

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

2 (9:02 a.m.)

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

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

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

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

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

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

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

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

2 CHAIR PINCUS: Okay.

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

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

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

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

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

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

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

22 And again, the discussion we had

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

8 MS. SHAHAB: Good morning, everyone.

9 I am going to be giving the overview of the  
10 Medicaid-eligible adult population and then  
11 Shaconna will be presenting the key points from  
12 the staff review of the 2014 adult Medicaid core  
13 set.

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

22 Among these adults, those who have



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

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

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

22 Also for the Medicaid population,

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

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

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

1 Medicaid.

2 As of February 2015, an additional  
3 11.7 million adults have enrolled in Medicaid.  
4 So the Medicaid expansion decisions and  
5 eligibility levels as a percentage of FPL varies  
6 by states, ranging from 138 percent to 300  
7 percent of the FPL. And these eligibility levels  
8 for adults remain low in states that have not  
9 adopted Medicaid expansion at this time, which  
10 results in gaps in coverage.

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

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

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

5 And you can see the ones that are  
6 adopted are in blue. Light blue is the three  
7 that are under discussion and orange is not  
8 adopting at this time. So this is -- compared to  
9 2014, only 27 states including D.C. had adopted  
10 the expansion and five were in an open  
11 discussion.

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

22 So, now that I've described the adult

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

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

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

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

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

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

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

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

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

1 measure.

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

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



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

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

11                   So, as you know, the NA reflects  
12          measures that are non-NQF-endorsed and out of the  
13          26, we have 24 that are NQF-endorsed and two that  
14          are non-NQF-endorsed. And there's further  
15          details of each of these measures in the Excel  
16          file.

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

21                   CHAIR PINCUS: Any questions for Zehra?  
22          Sue?

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

12 MS. SHAHAB: Yes.

13 MS. GORHAM: Good morning, welcome  
14 back.

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

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

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

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

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

22 MR. SLABACH: I have a question that

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

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

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

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

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

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

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

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

1 that was just one of the things they were  
2 studying.

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

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

14 CHAIR PINCUS: Okay. Sue?

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

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

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

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

11 CHAIR PINCUS: Thank you.

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

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

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

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

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

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

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



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

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

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

19 CHAIR PINCUS: So -- oh, Anne?

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

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

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

5 MS. COHEN: Okay.

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

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

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

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

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

4 MS. GORHAM: Sure.

5 CHAIR PINCUS: -- the measures so far?

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

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

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

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

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

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

18 So on your screen, you have a chart of  
19 all of the measures reported by state in 2013 and  
20 2014. We wanted to show you a comparison of the  
21 two years. The bold red horizontal line divides  
22 the 15 measures with high levels of reporting,

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

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

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

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

1 Management had six more states reporting in 2014.

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

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

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

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

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

4 MS. LASH: I think it's HEDIS.

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

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

10 CHAIR PINCUS: Yes.

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

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

14 MS. LILLIE-BLANTON: -- my figures.

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

18 CHAIR PINCUS: Oh, there's a code for  
19 --

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

22 CHAIR PINCUS: Okay. So the question

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

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

4 CHAIR PINCUS: Okay.

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

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

14 CHAIR PINCUS: It's the law.

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

22 CHAIR PINCUS: We may be able to get to



1       that later.

2               MR. SLABACH: Oh, okay.

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

7               DR. ANDREWS: Yes. In the earlier  
8       slides that we looked at in terms of the  
9       measures, BMI was not NQF-endorsed. And yet,  
10      when you look at what we just saw, not only in  
11      '13, but in '14, almost -- the states that are  
12      reporting the BMI almost doubled.

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

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

19              DR. ANDREWS: It is a CMS Star Measure.

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

21              DR. ANDREWS: And so it --

22              MS. LASH: -- widely used Measure.

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

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

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

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

19 MS. GORHAM: The one thing that is  
20 important about that is it was first collected in  
21 2014.

22 MS. COHEN: Oh, okay.

1 CHAIR PINCUS: Ann?

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

6 CHAIR PINCUS: Yes.

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

9 CHAIR PINCUS: Right.

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

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

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

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

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

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

9 CHAIR PINCUS: Alvia?

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

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

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

3 CHAIR PINCUS: Dan?

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

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

22 CHAIR PINCUS: BMI assessment or you --

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

3 CHAIR PINCUS: Right.

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

6 CHAIR PINCUS: Right.

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

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

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

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

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

16 CHAIR PINCUS: Nancy?

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

1 into the future.

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

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

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



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

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

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

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

1       wonderful to be able to dig deeper.

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

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

7               MS. COURT: But not --

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

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

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

22              So, again, I think what would help

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

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

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

13              MS. LILLIE-BLANTON: Right, yes it is  
14      --

15              MS. PELLEGRINI: So --

16              MS. LILLIE-BLANTON: It is.

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

18              MS. LILLIE-BLANTON: And hospitals --

19              MS. PELLEGRINI: -- exotic measures.

20              MS. LILLIE-BLANTON: Hospitals are  
21      reporting it. Hospitals are reporting it because  
22      --

1 MS. PELLEGRINI: Right.

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

6 CHAIR PINCUS: So, Anne?

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

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

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

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

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

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

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

1       \$400,000 per fielding of one question. And that  
2       was only the cost of the regular fielding the  
3       question, let alone all the development and all  
4       the other stuff.

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

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

17              So, Dan and Nancy? Dan?

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

1 BMI.

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

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

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

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

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

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

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

22 (Laughter.)



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

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

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

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

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

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

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

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

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

10              CHAIR PINCUS: Brock?

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

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

22              So, I think definitely we need to

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

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

19 CHAIR PINCUS: Okay. Brock?

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

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

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

13 CHAIR PINCUS: Okay. Shaconna?

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

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

1       2014.   Okay.

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

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

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

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

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

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

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

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

1       its importance.

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

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

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

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



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

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

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

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

21 MS. LASH: That actually is in --

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

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

2 MS. GORHAM: Yes.

3 MS. LASH: -- that looks like this.

4 There's a lot here, so it's easy to miss.

5 MS. GORHAM: Right.

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

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

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

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

20 CHAIR PINCUS: Anne?

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

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

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

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

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

22 MS. COHEN: It's a facility level

1 measure.

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

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

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

11 DR. SIDDIQI: Yes.

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

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

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

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

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

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

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

1 medication list and the medications ordered  
2 during the hospitalization.

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

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

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

19 MS. LASH: Sure. It's 2456.

20 DR. LESSLER: 2456.

21 MS. LASH: Yes.

22 MS. COHEN: And let me be clear, this

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

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

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

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

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

3 CHAIR PINCUS: Marissa?

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

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



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

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

10                  MS. SCHLAIFER: Yes.

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

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

1 reported, and that may be the case.

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

5 MS. LILLIE-BLANTON: Of course --

6 CHAIR PINCUS: And is that --

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

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

17 OPERATOR: Star, one.

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

20 OPERATOR: Ann Rosemary Bort  
21 (phonetic).

22 MS. LILLIE-BLANTON: Oh, great.

1 OPERATOR: One second.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11 MS. LILLIE-BLANTON: Yes.

12 MS. BORT: -- such as vital records.

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

14 MS. BORT: Those are challenging.

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

22 And that's one of the reasons I asked

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

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

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

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

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

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

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

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

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

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

7 CHAIR PINCUS: George?

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

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

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

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



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

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

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

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

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

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

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

22 CHAIR PINCUS: Marissa? Oh --

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

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

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

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

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

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

11 CHAIR PINCUS: Anne?

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

14 MS. SCHLAIFER: Yes.

15 MS. COHEN: -- because I would've lost  
16 --

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

19 MS. COHEN: But, so --

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

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

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

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

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

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

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

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

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

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

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

1 all managed and run by the plans and the vendors.

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

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

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

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

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

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

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

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

22 (Whereupon, the above-entitled matter



1       went off the record at 10:23 a.m. and resumed at  
2       10:36 a.m.)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22                  MS. COURT: Certainly. So first of



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

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

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

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

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

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

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

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

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

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

11 So what are some of the data  
12 collection barriers? I think we've talked about  
13 this already. One of my pet peeves, you may have  
14 noticed this already, but CAHPS survey. We know  
15 that when we do program evaluation, we get 80 to  
16 85 percent response rates.

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

1 survey, I don't think is very reliable.

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

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

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

22 None of that is shared with the state,

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

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

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

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

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

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

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

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

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

1 measures that was adopted by the governor.

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

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

6 MS. COHEN: It's not the same?

7 CHAIR PINCUS: -- actual  
8 rehospitalization.

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

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

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

16 MS. COURT: Yes.

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

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

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

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

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

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

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



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

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

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

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

19 DR. SULLIVAN: Yes.

20 CHAIR PINCUS: Okay.

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

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

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

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

16             DR. SULLIVAN: Right.

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

20             DR. SULLIVAN: Okay.

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

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

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

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

20 CHAIR PINCUS: Nancy?

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

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

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

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

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

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

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

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

1 population that generally have a huge burden of  
2 comorbidity medical, as well as psychiatric.

3 But, just some thoughts.

4 MS. COURT: Right.

5 CHAIR PINCUS: Lisa?

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

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

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

22 And I think that's part of the intent

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

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

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

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

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

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

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

22 MS. COURT: Right. We dreamed this up



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

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

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

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

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

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

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

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

16 MS. COURT: At this point.

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

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

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

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

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

22 In this case, if we had a really

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

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

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

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

1 it's on the general health side.

2 MS. COURT: Right.

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

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

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

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

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

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

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

17 MS. COURT: So, are we on --

18 CHAIR PINCUS: Ann?

19 MS. COURT: Oh, sorry.

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

22 CHAIR PINCUS: Okay.

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

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

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

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

1 we've done a lot of self-analysis.

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

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

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



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

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

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

20           CHAIR PINCUS: Anne?

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

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

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

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

21 I also like the idea of some of the  
22 measures that deal with diabetes, Alc 3, and

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

6 CHAIR PINCUS: Nancy and then Beverly.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4 CHAIR PINCUS: Beverly.

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

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

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

22 And this gets back to the point, I

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

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

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



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

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

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

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

1 Likewise, we would be rewarding mediocrity if in  
2 fact we didn't risk adjust those that are below  
3 36 percent, but they really could do better given  
4 what other nursing homes can do with a similarly  
5 severe patient population.

