NATIONAL QUALITY FORUM

+ + + + +

MEDICAID INNOVATION ACCELERATOR PROJECT
TECHNICAL EXPERT PANEL IN-PERSON MEETING

+ + + + +

TUESDAY
APRIL 18, 2017

+ + + + +

The Technical Expert Panels met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 9:00 a.m., Andrea Gelzer, Maureen Hennessey, Barbara McCann and Sheryl Ryan, TEP Chairs, presiding.

PRESENT:
ANDREA GELZER, MD, MS, FACP, Senior Vice President and Corporate Chief Medical Officer, AmeriHealth Caritas Family of Companies, BCN Technical Expert Panel Chair
MAUREEN HENNESSEY, PhD, CPCC, Senior Vice President and Director, Quality and Population Health Solutions, Precision Advisors, PMH Technical Expert Panel Chair
BARBARA McCANN, BSW, MA, Chief Industry Officer, Interim HealthCare, Inc., LTSS Technical Expert Panel Chair
SHERYL RYAN, MD, FAAP, Professor of Pediatrics, Chief Section of Adolescent Medicine, Department of Pediatrics, Yale School of Medicine, SUD Technical Expert Panel Chair
CHRISTINA ANDREWS, PhD, Assistant Professor, University of South Carolina
RICHARD BROWN, MD, MPH, Professor, University of Wisconsin School of Medicine and Public Health

JAMES BUSH, MD, FACP, State Medicaid Medical Officer, Wyoming Office of Health Care Financing
DAN CULICA, MD, PhD, Senior Research Specialist, Texas Health and Human Services Commission
CAMILLE DOBSON, MPA, CPHQ, Deputy Executive Director, National Association of States United for Aging and Disabilities (Non-voting)
ANGELA KIMBALL, National Director, Advocacy & Public Policy, National Alliance on Mental Illness
VIRNA LITTLE, PsyD, LCSW-r, MBA, CCM, SAP, Senior Vice President, The Institute for Family Health
DAVID MANCUSO, PhD, Director, Washington State Department of Social and Health Services
DENNIS McCARTY, PhD, Professor of Public Health, Oregon Health & Science University
DIANE McCOMB, MSEd, Aging and Disability Lead, Delmarva Foundation
DAVID MOSKOWITZ, MD, MAS, Medical Director, Hope Center, Alameda Health System
JUDIT OLAH, PhD, MS, Quality Improvement Coordinator, UCHealth
ROBERT SCHREIBER, MD, Medical Director, Hebrew SeniorLife
JAMES SCHUSTER, MD, MBA, Chief Medical Officer, Medicaid and Behavioral Services, UPMC Insurance Division
HOWARD SHAPS, MD, MBA, WellCare Health Plans, Inc.
JANICE TUFTE, Engaged Patient
TIFFANY WEDLAKE, MD, MPH, Physician Advisor HealthChoice, Maryland Department of Health and Mental Hygiene
LYNDA ZELLER, MA, Deputy Director, Behavioral Health and Developmental Disabilities Administration, Michigan Department of Community Health (Non-voting)

NQF STAFF:

KATE BUCHANAN, Project Manager
SHACONNA GORHAM, MS, PMP, Senior Project Manager
ANN HAMMERSMITH, JD, General Counsel
MIRANDA KUWAHARA, MPH, Project Analyst
TARA MURPHY, Project Manager

ELISA MUTHALI, MPH, Vice President, Quality Measurement

MARGARET (PEG) TERRY, PhD, MS, RN, Senior Director

MARCIA WILSON, PhD, MBA, Senior Vice President, Quality Measurement

ALSO PRESENT:

KAREN LLANOS, MBA, Director, Medicaid Innovation Accelerator Program, Center for Medicaid and CHIP Services

*** present by teleconference**

CONTENTS

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

9:08 a.m.

DR. TERRY: Hello everybody. If you could just take your seats, and we're actually going to get started.

