the results of our prioritization. And then we'll wrap up.

MS. SHAHAB: So, the number one prioritized measure was the non-NQF-endorsed use of contraceptive methods by women aged 21 to 44 years. And there were 13 votes for that.

Number two, three, and four tied with nine votes each were the non-NQF-endorsed Effective Postpartum Contraception Access, 1932 and 1927. They each got nine votes. Sorry, those were three, four, and five. So, the second recommended was 2602. And that got 11 votes.

MS. LASH: That's Blood Pressure Control for People with Serious Mental Illness.

Okay. We shared these yesterday, but just to remind you, we're expecting a 30-day public comment period to begin in early July and end in early August. Task Force members are welcome to comment at that point to help refine the voice of the report, or also to leverage your larger stakeholder networks in engaging with this work.

At a date in mid- to late August that we have yet to pin down, the MAP Coordinating

Committee will meet to review these recommendations, the recommendations from the Child Task Force, and additionally our annual input to the CMS duals office from another component of the MAP.

The final report on Adult Core Set recommendations is due to CMS on August 31 and will be publically available after that point.

CHAIR PINCUS: So, I just want to thank all of you for really your terrific participation in this. It's been a really good discussions. I think we all learned a lot. Hopefully CMS has learned from this and NQF.

I want to thank Marsha and the CMS staff. It's been terrific to have this partnership evolve as it has. And I especially want to thank Sarah and the NQF staff. It's just really remarkable how effective they are in providing staff support to this incredibly complicated set of issues that we're dealing with, weighing so many different issues at the same time. And somehow we are able to come with

a reasonable consensus. So, thank you all for that.

MS. LASH: And thank you to our Chair. Travel safe, everyone.

(Whereupon, the above-entitled matter went off the record at 2:08 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: In-Person Meeting Map Medicaid Adult Task Force

Before: NQF

Date: 06-11-2015

Place: Washington, D.C.

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