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

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

22           Lots of barriers that we talked about

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

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

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

22 Again, things that will encourage

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

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

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

22 CHAIR PINCUS: This has been really

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

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

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

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

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

1 this afternoon. I think it would be helpful to -  
2 -

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

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

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

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

1 with serious mental illness.

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

17 CHAIR PINCUS: Any other public  
18 comment?

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

1 DR. LIU: They are all endorsed by NQF.

2 DR. SIDDIQI: Sure. I meant the opioid

3 --

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

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

9 DR. SIDDIQI: That's great.

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

12 (Laughter.)

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

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

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

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

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

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

9 CHAIR PINCUS: Okay.

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

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

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

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

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

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

22 As I just said, we've been over the

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

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

15 So I want to remind everyone about the  
16 voting procedure quickly. We have it looks like  
17 12 of you voting members currently in the room.  
18 Our federal partners are non-voting as are the  
19 states. Harold will plan to recuse himself from  
20 some of the voting and I'll ask him to describe  
21 that in just a second.

22 But either way, whether there are --

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

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

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

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



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

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

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

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

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

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

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

19 CHAIR PINCUS: Okay. Just one --

20 MS. LASH: Sure.

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

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

3 MS. LASH: Right.

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

7 MS. LASH: The opioid measures? Sorry.

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

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

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

21 CHAIR PINCUS: Right. It could be so  
22 --

1 MS. LASH: -- and identify different  
2 populations.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

9 DR. SIDDIQI: So I agree --

10 DR. LIU: And --

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

18 CHAIR PINCUS: Just to clarify your  
19 question.

20 DR. SIDDIQI: I'm just clarifying.

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

1 DR. SIDDIQI: For --

2 CHAIR PINCUS: Because I think --

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

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

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

10 CHAIR PINCUS: Okay.

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

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

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

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

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

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

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

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

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

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

14 CHAIR PINCUS: It's different.

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

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

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

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

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

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

11 CHAIR PINCUS: Right.

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

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

1 CHAIR PINCUS: Right.

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

4 CHAIR PINCUS: So it's --

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

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

10 MS. COHEN: So --

11 CHAIR PINCUS: -- Ann too.

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

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

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

3               CHAIR PINCUS: Ann?

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

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

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

22              DR. SULLIVAN: Permission of their

1 provider --

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

4 DR. SULLIVAN: -- their after care  
5 provider?

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

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

16 MS. COHEN: A mental health diagnosis.

17 CHAIR PINCUS: -- mental health  
18 diagnosis.

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

20 CHAIR PINCUS: Yes. That's it. And  
21 then say of those, what proportion of them within  
22 30 days had any encounter that had a --



1 MS. COHEN: Then it's --

2 CHAIR PINCUS: -- billing diagnosis?

3 MS. COHEN: Then it's --

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

6 MS. COHEN: No, no, no --

7 DR. SIDDIQI: -- has to be --

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

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

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

18 MS. COHEN: That's the issue.

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

21 MS. COHEN: That's what it is.

22 DR. SIDDIQI: -- what she's saying

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

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

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

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

14              MS. COHEN: The encounter of the ER --

15              DR. SIDDIQI: The follow-up visit --

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

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

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

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

1       says though.

2                   CHAIR PINCUS: Right.

3                   DR. LEIB: It says the primary  
4       diagnosis.

5                   CHAIR PINCUS: So I'm --

6                   DR. LEIB: So how is this operational?

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

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

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

1 the claims data.

2 CHAIR PINCUS: But I think the --

3 DR. SIDDIQI: Because it's primary.

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

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

11 CHAIR PINCUS: -- the lacerations --

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

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

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

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

15                  CHAIR PINCUS: Anne?

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

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

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

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

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

17             MS. COHEN: Then that's fine.

18             DR. SIDDIQI: -- and the mental health.

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

1 where I'm going Harold?

2 CHAIR PINCUS: Yes, I do. Nancy?

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

12 DR. SIDDIQI: Yes.

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

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

1 I'll just sort of leave there.

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

8 CHAIR PINCUS: Yes.

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

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

15 DR. LESSLER: Okay.

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

20 DR. LESSLER: I understand.

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



1 wellness.

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

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

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

8 MS. LASH: You like better?

9 MS. SCHLAIFER: Yes.

10 CHAIR PINCUS: Okay.

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

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

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

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

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

14 DR. LIU: Yes.

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

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

22 DR. SULLIVAN: Yes.

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

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

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

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

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

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

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

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

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

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

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

21 DR. LEIB: I agree.

22 DR. SIDDIQI: -- in follow-up.

1 CHAIR PINCUS: Marc?

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

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

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

1 world.

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

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

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

19 CHAIR PINCUS: Marsha?

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

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

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

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

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

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

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



1 the setting.

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

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

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

22 DR. SIDDIQI: I think, just one last

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

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

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

18 CHAIR PINCUS: Move to the next one?

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

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

4 CHAIR PINCUS: Cindy?

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

9 CHAIR PINCUS: I could answer that.

10 MS. PELLEGRINI: Oh, thank you.

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

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

20 CHAIR PINCUS: Oh.

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

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

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

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

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

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

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

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

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

22 CHAIR PINCUS: Ann and then Anne and

1 Nancy.

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

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

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

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

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

7 DR. SULLIVAN: Oh, okay.

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

11 DR. SULLIVAN: Okay.

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

14 DR. SULLIVAN: And then --

15 MS. LASH: -- NQF endorsed.

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

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

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

20                   CHAIR PINCUS: Anne and Nancy?

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



1 counterpart from New York.

2 CHAIR PINCUS: Anne with an E.

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

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

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

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

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

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

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

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

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

22 I think there are more issues with the

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

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

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

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

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

22 DR. SULLIVAN: I think you want to go

1 beyond just the screening, you'd want to include  
2 the comprehensive care for diabetes as well.

3 Now, I don't know how many measures you can add.

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

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

14 DR. SULLIVAN: Oh, okay.

15 CHAIR PINCUS: -- a prioritization  
16 process.

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

1 MS. LASH: Can you give us the numbers?

2 DR. SULLIVAN: -- 1927.

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

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

11 CHAIR PINCUS: 2603?

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

14 CHAIR PINCUS: 2602?

15 DR. SULLIVAN: Right.

16 CHAIR PINCUS: So 1927, 2603, and 2602?

17 DR. SULLIVAN: Right.

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

22 CHAIR PINCUS: Is there a specific

1 measure? Or is --

2 DR. HANRAHAN: No, unfortunately. I  
3 thought Sarah was asking where the gaps were and  
4 --

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

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

11 CHAIR PINCUS: Okay.

12 DR. HANRAHAN: -- for people --

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

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

18 CHAIR PINCUS: Yes.

19 DR. HANRAHAN: All right.

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

22 DR. SULLIVAN: I would just like to

1 throw one more into the mix which is --

2 CHAIR PINCUS: And Lisa.

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

5 CHAIR PINCUS: And 2605?

6 DR. SULLIVAN: Right. That's it.

7 CHAIR PINCUS: Okay. Dan?

8 DR. LESSLER: So first, just a question  
9 about 2603 versus, and maybe I'm just not --  
10 1932. So both of these are looking at getting an  
11 Alc done in slightly different contexts. Is that  
12 right?

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

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

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

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

9 CHAIR PINCUS: It's 2606.

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

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

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



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

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

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

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

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

1 the early adopters that has reports in here.

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

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

18 CHAIR PINCUS: Okay.

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

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

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

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

20 MS. KENDIG: Yes.

21 DR. SULLIVAN: -- to the state.

22 MS. KENDIG: I know we spent a

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

9 CHAIR PINCUS: Anne and then Cindy.

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

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

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

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

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

10 MS. COHEN: Yes.

11 CHAIR PINCUS: Okay.

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

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

18 CHAIR PINCUS: There is no --

19 MS. COHEN: -- of the exclusions.

20 CHAIR PINCUS: There is no Medicaid --

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

1 Right?

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

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

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

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

15 CHAIR PINCUS: Yes.

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

18 CHAIR PINCUS: Okay.

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

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

1       --

2               MS. COHEN: Okay. Never mind then.

3               CHAIR PINCUS: But it's --

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

6               CHAIR PINCUS: While they're looking,  
7       Cindy?

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

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

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

22              At which point we're adding a huge

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

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

13 CHAIR PINCUS: So let me --

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

16 CHAIR PINCUS: -- maybe suggest  
17 something that might help you. One is that these  
18 are all sort of stratified measures, so the  
19 incremental effort to collect the data is small.  
20 Because they're basically off of already existing  
21 measures. So that's part of the argument why  
22 that is simply looking at it from a stratified



1 point of view.

2 From my perspective, I think Dan's  
3 right on track. I mean, it's cardiovascular  
4 disease and tobacco use that's underlying it.  
5 And then all of which is sort of undergirded by a  
6 failure of coordination of care. So I don't know  
7 if that helps you, but that's -- so any other  
8 nominations?

9 MS. COHEN: This isn't, I know this  
10 isn't a specific measure, but I have to add the  
11 concept to the list. So we talked a lot  
12 yesterday about trauma-driven care and I think  
13 for this group that's pretty critical, so I think  
14 that needs to be captured somewhere. And then  
15 the idea of quality of life also.

16 I do have a measure, but it's not very  
17 well loved, so I'll throw it up there anyway just  
18 so you have a number. But it's the 0260. It's  
19 the quality of life measurement tool, instrument,  
20 whatever. Actually this will go for behavioral  
21 health. For that subpopulation.

22 CHAIR PINCUS: So just -- what exactly

1 is that Measure? What's the --

2 MS. COHEN: So it's -- let me pull it  
3 up.

4 MS. SHAHAB: So 0260 is Assessment of  
5 Health-Related Quality of Life Physical and  
6 Mental Functioning. And it's by the RAND  
7 Corporation. The description is percentage of  
8 dialysis patients who receive a quality of life  
9 assessment during the KDQOL-36 question survey  
10 that assesses patient's functioning and well  
11 being at least once per year. Yes.

12 MS. COHEN: 0260. Now, we use this for  
13 this group because we wanted to look at social  
14 deterrents of health as like sort of the pacer.  
15 But we kind of eliminate the concept of diabetes  
16 care.

17 And it's the idea that you're trying  
18 to get at -- we're a little rebellious in the  
19 duals group. Yes. But we wanted some way in the  
20 report to capture that you need to look at  
21 certain determinants of the health other than the  
22 specific health stuff.

1 CHAIR PINCUS: Let me just take my  
2 Chairman's hat just to speak against that.  
3 Because I think it's -- number one, it's kind of  
4 distal to actually improving quality of life.  
5 And it may be particularly burdensome both at a  
6 clinician level and at a health plan level. So I  
7 would put it lower on my priority --

8 MS. COHEN: Yes. Now, I would agree  
9 that it's not necessarily something that we're  
10 going to add today. But I think that we need to  
11 put somewhere in the report that there needs to  
12 be consideration for other things other than pure  
13 health-related quality.

14 CHAIR PINCUS: Right. And I think  
15 that's something that when we get to gaps, that's  
16 something you can --

17 MS. COHEN: Okay.

18 CHAIR PINCUS: -- sort of --

19 MS. COHEN: Maybe that's a gap.

20 CHAIR PINCUS: -- maybe rather than  
21 having it -- so really what we're putting up here  
22 are measures that we would actually vote on.

1 MS. COHEN: Okay. So then I would  
2 agree; eliminate it from the list and Sarah can  
3 add it to gaps.

4 CHAIR PINCUS: Okay.

5 MS. COHEN: And also the trauma care  
6 would be helpful. Thanks.

7 CHAIR PINCUS: And Zehra, did we find  
8 the Measure about rehospitalization?

9 MS. SHAHAB: Were you talking about the  
10 readmissions ones? The two readmissions ones  
11 that Anne had mentioned? Yes, they're for  
12 Medicare beneficiaries.

13 CHAIR PINCUS: So is that -- would the  
14 specifications be different for Medicaid?  
15 Because there is -- AHRQ puts out these reports  
16 on Medicaid readmission rates, so it must be  
17 available.

18 MS. LASH: So the measure 2502 about  
19 inpatient rehab, the denominator and the data  
20 source was constructed around Medicare fee-for-  
21 service. I think it's probably too much of a  
22 stretch.

1 CHAIR PINCUS: Okay. So this would  
2 also go in as an example in the gap area? Of  
3 looking at rehospitalization rates both overall  
4 as well as with these different numerators? And  
5 denominators actually.

6 MS. LASH: I also think that the type  
7 of facility is not a mental health facility in  
8 general.

9 CHAIR PINCUS: Yes. But that was, I  
10 think there were two.

11 MS. LASH: Okay.

12 CHAIR PINCUS: One was the general  
13 hospital, one was --

14 MS. LASH: Got it.

15 CHAIR PINCUS: -- the sub-acute one.  
16 So we'll put that in the gaps as something that,  
17 again, looking at overall readmission rates and  
18 readmission rates for people with a mental  
19 disorder, both within a -- both for a mental  
20 disorder as well as for other conditions. Okay?

21 So we have how many measures? One,  
22 two, three, four, five, six, seven measures to

1 vote on. Should we vote on these before or after  
2 lunch?

3 DR. SIDDIQI: I was just going to  
4 propose -- but can we do a work through lunch to  
5 just kind of go through the voting? So we grab  
6 our food --

7 CHAIR PINCUS: Okay. So --

8 DR. SIDDIQI: -- and then -- just in  
9 the interest of traveling today and --

10 CHAIR PINCUS: I think that's a great  
11 idea.

12 DR. SIDDIQI: -- getting out on time.

13 CHAIR PINCUS: Okay.

14 MS. SCHLAIFER: (Off mic comment) --  
15 help us to prioritize? I mean, otherwise we  
16 could just vote yes on everything. And I think,  
17 I don't know, it seems like --

18 MS. LASH: Let me put out some  
19 parameters --

20 MS. SCHLAIFER: Yes.

21 MS. LASH: -- around what CMS has been  
22 able to do in the past in terms of a level of

1 change. The most recent annual update had one  
2 measure removed and one measure added. Although  
3 MAP had recommended we elect three measures. We  
4 already, yesterday, picked out two that we liked  
5 related to the maternal and perinatal care. And  
6 --

7 MS. SCHLAIFER: And we've got more  
8 going on besides mental health.

9 MS. LASH: -- we still have the access  
10 to primary and specialty care subject area to go  
11 through after this. And we also haven't  
12 discussed the opiate measures from PQA. So it  
13 would probably behoove the group to pick out no  
14 more than two, three at the very most of these  
15 behavioral health measures.

16 CHAIR PINCUS: Beverly?

17 MS. COURT: It would be helpful to  
18 states to know of these other emerging measures,  
19 that if they can tie them into, for example,  
20 existing quality improvement projects or if they  
21 feel that there's a particular issue in their  
22 state. Because when we look at -- when people

1 say, okay, well what do you want to measure?

2 Well, we kind of, let's just grapple around and  
3 see what's out there.

4 I mean, there's usually 170, I think  
5 we, I forget how large our list was, but it was  
6 excruciatingly long. But if it looks like these  
7 are emerging, then we can start building that  
8 infrastructure.

9 CHAIR PINCUS: So I -- as much as I  
10 hate to disagree with my colleague, Sarah, I  
11 agree with you, Beverly. I think that we're  
12 supposed to give our opinions, so we might as  
13 well give our opinion. And CMS doesn't have to  
14 listen to us.

15 But I think alerting people that these  
16 measures exist, that they may be useful, and CMS  
17 could look at the priority -- we will then later  
18 prioritize these and CMS can look at our  
19 priorities and decide whether they agree or not.

20 MS. LASH: Right. We describe these --

21 CHAIR PINCUS: Yes. And I don't see a  
22 need --



1 MS. LASH: -- all 11 of these measures

2 --

3 CHAIR PINCUS: -- to pre-censor  
4 ourselves before we prioritize. Okay. So why  
5 don't we get lunch. Is it out there?

6 MS. LASH: Yes.

7 CHAIR PINCUS: Why don't we get lunch  
8 and come back in ten minutes? Okay. Yes.

9 (Whereupon, the above-entitled matter  
10 went off the record at 12:39 p.m. and resumed at  
11 12:49 p.m.)

12 CHAIR PINCUS: If everybody could  
13 please be seated. We want to go through the  
14 voting process before we lose a quorum. And  
15 people will be pardoned if they speak with their  
16 mouths full.

17 MS. LASH: Yes. Okay. So we will take  
18 a vote on each of these Measures individually.  
19 And if they gain the support of eight or more of  
20 you, they will be --

21 CHAIR PINCUS: We're missing somebody.

22 MS. LASH: Yes. George has left for

1 the day, I believe. Kirstin I just saw, so she  
2 must be in the ladies. So we'll give her a  
3 moment. And then --

4 CHAIR PINCUS: If George has left for  
5 the day, does that change the voting?

6 MS. LASH: Yes.

7 CHAIR PINCUS: No, we're going to  
8 prioritize later.

9 MS. LASH: So, we've heard a lot of  
10 discussion about the importance of this body of  
11 measures broadly and notifying state partners  
12 that there are these additional things they might  
13 want to look at above and beyond core set  
14 requirements. I think that would be part of the  
15 discussion.

16 And yet, the final product that we  
17 deliver to CMS will involve a one, two, three,  
18 four, and so on ranked list of measures. The  
19 vote right now is about whether you want these  
20 indicators behind me to make it onto that ranked  
21 list.

22 And the last thing we will do today,

1 hopefully in the next hour, is to give you all  
2 stickers and you can do what you saw the Child  
3 Task Force doing yesterday, where you can  
4 indicate what priority order you would like CMS  
5 to address the measures in.

6 The list can be fairly long, but the  
7 bottom of that list is rather unrealistic for  
8 action within the next year. Does that make  
9 sense? Can you use your mic Marissa?

10 MS. SCHLAIFER: I asked before in a  
11 different way. I mean, is there a point -- CMS  
12 is having us do this because they need advice on  
13 what we -- if the list gets too long, does it  
14 become like, why did we even bring you together  
15 because you like everything? I just, I mean, I  
16 just feel like that's --

17 MS. LASH: No. I think, I will speak  
18 for CMS in saying they find the whole discussion  
19 very valuable. There are some short-term and  
20 long-term actions that they will be taking to  
21 strengthen the measure set.

22 The most immediate and short-term is

1 the addition of some small number of measures.  
2 And that determination of the number is up to  
3 them. But just as last year we discussed asthma  
4 medication and another care transition measure  
5 that didn't make it, MAP still signaled the  
6 emphasis for those two measures.

7 CHAIR PINCUS: So Sue and then Beverly,  
8 and then we'll begin voting.

9 MS. KENDIG: I just have a clarifying  
10 question. So some of these Measures are  
11 available without the behavioral health or the  
12 mental health qualifier, like diabetes screening  
13 and so forth, right? So if those are already  
14 available, is there anything to -- I guess that  
15 would be reported as discrete indicators, so a  
16 state would have to run both those Measures and  
17 then overlay them and look at them. Correct?

18 CHAIR PINCUS: Correct.

19 MS. KENDIG: Okay.

20 CHAIR PINCUS: Beverly?

21 MS. COURT: There's already -- in the  
22 AQM reporting, there is reporting for

1 subpopulations. It's looking at disparity  
2 analysis. So for example, disabled non-disabled  
3 by ethnicity group, by race. So just that may be  
4 where you could implant a stratification of SMI/  
5 non-SMI that might be helpful. And, again, for  
6 those states that can do that kind of  
7 bifurcation, that may get you --

8 CHAIR PINCUS: I mean --

9 MS. COURT: -- a long ways to what  
10 you're looking for.

11 CHAIR PINCUS: That's basically what  
12 these are or some of them are. And that was the  
13 intention was to actually to not necessarily have  
14 them be separate measures. But apparently by NQF  
15 rules, they had to go through and be separate  
16 measures.

17 MS. COURT: Oh.

18 MS. LASH: I think some of them are  
19 slightly different from the original.

20 CHAIR PINCUS: Yes. A couple are  
21 slightly -- most of them. So, okay. Why don't  
22 we get started and --

1 MS. COHEN: Wait, wait, wait. One more  
2 quick thing.

3 CHAIR PINCUS: Okay.

4 MS. COHEN: So, sorry, Beverly, but I  
5 have a little challenge with that. So in most  
6 states, they have display aid codes, but they  
7 don't have any more information other than the  
8 aid code. And in many states, they're not even  
9 able to talk to the mental health carve-out to  
10 find out who actually is in mental health. So I  
11 don't know how that would work without a separate  
12 measure that triggers them to actually do it.

13 MS. COURT: So the stratification is  
14 voluntary reporting. Breakdown, for example,  
15 between disabled non-disabled populations. I'm  
16 just suggesting that where states are capable of  
17 doing it, and we are, in Washington state for  
18 example, that, that might be an easy win, rather  
19 than imposing a new measure is use the  
20 stratification which is already voluntary.  
21 There's already a place, and dear God, I love  
22 entering all that information into CARTS, but

1 that is one more that I could do. So, I'm just  
2 offering that as an option.

3 MS. COHEN: I totally get where you're  
4 coming from. I totally agree. That would be my  
5 only caveat is that I don't know how for a  
6 particular sub-disability group that  
7 stratification could happen. Only because  
8 there's no indicator. Do you see where I'm  
9 going?

10 MS. LASH: So we need now seven votes,  
11 with the Chair being recused, to pass the  
12 measure.

13 CHAIR PINCUS: So let's move through  
14 these quickly. First one up is 1932, which is  
15 the Diabetes Screening for People with  
16 Schizophrenia or Bipolar Disorder who are Using  
17 Antipsychotic Medications. How many voting to  
18 support this measure? It's up there, it's on the  
19 screen. Okay. Nine. Okay. Bev?

20 MS. COURT: All I ever hear is the  
21 numerator, not the denominator, so I don't know  
22 what nine means.

1 MS. LASH: We need seven or more.

2 MS. COURT: Okay. Thank you.

3 CHAIR PINCUS: Okay. 1927,  
4 Cardiovascular Health Screening for People with  
5 Schizophrenia or Bipolar Disorder who are  
6 Prescribed Antipsychotic Medication. What?

7 MS. DAWSON: Can we give  
8 recommendations to the measure steward on this as  
9 well? Or is this just as is for the measure?

10 CHAIR PINCUS: This is an already  
11 endorsed measure.

12 MS. DAWSON: Right. I think our  
13 question would be, because of the age range, it's  
14 25 to 64, to making sure that it aligns with the  
15 other age ranges for the other HEDIS measures.  
16 For the 1932, that's the age range of 18 to 64.  
17 That would just be my only caveat.

18 DR. LIU: If I could help with that.  
19 We actually intentionally did not align that  
20 during the development process because expert  
21 panels advised us to raise the age range for the  
22 cardiovascular screening measure because they



1 think the health risk for that condition needs to  
2 be at the older populations. And that's the  
3 recommendation, the rationale for that.

4 CHAIR PINCUS: So I'm voting on 1927.  
5 All in support, raise your hand.

6 MS. LASH: Seven.

7 CHAIR PINCUS: Okay. Next is 2602,  
8 which is Blood Pressure Control for the Seriously  
9 Mentally Ill, which is actually on the handout  
10 from NCQA. Okay. All in favor of that one?

11 MS. SHAHAB: 2602 is seven votes, so it  
12 passes.

13 CHAIR PINCUS: Okay. The next one is  
14 2603, which is A1c testing, which is also on your  
15 handout.

16 MS. COHEN: So, can you -- forgive me  
17 because now I'm getting them all confused.  
18 Between 1932, 2603, what's the difference? And  
19 what's the -- and I assume 2603 and 2608, they're  
20 obviously very different, right?

21 CHAIR PINCUS: 2608 is A1c control.

22 MS. COHEN: Yes. I understand that.

1 So that's newly diagnosed, and that's already  
2 diagnosed? The 2603?

3 DR. SULLIVAN: One's for testing and  
4 the other is controlled.

5 MS. COHEN: Okay.

6 MS. LASH: The top measure looks to see  
7 if someone needs to be diagnosed with diabetes.  
8 The next measure of Alc testing, once you are  
9 identified to have diabetes, is your Alc tested?  
10 And the control is an intermediate outcome  
11 measure of how well it's being managed.

12 MS. COURT: Do we want to quickly  
13 identify which are admin, which are survey, and  
14 which are hybrid?

15 CHAIR PINCUS: No, I don't think so.  
16 It's a lab testing. It is a survey?

17 MS. LILLIE-BLANTON: Unfortunately it  
18 is. It's from the CAHPS survey.

19 DR. LIU: It's not a -- this is Junqing  
20 Liu from NCQA. The 2603 measure is a hybrid  
21 measure, so it's not using survey.

22 CHAIR PINCUS: In the current data set.

1 1932?

2 DR. LIU: That one is a claims-based  
3 measure. The test are -- it has codes for the  
4 tests.

5 CHAIR PINCUS: So we were on -- so  
6 we're just going back to where we were on the  
7 voting. So Alc testing for people with comorbid  
8 diabetes and serious mental illness. Yes. So  
9 we're taking a vote. So all in support of that  
10 measure?

11 No, this is 2603. Yes. Yes. It's  
12 not on antipsychotics; it's -- and mental  
13 illness. So what was the number? Okay. We're  
14 voting now on 2603. Everybody raise your hand  
15 high.

16 MS. SHAHAB: So 2603, there were six  
17 votes. It does not pass.

18 CHAIR PINCUS: The next one is Follow-  
19 Up After Emergency Department. That's 2605, as  
20 it is currently defined. All in favor of that,  
21 in support of that, raise your hand.

22 MS. SHAHAB: 2605, three votes, does

1 not pass.

2 CHAIR PINCUS: Okay. 2600, which is  
3 Tobacco Use Screening and Follow-Up for People  
4 with Serious Mental Illness or Alcohol or Other  
5 Drug Dependence.

6 DR. SIDDIQI: Can I get clarification  
7 from the measure steward? What is the follow-up  
8 that is counted in this measure? How do you  
9 capture that with the claims? For follow-up for  
10 tobacco screening? I understand the tobacco  
11 screening part, but it's the follow-up that's  
12 unclear.

13 DR. LIU: The follow-up requires two  
14 events of services. That could be two events of  
15 counseling or psychotherapy. So this is also a  
16 hybrid measure. You can meet the numerator by  
17 claims codes or medical record review.

18 DR. SIDDIQI: Right. So it would  
19 require hybrid? It can't be just all claims?

20 DR. LIU: Right.

21 CHAIR PINCUS: Okay. All in support of  
22 that measure?

1 MS. SHAHAB: 2600, four votes, does not  
2 pass.

3 CHAIR PINCUS: Okay. Next one is 2608,  
4 Alc control. All in favor of that?

5 MS. SHAHAB: 2608, six votes, does not  
6 pass.

7 CHAIR PINCUS: Actually, I'm just  
8 curious as to why this more outcomes measure did  
9 not pass as compared to the one that was more of  
10 a process measure?

11 (Laughter.)

12 CHAIR PINCUS: I was just wondering  
13 what the difference was. Okay.

14 MS. LASH: Okay. Let's move on. All  
15 right. The next measure for your consideration  
16 was to address the previously identified gap area  
17 of access to primary and/or specialty care.  
18 There is an NCQA stewarded, but not NQF endorsed  
19 measure titled Adults' Access to  
20 Preventative/Ambulatory Health Services:  
21 Percentage of Members 20 Years and Older Who had  
22 an Ambulatory or Preventative Care Visit.

1                   So it's a fairly straightforward  
2                   indicator of utilization as a proxy for access.  
3                   And the details of the Measure are in your Excel  
4                   file.

5                   MS. SCHLAIFER: It's not endorsed?

6                   MS. LASH: It is not endorsed or under  
7                   consideration. I don't believe NCQA has  
8                   submitted it. They're -- I'm not positive. You  
9                   might know.

10                  DR. LIU: That's correct. We haven't  
11                  submitted this measure yet.

12                  MS. LASH: Do you think you're going  
13                  to?

14                  DR. LIU: It's in HEDIS. It's reported  
15                  by health plans.

16                  CHAIR PINCUS: Do you plan to submit  
17                  it?

18                  DR. LIU: I think that's a good  
19                  question. This measure's in a different domain,  
20                  that's utilization domain. We may consider that,  
21                  but we also have to weigh all the other measures  
22                  to go through the process.

1 MS. LASH: There might be a potential  
2 for it not to pass because it is more of a  
3 utilization indicator than a performance or  
4 outcome indicator. Alvia?

5 DR. SIDDIQI: I was just going to state  
6 that I do think states are looking at this.  
7 Illinois definitely looks at this one in  
8 particular as a HEDIS measure. And I think  
9 pending NQF endorsement and saying that I think  
10 to NCQA and giving that feedback may help move  
11 things along on this one.

12 When we're talking about ACA  
13 expansion, access to care is going to be a huge  
14 issue and already is an issue. I think this is  
15 one that states can hold plans accountable to and  
16 I think it's something that could be useful to  
17 the state, in terms of trying to address care  
18 coordination and access issues. So I do support  
19 this one.

20 CHAIR PINCUS: Other comments on this?  
21 Marissa?

22 MS. SCHLAIFER: I was just going to

1 say, I think based on the conversation rather  
2 than just having the discussion to support or not  
3 support it, it sounds like we might want to throw  
4 the conditional support into this.

5 CHAIR PINCUS: Okay. Dan?

6 DR. LESSLER: Yes. I just, I mean, it  
7 is sort of a useful utilization measure. It's  
8 hard to --- as a quality measure or process  
9 measure, it's harder to wrap my head around.

10 I wonder though if -- one of the  
11 things with respect to access and not to dig up  
12 our earlier conversation here, but the idea that  
13 certain people coming out of an emergency room  
14 visit should be seen in follow-up, I mean, people  
15 with chronic illness and so forth and in a timely  
16 manner.

17 And that strikes me, I mean, I know  
18 that's something we're struggling with, with our  
19 ED utilization work in Washington right now. And  
20 that strikes me as the kind of measure of access  
21 that would be helpful and that might be more  
22 reflective of quality.



1                   And I don't know if there is such a,  
2                   and I didn't have a chance to really go searching  
3                   around, such a, either NCQA or NQF. But it just  
4                   strikes me as a bit more helpful in this access  
5                   realm.

6                   CHAIR PINCUS: Cindy?

7                   MS. PELLEGRINI: Maybe it's just  
8                   because I had lunch and I'm perking up now. But  
9                   I'm really kind of liking this measure. And for  
10                  two main reasons.

11                  The first is that with Medicaid  
12                  expansion, I think we could potentially have a  
13                  different profile of people going into preventive  
14                  care. And seeing how those rates change over  
15                  time could be very useful.

16                  The second is, coincidentally, today  
17                  the White House launched a new campaign called  
18                  Healthy Self where they're trying to encourage  
19                  people who have health care to utilize the  
20                  preventive health benefits available. So this is  
21                  sort of consistent with some of those concepts  
22                  where we're really trying hard to promote

1 preventive care and this would give us a way to  
2 track that over time.

3 So it's kind of -- it's a little bit  
4 crude. It's not terribly granular, but it would  
5 give us some basic information to point us in the  
6 right direction I think.

7 CHAIR PINCUS: Beverly?

8 MS. COURT: I would encourage people to  
9 look at the specs for this if this is the  
10 ambulatory care in the current -- HEDIS 2015.  
11 For example, exclusions of principle diagnosis of  
12 mental health or chemical dependency, that's  
13 excluded. There's also the actual reporting of  
14 the Measure is extensively -- there's all sorts  
15 of breakdowns, age, by member months, outpatient  
16 visits, ED visits.

17 So anyways, I think it would be useful  
18 to look and I believe this one also includes  
19 audiology. That's my pet peeve. Can you tell?  
20 Thinking that audiology is somehow indicative  
21 that someone has preventative care.

22 MS. PELLEGRINI: Where can we --

1 MS. COURT: So I guess I would look at  
2 this -- it would be helpful to look at the specs.  
3 Because it's more limited than you may think.

4 MS. PELLEGRINI: Where can we see  
5 those? Because the grid that I'm looking at here  
6 that we got says there are no exclusions in the  
7 denominator.

8 MS. LASH: We have incomplete  
9 information because this isn't endorsed. So  
10 that's an error.

11 CHAIR PINCUS: Alvia?

12 DR. SIDDIQI: I was just going to add  
13 that we already look at this measure through the  
14 Illinois health care program on our profiles that  
15 we send to primary care providers. And the  
16 wellness visit is essentially what this is  
17 getting at. Your preventative annual physical  
18 maintenance visit.

19 And, again, when we're talking about  
20 access to care, this is a really big one because  
21 it's an issue about your general Medicaid adult  
22 population, are they getting in to actually see

1 the doc once a year, the provider office for the  
2 preventive visit? And that's where you address  
3 all the other preventive screening issues. Your  
4 mammograms, your breast cancer screening,  
5 cervical cancer, et cetera, et cetera.

6 So, just wanted to clarify that the  
7 claims data -- this is one that can be done  
8 through claims. It's pretty easy to do and  
9 report on. So I just wanted to echo that again.

10 CHAIR PINCUS: I just wanted to call on  
11 myself on this one. I guess I'm generally not  
12 disposed towards utilization measures per se,  
13 unless they're useful from the point of view of  
14 being kind of a balance measure.

15 So for example, one of the problems I  
16 have with our initiation and engagement measures  
17 for substance abuse is that it's highly dependent  
18 upon utilization of substance abuse. So that --  
19 and whether there's a screening program in place.  
20 So that if you are screening, you're going to  
21 identify people that are less highly motivated to  
22 follow-up as compared to just taking people who

1       come in without any screening.

2                   And so, in some studies we've done,  
3       we've shown that places that actually screen,  
4       like the VA, does much more poorly on those  
5       Measures as compared to private plans that don't  
6       screen at all. And so having a utilization  
7       measure of looking at utilization of substance  
8       abuse services would make sense as kind of a  
9       balancing thing. What would this be balancing?

10                   DR. SIDDIQI: I think you're balancing  
11       -- well, you're also talking about alignment with  
12       the Pediatric Core Set, so the adolescent well  
13       visit, the well-child visits. Again, the  
14       emphasis on preventative visits where you can  
15       address, as a primary care provider, all of the  
16       preventative screening measures that are needed  
17       for preventative health care maintenance. And  
18       then the other part about this one, is this is an  
19       access measure, so if we're talking about a gap  
20       area in the Adult Core Set right now, there isn't  
21       really a good access measure.

22                   CHAIR PINCUS: But is there a

1 recommendation that there should be an annual  
2 health care visit? For everybody?

3 MS. COHEN: I'm almost positive, and I  
4 could be wrong, but there's --

5 CHAIR PINCUS: I can't hear, you got to  
6 put on your --

7 MS. COHEN: I'm almost positive that  
8 it's required under the conduct standard for the  
9 plans --

10 DR. LEIB: For children, but not for  
11 adults.

12 MS. COHEN: I think it is for adults.

13 DR. LEIB: Well, maybe in your state.  
14 I don't think it's required in ours.

15 MS. COHEN: I thought that there was a  
16 federal requirement, but maybe I'm wrong. Maybe  
17 it's just a well-child visit then.

18 CHAIR PINCUS: Okay. Ann and then  
19 Marc.

20 DR. SULLIVAN: That was also my  
21 question, that there is a requirement in those  
22 younger years for an annual health visit that

1 people are supposed to -- in their early 20s?  
2 That was my first question. My second is, what's  
3 being excluded in mental health? Is it a mental  
4 health visit that you're excluding? Or what was  
5 the --

6 DR. LIU: Let me help here. This  
7 measure does not have exclusion as it's shown on  
8 the screen. So the mental health population is  
9 included.

10 DR. SULLIVAN: So when you say  
11 ambulatory, you're not -- if someone had a mental  
12 health visit, but not a visit to a primary care  
13 doctor, that would be counted? Or that wouldn't  
14 be counted?

15 DR. LIU: It's a wellness visit.

16 DR. SULLIVAN: It doesn't say that,  
17 though.

18 DR. LEIB: But that's not what it says.

19 DR. SULLIVAN: That's not what it says.  
20 So that's why I'm just asking. It says  
21 ambulatory or preventative care visit. It  
22 doesn't just say a wellness visit.

1 DR. LEIB: The way this is worded,  
2 going to your orthoped for knee pain would  
3 satisfy this without ever having anyone listen to  
4 your heart, your lungs, do a lab, basic lab tests  
5 or anything else. This is not going to get the  
6 equivalent of a child wellness, a well-child exam  
7 that we have specifically in the Child Core Set.  
8 This is not the same.

9 CHAIR PINCUS: Well, I mean, first of  
10 all, you guys got to use the microphones, number  
11 one.

12 (Laughter.)

13 CHAIR PINCUS: Number two, we actually  
14 have the steward here.

15 DR. LIU: The question of whether  
16 screening and well care visit are included in the  
17 measure, is that the --

18 CHAIR PINCUS: Are specialist visits  
19 and any kind of ambulatory visit included in the  
20 measure?

21 DR. LIU: Yes.

22 CHAIR PINCUS: So it's not purely a



1 wellness visit? That's -- so, any more comments?

2 Do we want to vote on this? Oh, Marsha?

3 MS. LILLIE-BLANTON: I know I can't  
4 vote on this, but, to me, this measure is similar  
5 to what we get with MEPS, Medical Expenditure  
6 Panel Survey. And so, to me, there are trade-  
7 offs in our core set.

8 And so while I think this will give us  
9 some measure of the proportion who made any  
10 visit, I'm not quite sure what else you get from  
11 that. Because, like, with children, we do have  
12 requirements -- not requirements, excuse me --  
13 guidance that encourages pediatricians to use the  
14 AAP Bright Futures Guidelines for visits per  
15 year, or at least for the first maybe five or six  
16 years of life. And then there's guidance. And  
17 then after six years, it's maybe once a year.  
18 But before then, it's more than once a year.

19 So I'm not quite sure what we get from  
20 this other than proportion with a visit. And  
21 that's not bad to have. But we do have, in the  
22 CAHPS, measures that talk about unmet needs. I

1 mean, whether or not you needed care and didn't  
2 get it.

3 And the problem, of course, with CAHPS  
4 is that it's a survey data. But at least you  
5 have a sense of was there a need and was your  
6 need fulfilled. So, this one I'm on the fence,  
7 but I'll defer to the MAP, of course.

8 CHAIR PINCUS: Marc, do you still want  
9 to comment?

10 DR. LEIB: For me, maybe it's the  
11 lawyer hat on me sometimes, that words matter in  
12 how I interpret these things. And I look at what  
13 it actually says when I try and figure out if  
14 it's the kind of measure we want. And I just  
15 don't think this one gets to the data we'd want  
16 to have or need.

17 CHAIR PINCUS: Okay. Alvia?

18 DR. SIDDIQI: Just in the record, if we  
19 could give feedback to the measure steward about  
20 this one. Really we're trying to get at the  
21 preventative care visit and I think that would be  
22 more meaningful for access.

1 CHAIR PINCUS: So is there a motion to  
2 support with or without conditions for this?

3 Okay. Let's move on.

4 MS. LASH: I think that brings us to  
5 opioids, where we do not have any slides.

6 CHAIR PINCUS: So then we refer you to  
7 --

8 MS. LASH: So we are -- yes, looking at  
9 our PQA handouts.

10 CHAIR PINCUS: Actually there are two  
11 handouts that everybody got?

12 MS. LASH: They have two. They're  
13 about the same measure set. One is a little bit  
14 more detailed than the other. It was most  
15 helpful to look at the section in the middle of  
16 the page where there are numerators described for  
17 Measures 1, 2, and 3.

18 CHAIR PINCUS: Alvia?

19 DR. SIDDIQI: So, I just wanted to  
20 clarify. But since this hasn't even been  
21 submitted for NQF endorsement, we're talking at  
22 least a year-long process. So I'm thinking these

1 are measures that may be able to come back to the  
2 MAP next year rather than this year for our  
3 purview.

4 MS. LASH: That would be possible.

5 CHAIR PINCUS: Right. But we can also  
6 -- one of the options is to support conditional  
7 upon NQF endorsement, is one of the options.

8 DR. SIDDIQI: But if it's not ready  
9 before the next MAP meeting, then it wouldn't be  
10 submitted. Correct? Like, it's not going to go  
11 through the process and be ready before the next  
12 MAP meeting, I would assume.

13 MS. LASH: It would likely not be  
14 endorsed by the time CMS is issuing their update  
15 for 2016 reporting. But that recommendation  
16 could stand into the following year.

17 Additionally, this group could decide you would  
18 not like to take a vote on it at this time and  
19 that we would like to re-review it at a later  
20 date.

21 CHAIR PINCUS: So is there a motion on  
22 the floor to either support this measure, or to

1 support it conditionally pending NQF endorsement,  
2 or support it conditionally pending other issues?

3 MS. SCHLAIFER: I would say that this  
4 is a measure that I think is very needed and does  
5 need to move forward. I get the sense from both  
6 the questions and the kind of look on some  
7 people's -- that I think the guidance of the NQF  
8 -- I think there's certain measures where we just  
9 look at it and go, even though it hasn't been NQF  
10 endorsed, we want -- just the reactions, I feel  
11 like there is a sense that we want to see the NQF  
12 process.

13 This is a measure that is very  
14 important in the Medicaid population, as well as  
15 the Medicare population and the commercial  
16 population. But that from a pharmacy benefit  
17 management point of view, it is a measure that is  
18 definitely needed. Whether I get the sense that  
19 --

20 CHAIR PINCUS: There's no harm in  
21 nominating --

22 MS. SCHLAIFER: Well, I think, at least

1 the sense I'm getting, and maybe I'm not getting  
2 the sense, is that whether you need a measure and  
3 whether this measure is perfect, is what the  
4 question seems to be. But I would advocate that  
5 we definitely need a measure in this area.

6 I mean, in concept, I think we all  
7 would endorse it -- I cannot speak for anyone  
8 else -- that we'd want to endorse it. We talked  
9 several years ago about getting away from  
10 endorsing in concept. I think that's something  
11 that if that was still an option, I'd want to do.

12 But I think that conditional support  
13 with saying that as soon as it's NQF endorsed --  
14 I think your question is, you want more  
15 information about how it does in the NQF. I'm  
16 just trying to translate what I think you're  
17 trying to say.

18 DR. SIDDIQI: Right. Yeah, I think  
19 that if it's still going to go through NQF  
20 submission, it's going to go through a whole  
21 review process, it's going to be tweaked, it may  
22 look very different from what it's being

1 presented today. And I think, for the record, we  
2 should state that we do think that this is a very  
3 important topic. This is a topic where there is  
4 a gap that we do need measures for this topic.

5 But I just think that, looking at  
6 timing, I think next year's MAP will be able to  
7 actually address whether or not to include some  
8 of these measures. And then, of course, staff  
9 would review them at that time and then it  
10 would've gone through the whole NQF endorsement  
11 process.

12 Whereas some of the other measures  
13 were actually on track and through the NQF  
14 process, they were just closer, at least on path.  
15 This one's a little too premature, I think, for  
16 us.

17 MS. LASH: And I think this is in a  
18 similar place as some of the measures not  
19 endorsed that were recommended in the Child Core  
20 Set. So, the development is complete, but there  
21 has not yet been an opportunity to have a  
22 matching endorsement project. Although there

1 might be in the coming year.

2 DR. LESSLER: So, if I could comment.  
3 Actually it's interesting, tomorrow I'm in an all  
4 day meeting in Washington state where we have the  
5 updated Agency Medical Directors' guideline for  
6 opiate prescribing that is being released and  
7 presented in a CMA that has gotten very wide  
8 recognition and utilization.

9 I think this is an extraordinarily  
10 important area to have measurement in and  
11 especially in the Medicaid population. And I  
12 think the idea of going through NQF endorsement  
13 is important.

14 I'm a little bit concerned about these  
15 particular measures. I mean, I think they're  
16 trying to get at the right thing. But, for  
17 example, the 120 milligram equivalent of morphine  
18 -- you know, I think increasingly people are very  
19 unclear what sort of that high dose limit should  
20 be. And it's the kind of thing where I think  
21 people are realizing that it's sort of like  
22 unsafe at any speed. And there are a lot of



1 people who -- I mean, it's not just the people on  
2 120 mil equivalents that are at risk and so  
3 forth.

4 So I really, I mean, I endorse the  
5 concept, I guess, as somebody was saying. But I  
6 do have concerns that these measures are getting  
7 at what really needs to be -- the best way of  
8 getting at what we need to be able to measure  
9 with respect to opiate use.

10 CHAIR PINCUS: So, a couple of points,  
11 maybe to summarize. So, on the one hand, there's  
12 a concern about, are these the ideal measures?  
13 Do we wait for NQF endorsement?

14 The other side of it is that it's kind  
15 of at the same level as some of the child  
16 measures, which were supported, but conditional.  
17 One of the issues that comes up is the process by  
18 which such a measure would be taken up for NQF  
19 endorsement.

20 And it's unclear to me what the --  
21 because NQF starts these endorsement processes  
22 based upon some kind of, I guess, contract from

1 HHS, and so I don't know if -- are any of those  
2 trains going to be running over the next year?

3 MS. LASH: We are expecting to start a  
4 variety of projects. I couldn't say for sure  
5 which would be the best opportunity to review  
6 this measure.

7 CHAIR PINCUS: But I guess one question  
8 is -- Marissa if you want to recommend it --

9 MS. SCHLAIFER: Well, based on -- that  
10 the child first did this yesterday or the day  
11 before yesterday --

12 MS. LASH: Could you use your  
13 microphone?

14 MS. SCHLAIFER: I'm sorry. Based on  
15 the other comment that the other task group did  
16 do this yesterday, then I would recommend that  
17 these move forward. I think I'm reflecting on  
18 some of the conversations that have gone on in  
19 the Coordinating Committee and the discomfort  
20 with the Coordinating Committee by doing that.

21 So, if I don't have to subject that on  
22 top of it, I would recommend that they move

1 forward. I just think --

2 CHAIR PINCUS: So you're --

3 MS. SCHLAIFER: I'm making the  
4 recommendation. I'm changing --

5 CHAIR PINCUS: You're making the  
6 motion?

7 MS. SCHLAIFER: Yes. Based on the fact  
8 that --

9 CHAIR PINCUS: So you're making the  
10 motion. Okay. Is there a second?

11 MS. LASH: Actually, can I pause?  
12 There's actually three measures here. Are you  
13 suggesting conditional support of all three  
14 measures?

15 MS. SCHLAIFER: I've lost it in all my  
16 papers.

17 MS. PATTON: Sarah, can I just ask a  
18 quick question? Sorry. Are there other already  
19 NQF-endorsed measures that get at elements of  
20 this?

21 MS. LASH: I've been searching through  
22 and there's nothing that says opioid or drug

1 abuse.

2 MS. PATTON: Yes. Okay. Thanks.

3 CHAIR PINCUS: There's nothing that's  
4 come up that I know of.

5 MS. PATTON: Okay.

6 MS. LASH: Yeah, I did just search.

7 DR. SIDDIQI: Just to clarify, Sarah.

8 The pediatric concurrent antipsychotic multiple  
9 medication one, wasn't that at least being  
10 submitted through NQF though? It's just  
11 starting? Or is it -- so when it's complete, it  
12 doesn't even mean that it's submitted? I see.

13 So even though we may make the  
14 recommendation, the likeliness of CMS accepting  
15 that one, I think, would be pretty low then,  
16 perhaps. That's just -- okay.

17 CHAIR PINCUS: So, is there a second?

18 DR. SULLIVAN: Second.

19 CHAIR PINCUS: Okay. Any further  
20 discussion? Okay. So do we want to vote on each  
21 of these separately?

22 MS. LASH: I think we should vote on

1       them separately.

2                   CHAIR PINCUS: Okay.

3                   MS. LASH: Could you use your  
4       microphone, Marc?

5                   DR. LEIB: I'd like to make an  
6       amendment to the motion. I have no problem if it  
7       gets NQF endorsement substantially as it's  
8       written, that's one thing. If it's modified  
9       significantly, I think we'd want to re-see the  
10      new measure, or the modified measure, to  
11      determine whether it still answers the questions  
12      we want to know.

13                  MS. LASH: So, we will take individual  
14      votes to conditionally support the measure if it  
15      gains NQF endorsement in its current form without  
16      material changes.

17                  DR. LEIB: Essentially its current  
18      form, yes.

19                  MS. LASH: Yes.

20                  DR. LEIB: If you modify a few words --

21                  MS. LASH: Yeah, I don't mean a few  
22      codes here and there.

1 DR. LEIB: Yes.

2 MS. LASH: Okay. So there are three  
3 measures here. I'll quickly name them. First is  
4 a measure of high dosage opioid use, the  
5 proportion of individuals without cancer who are  
6 on a daily dose of opioids greater than 120  
7 milligram morphine equivalent dose for 90 days or  
8 longer.

9 The second measure will be the  
10 proportion of individuals without cancer  
11 receiving prescriptions for opioids from four or  
12 more prescribers and four or more pharmacies.

13 And the third is the proportion of  
14 individuals without cancer receiving  
15 prescriptions for opioids greater than the  
16 equivalent dose of 120 milligrams and for 90  
17 consecutive days or longer and who are going to  
18 four prescribers and four pharmacies. So it's a  
19 composite of the first two.

20 Show of hands, please, for members in  
21 favor of conditional support for Measure Number 1  
22 of high dosage? That's nine votes, so it passes.

1 Did you vote for it? Then that's ten. Okay.

2 Second measure, multiple prescribers  
3 and multiple pharmacies. Show of hands? Eleven,  
4 Nancy raised hers up at the last minute. That  
5 also passes.

6 And the composite measure of multi-  
7 providers and high dosage. Show of hands?  
8 That's ten. That also passes.

9 CHAIR PINCUS: Are there any other  
10 nominations?

11 MS. LASH: Yes, are there additional  
12 measures on any topic the Task Force members  
13 would like to consider at this time? Anne?

14 MS. COHEN: Two I previously brought up  
15 --

16 CHAIR PINCUS: Mic?

17 MS. LASH: Marc, you'll need to turn  
18 yours off. Marc, off, so Anne can turn on.

19 MS. COHEN: The two I previously  
20 brought up, the all new admissions, readmissions  
21 measures for long-term care and rehab facilities.  
22 I mean, if we're going to consider all admission

1 ones, can we like cover those as a group? I  
2 don't know if we are. I have them if you need  
3 it.

4 CHAIR PINCUS: For Medicaid?

5 MS. COHEN: Oh, never mind. I forgot.  
6 It's the end of the afternoon. Forgive me.  
7 Strike that.

8 MS. LASH: It's unfortunate that  
9 they're not that flexible. Sorry, I'm  
10 editorializing.

11 Any other additional measures?

12 CHAIR PINCUS: But we will include  
13 those in the gap area. Medicaid all-cause  
14 readmission.

15 MS. LASH: Okay, I think we're now at  
16 the point of prioritization. And to finish  
17 defining the universe of the measures supported  
18 that we want to prioritize.

19 Last year, there were two that were  
20 supported: 1799, Medication Management for People  
21 with Asthma, and 0647, Transition Record With  
22 Specified Elements Received by Discharged



1 Patients. Which is very similar to a care  
2 transition measure currently --

3 CHAIR PINCUS: Which was the most  
4 annoying one.

5 MS. LASH: Which we got some negative  
6 feedback on. Especially for that reason, I think  
7 we need to take a vote on whether these should  
8 continue to carry over on the list of measures to  
9 CMS for this annual update.

10 The information on these two is in  
11 your Excel file in the tab titled 2014  
12 Recommendations by MAP. Beverly said it was  
13 difficult to report.

14 CHAIR PINCUS: It was among the least  
15 reported measures and the one that caused the  
16 most consternation amongst state officials  
17 reporting.

18 MS. LASH: Yeah, she recommended a  
19 different type of care transition measure for  
20 which we could not find an appropriate  
21 substitute. Alvia?

22 DR. SIDDIQI: I was just going to say

1 that it looks like, at least if we look in the  
2 past, that CMS, when they added a measure, they  
3 took out a measure. And it's possible that we're  
4 making all these recommendations, that measures  
5 may have to go as well.

6 And I just think that the care  
7 transition measure is one that I would still kind  
8 of recommend that, if CMS was to consider  
9 removing one, that would be one to consider  
10 removing. Because it is such a challenging one  
11 to do, even with hybrid chart reviews and claims  
12 units. It could be very challenging. And not to  
13 add another measure that would be like that, that  
14 would be really challenging to do, again, for  
15 Medicaid patients.

16 The Medication Management for People  
17 with Asthma, I remember serving on this MAP Task  
18 Force last year and really supporting it, but I  
19 do think there's some concerns again about  
20 unintended consequences of picking a measure.  
21 And for this one, some of the literature suggests  
22 that providers may then overly prescribe

1 controlled medications for patients that may even  
2 not have chronic asthma to try and meet this  
3 measure.

4 They're concerned that it was  
5 capturing data that the patient had asthma and  
6 now needs the medication, actually causing  
7 increases in morbidity and sometimes mortality  
8 from improper medication use. So I just think it  
9 is important to think about our measures and what  
10 we're selecting and what we're recommending. So,  
11 I would not recommend either one to be added.

12 MS. LASH: We can take a vote on the  
13 removal of the care transition measure once we're  
14 finished with this aspect of the discussion. Any  
15 other questions or comments on last year's  
16 recommended measures?

17 I will also note that the Medication  
18 Management for People with Asthma is also in the  
19 Child Core Set. So this would be an area of  
20 alignment. And I think that was one of the  
21 reasons the prior group favored it. It's,  
22 essentially, I think --

1 CHAIR PINCUS: If we fail to resupport  
2 it, it just goes away.

3 MS. LASH: It goes away.

4 CHAIR PINCUS: Marissa?

5 MS. SCHLAIFER: I will make a motion  
6 that we resupport the medication management  
7 measure.

8 MS. LASH: All in favor, raise your  
9 hands.

10 CHAIR PINCUS: I'd like to actually see  
11 the --

12 MS. LASH: This is 1799. I'll read the  
13 description since I know not everyone has this  
14 file open. This measures the percentage of  
15 patients 5 to 64 years -- so, in the Adult Core  
16 Set it would be some subset of that -- who are  
17 identified as having persistent asthma and were  
18 dispensed appropriate medications that they  
19 remained on during the treatment period.

20 There are two subrates, the percentage  
21 of patients who remained on a controller  
22 medication for at least 50 percent of their

1 treatment period and the percentage of patients  
2 who remained on the controller for 75 percent of  
3 the treatment period.

4 CHAIR PINCUS: Given the fact that it's  
5 undergoing annual update, that's what it says  
6 here, Marissa, would you consider changing the  
7 recommendation to be conditionally support  
8 pending renewal of this annual update?

9 MS. SCHLAIFER: Definitely.

10 CHAIR PINCUS: Okay.

11 MS. LASH: Are we ready for the vote?

12 All in favor of conditional support pending  
13 completion of the annual update and no  
14 significant changes, please raise your hand.  
15 That's ten and it passes.

16 Now for Measure 0647, Transition  
17 Record with Specified Elements Received by  
18 Discharged Patients. Any discussion? Is there a  
19 motion to renominate the measure?

20 CHAIR PINCUS: I think this is a chart  
21 review.

22 MS. LASH: This requires chart review.

1 And has only three to five states reporting at  
2 this time. Or the similar measure. Okay. I'm  
3 not hearing a motion. We will remove 0647 from  
4 the list of support.

5 MS. SHAHAB: So, just because we voted  
6 on a lot of measures, I just wanted to say the  
7 numbers, the measure number, and then the votes  
8 for the people who aren't in the room as well.  
9 So today we voted on 1932, with nine votes, it  
10 passes. 1927 --

11 CHAIR PINCUS: Can you give the title  
12 also?

13 MS. SHAHAB: I don't have all those.

14 CHAIR PINCUS: Aren't they on there?

15 MS. SHAHAB: So, 1932 is diabetes  
16 screening antipsychotics. 1927, cardiovascular  
17 screening and antipsychotics. And that's seven  
18 votes, so it does pass. 2602, blood pressure  
19 control for persons with serious mental illness.  
20 And seven votes, it does pass. Those are all the  
21 ones that passed. And then the three opiate  
22 ones. But there's a few that did not pass.

1 1799, there was ten votes, which made it pass  
2 with conditional support pending NQF update from  
3 annual review.

4 (Pause.)

5 MS. SHAHAB: So we're all still here.  
6 We're just writing the list of measures to  
7 prioritize in the room. And then the Task Force  
8 will prioritize those accordingly.

9 MS. SCHLAIFER: We haven't talked about  
10 the gap list, about if we have measures to hit  
11 the gap list. Is that going to happen before we  
12 vote? Or is that --

13 MS. LASH: We had planned to take the  
14 prioritization vote and then talk about gaps, but  
15 --

16 CHAIR PINCUS: Do we want people to go  
17 and --

18 MS. LASH: In a moment. We're still  
19 compiling. There was, I believe, a total of nine  
20 measures supported.

21 CHAIR PINCUS: Are you including the  
22 ones from yesterday?

1 MS. LASH: Including yesterday's. And  
2 so we will give folks five votes, six?

3 CHAIR PINCUS: That many?

4 MS. LASH: Four?

5 CHAIR PINCUS: Yeah, four.

6 MS. LASH: Four. Each of you will get  
7 four stickers to indicate your preferences.

8 CHAIR PINCUS: Maybe five. We should  
9 give five out. When you vote, you can use your  
10 five dots for a single measure or spread it  
11 around to five. Or whatever combination in  
12 between. Okay. Everybody let's get up, and then  
13 sit right down to talk about gaps. Okay.

14 (Whereupon, the above-entitled matter  
15 went off the record at 1:46 p.m. and resumed at  
16 1:52 p.m.)

17 CHAIR PINCUS: So, Avlia, we're now  
18 going to take any motions on removing any  
19 measures from the existing set.

20 DR. SIDDIQI: So, I would make a motion  
21 to remove the transition of care record measure  
22 from the Adult Core Set.



1 CHAIR PINCUS: So is there discussion  
2 on that? Dan, did you want to?

3 DR. LESSLER: I would second it.

4 CHAIR PINCUS: You were going to second  
5 it? And can you maybe state more explicitly what  
6 the problem is?

7 DR. SIDDIQI: Sure. So, I think the  
8 problem with that one is, although it's very,  
9 very important, it's extremely challenging to do  
10 in terms of linkages of data. We've talked about  
11 even getting vitals data to link with claims data  
12 is so challenging.

13 So this one really requires multiple  
14 different sites and facilities that you have to  
15 check in with to see if the transition of care  
16 record has actually been received throughout the  
17 process of care coordination. And although it is  
18 important and it is something that I think states  
19 and plans and providers are all striving towards,  
20 and I think maybe even certain health systems  
21 even measure it on their own or they have their  
22 own ways of looking at it, I think from a state

1 perspective, reporting this for Medicaid across  
2 the board for the Adult Core Set is really  
3 challenging.

4 And I think we have so many other  
5 measures that we've recommended, I think it's  
6 time to actually give CMS some feedback about a  
7 measure that we could potentially remove as well.

8 MS. GORHAM: So, Alvia, just for the  
9 record, you're referring to Measure 0648?

10 DR. SIDDIQI: That's correct.

11 MS. LASH: 0647 was recommended last  
12 year, is not in the core set.

13 CHAIR PINCUS: Right.

14 MS. LASH: It's a vote to remove a  
15 similar measure entitled Timely Transmission of  
16 Transition Record, and that is, I believe, 0648.

17 MS. GORHAM: 0648.

18 MS. LASH: So the slide is somewhat  
19 confusing. Just listen to, yes, what Alvia has  
20 just said. Are we ready for the vote?

21 CHAIR PINCUS: All in favor?

22 MS. LASH: Show of hands? That's 11,

1 the motion passes.

2 CHAIR PINCUS: So now we can go on to  
3 gaps. Or do you want to have public comment  
4 first?

5 MS. LASH: It's been a while since we  
6 took comments. It might be prudent to stop here  
7 for a public comment.

8 Operator, could you give the  
9 instructions for anyone on the phone while people  
10 in the room go to the microphone?

11 OPERATOR: And at this time if you  
12 would like to make a public comment, please press  
13 star then the number 1 on your telephone keypad.  
14 And there are no public comments at this time.

15 MS. LASH: Thank you. No one in the  
16 room? Great, we'll move on to prioritizing or in  
17 general refining remaining gap areas in the core  
18 set. Zehra?

19 MS. SHAHAB: So, obviously, MAP has  
20 identified gaps in the measure set so that NQF  
21 and CMS can search for measures in those topic  
22 areas. And this year's recommendations may have

1 changed the landscape of which gaps remain.

2 So, others will need to be carried  
3 over to the next annual review because we don't  
4 have measures on certain topics, such as the  
5 Medicaid funded long-term support services. And  
6 so, from your perspective, you can see this list  
7 of the gap areas here.

8 Access to primary and specialty care.  
9 Beneficiary reported outcomes. Care  
10 coordination. Cultural competency of private  
11 providers. Efficiency. Long-term supports and  
12 services. Maternal health. Promotion of  
13 wellness. Treatment outcomes for behavioral  
14 health conditions and substance abuse disorders.  
15 And workforce.

16 So, those are from last year's gap  
17 list, but we have additional ones that we noted  
18 from this year. And those are the new chronic  
19 opiate use. Polypharmacy. Psychiatric  
20 rehospitalization. All-cause readmission. Home-  
21 and community-based services. Engagement  
22 activation in healthcare. Trauma-informed care.

1 And health-related QOL.

2 So, from your perspective, have any of  
3 the gap areas been satisfied? Are there others  
4 that need to be added? And I'll turn it over the  
5 Harold to lead the discussion of the Task Force.

6 CHAIR PINCUS: So are there any other  
7 -- actually, exactly what Zehra said, anything  
8 that we can remove off the previous list?  
9 Anything that we need to add to either list? And  
10 thirdly, anything that we need to refine to be  
11 more specific about? Anne?

12 MS. COHEN: I would just say, and it  
13 sounds like some of the states are already doing  
14 this, but stratification for at-risk populations  
15 to look for health disparities.

16 CHAIR PINCUS: Okay. Any comments,  
17 thoughts about that? I actually have two  
18 refinements and sort of -- actually, three  
19 refinements to make. Sue, do you want to go?

20 MS. KENDIG: I don't know quite how to  
21 phrase this, but when I look at this list, I  
22 think they're all important. But there are some

1 -- we've talked a lot about the burden on the  
2 states in terms of collecting data.

3 What we haven't talked about is the  
4 burden on the provider in implementing processes  
5 that would actually support appropriate outcomes  
6 in the care coordination piece, the cultural  
7 competency pieces, and so forth. And those are  
8 very important issues.

9 I wonder if there would be a way in  
10 the report to just sort of recognize that when  
11 measures -- that to get the outcomes we want, we  
12 need to recognize that there may be a burden on  
13 providers also and figure out how we are going to  
14 address that. So if that concept could somehow  
15 be included, I think that would be important to  
16 get us all going down the same path. Thank you.

17 CHAIR PINCUS: Other suggestions,  
18 comments, refinements? So I have a couple of  
19 things just in terms of refinements. One is I  
20 think there's a specific issue in terms of the  
21 access issue with regard to access to specialty  
22 behavioral health care. And I think some

1 creative thinking about how to deal with that.

2 We published a paper last year in JAMA  
3 Psychiatry showing that 40 percent of  
4 psychiatrists take no form of insurance. And  
5 it's much more so with regard to Medicaid. And  
6 there are pockets of the country where, more than  
7 half the counties in the country, have no  
8 behavioral health providers. And so I would  
9 suggest that refinement to that one.

10 I think, around care coordination, I  
11 think another refinement there is, again, what I  
12 mentioned earlier today, care coordination  
13 between and among mental health, substance abuse,  
14 and general healthcare as a specific area of  
15 focus for care coordination.

16 And number three is, I might refine  
17 the psychiatric rehospitalization and all-cause  
18 readmission. I think the psychiatric  
19 rehospitalization one is, in a sense, a  
20 subsidiary of all-cause readmission, but also is  
21 different, and we talked about looking at it from  
22 two points of view.

1                   One is for people with psychiatric  
2                   conditions who are hospitalized, people who are  
3                   hospitalized with a psychiatric condition or a  
4                   behavioral health condition, to what extent are  
5                   they rehospitalized within 30 days for that  
6                   condition or for a behavioral health condition?  
7                   And to what extent are they rehospitalized for  
8                   any condition? So it needs to be a bit more  
9                   refined about that. Any comments or --

10                  DR. SIDDIQI: And this will be my last  
11                  comment as I go to catch a cab to the airport.  
12                  So thank you so much for this experience and this  
13                  opportunity.

14                  But I was just going to refine that  
15                  first one. I agree, Harold, that we need to say  
16                  access to primary care, specialty care, and  
17                  behavioral health services or providers. Because  
18                  what's happening is, for example, the opioid  
19                  measure, that looks promising. But the challenge  
20                  with that for providers and plans is, where do  
21                  you want us to send these patients to that have  
22                  these issues with chronic opioid dependence and



1 substance abuse issues?

2 The networks aren't there. A lot of  
3 the plans are being held accountable now to  
4 improve those networks. And so, again, we've  
5 talked about CMS's proposed rules on Medicaid  
6 managed care and trying to improve oversight of  
7 some of the care coordination that takes place.

8 But I do think that's where we need to  
9 find some measures that can actually talk about  
10 access to the network in terms of specialty  
11 network adequacy, but also behavioral health  
12 services and network adequacy there. Because  
13 primary care providers are really struggling with  
14 seeing Medicaid patients with these issues. And  
15 they want to do the right thing, but they're  
16 really struggling. Thank you. Thank you for  
17 this experience.

18 CHAIR PINCUS: And I think we have to  
19 get beyond the carve-out situation and really  
20 sort of instantiate this within the contracts on  
21 both sides of the issue.

22 Other suggestions for additions or

1 refinements? Do you have enough to write this  
2 up?

3 MS. LASH: I think so. The next  
4 question is, are there gaps you want to emphasize  
5 on the very long list of gaps at this point?  
6 Perhaps not, but always being more precise in  
7 this feedback is of benefit to CMS. Marsha?

8 MS. LILLIE-BLANTON: Before we move on  
9 to how to fill it --

10 MS. LASH: Could you get a little  
11 closer to the microphone?

12 MS. LILLIE-BLANTON: Oh, I'm sorry.  
13 Before we move on, I just want to make sure that  
14 that list gets added to that? Okay. It does.

15 CHAIR PINCUS: Any bright ideas?

16 MS. SCHLAIFER: Can I ask a question?  
17 The new chronic opioid use, what exactly was  
18 that?

19 MS. LASH: That's a good reminder for  
20 us. It was a suggestion that came out of a state  
21 presentation on the first day of the meeting  
22 during the Child Task Force that there's sort of

1 a critical period right around 45 days where  
2 someone might have had an orthopedic injury, gets  
3 a short term prescription, and then a 30-day  
4 refill on top of that. And Jeff Schiff from  
5 Minnesota described that they have, I think,  
6 between 30,000 and 40,000 people a year in their  
7 Medicaid program who sort of hit this 45-day  
8 window where they could very easily become long-  
9 term addicted and at risk for later heroin use.

10 So I think that the opioid measures  
11 that PQA brought forward maybe partially address  
12 this issue. But also perhaps not. So it would  
13 be more an early intervention for people who  
14 could go on to have long-term, chronic painkiller  
15 --

16 CHAIR PINCUS: So, anything else that  
17 people want to add? Any other comments? I think  
18 we're done.

19 MS. LASH: We should share, for the  
20 record and for everyone's information, the  
21 results of our prioritization. And then we'll  
22 wrap up.

1 MS. SHAHAB: So, the number one  
2 prioritized measure was the non-NQF-endorsed use  
3 of contraceptive methods by women aged 21 to 44  
4 years. And there were 13 votes for that.

5 Number two, three, and four tied with  
6 nine votes each were the non-NQF-endorsed  
7 Effective Postpartum Contraception Access, 1932  
8 and 1927. They each got nine votes. Sorry,  
9 those were three, four, and five. So, the second  
10 recommended was 2602. And that got 11 votes.

11 MS. LASH: That's Blood Pressure  
12 Control for People with Serious Mental Illness.

13 Okay. We shared these yesterday, but  
14 just to remind you, we're expecting a 30-day  
15 public comment period to begin in early July and  
16 end in early August. Task Force members are  
17 welcome to comment at that point to help refine  
18 the voice of the report, or also to leverage your  
19 larger stakeholder networks in engaging with this  
20 work.

21 At a date in mid- to late August that  
22 we have yet to pin down, the MAP Coordinating

1 Committee will meet to review these  
2 recommendations, the recommendations from the  
3 Child Task Force, and additionally our annual  
4 input to the CMS duals office from another  
5 component of the MAP.

6 The final report on Adult Core Set  
7 recommendations is due to CMS on August 31 and  
8 will be publically available after that point.

9 CHAIR PINCUS: So, I just want to thank  
10 all of you for really your terrific participation  
11 in this. It's been a really good discussions. I  
12 think we all learned a lot. Hopefully CMS has  
13 learned from this and NQF.

14 I want to thank Marsha and the CMS  
15 staff. It's been terrific to have this  
16 partnership evolve as it has. And I especially  
17 want to thank Sarah and the NQF staff. It's just  
18 really remarkable how effective they are in  
19 providing staff support to this incredibly  
20 complicated set of issues that we're dealing  
21 with, weighing so many different issues at the  
22 same time. And somehow we are able to come with

1 a reasonable consensus. So, thank you all for  
2 that.

3 MS. LASH: And thank you to our Chair.  
4 Travel safe, everyone.

5 (Whereupon, the above-entitled matter  
6 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

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Task Force

Before: NQF

Date: 06-11-2015

Place: Washington, D.C.

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