So good morning, everybody. My name is Peg Terry, and I'm the senior director on this project, and I want to welcome everybody and thank you for joining us today as we begin our deliberations and recommendations for measures in these four program areas.

I also want to thank the public and members who are actually in the room or on the phone for joining us as well. Before I turn it over to the chairs, I just want to talk about what I call the housekeeping issues that we all need to know.

In case you don't know, the bathrooms are out here and down the hall to the right. If you would put your phones on mute, and if you need to take a call, please step out of the room to do that.

We have login information here. I'm sure everybody's probably logged in by now, but we have it over here if you need any help. And we have people on site who can help you if you're having any difficulties.

We will have breakfast and lunch each day. So if you've not been in an NQF meeting, we use tents here to indicate we want to say something. And we put our name tent up and you'll be recognized, as well as when you finish -- and you'll have to put your speaker on. And when you finish, please turn that off.

We can only have three speakers on at the same time, just so you know that. And with that, I think those are the basic housekeeping, and there's staff here, if you have any other questions, you can ask them. So thank you.

So now I'm going to turn it over. And Maureen, do you want to -- and the chairs are going to introduce themselves and make a few comments. Yeah, why don't we start with Barbara, I'm sorry. We'll go that way. Sorry, Barbara.

CHAIR McCANN: Good morning. I'm Barbara McCann. I am a social worker by training, and also a provider of the services LTSS in a number of states. I think I have one remark to make. We are at the beginning of a journey, and it is very, very tough to remember that sometimes.

I had the privilege of working on the OASIS measures, which is the standardized data set for home health. We began when my son was five. The day that this report is turned in, he will be 33. And we are still working on OASIS.

But I have heard your enthusiasm this morning and your passion, and that's the beginning of creating measures. And it's my privilege to be here. Thank you.

CHAIR HENNESSEY: Good morning, my name's Maureen Hennessey, and I'm a senior VP and director of quality and population health services with Precision Advisors. I have actually worked in the health and behavioral health field integrating the two for probably

about 30 years now.

I have a doctorate in clinical community psychology and have done a great deal of work with Medicaid consumers, both clinically and also from an administrative perspective, in terms of managing health plans.

And one of the observations I would say is that all of us, I think, who work with individuals with severe and persistent mental illness experience that integration of physical health into the care or with the care of individuals who are living with serious and persistent mental illness has long been overlooked, and at great cost from a perspective of morbidity and mortality.

And I think this is a great opportunity for us to look at those measures that can potentially help provide us with some additional milestones, if you will, to begin to better integrate that care. So I'm looking forward to our conversations the next few days. Thanks.

CHAIR GELZER: Good morning, I'm Andrea Gelzer, and I'm chairing the high costs, conflicts needs group. And I'm an internist by training, and also an informaticist.

And I'm corporate chief medical officer for the AmeriHealth Caritas family of companies. We do Medicaid -- primarily Medicaid-managed care -- in a number of states.

And just as my two predecessors have stated, I'm honored to be here, and this is tremendously important work. I worked on the CORE Collaborative consensus -- I guess -- work that's been going on primarily with commercial payers on core measure sets.

And this to me is parallel work for Medicaid, and it's so important to ensure that at least the existing measures we have actually -- as we move to value-based payment, actually do move the quality curve so we get the intended outcomes that we want for these very complex individuals.

So I'm very excited to be here, thank

you.

CHAIR RYAN: Good morning, my name is Sheryl Ryan and I am a pediatrician by training, and a specialist in adolescent medicine. And I am a professor of pediatrics at Yale in the medical school.

I come from the perspective of being in the trenches, working in clinical medicine, teaching medical students and residents. And I'm the head of the Substance Use Disorder Task Force here.

I would say one of the other hats I wear is that I'm also representing the American Academy of Pediatrics. We have a committee on substance use and prevention, and I'm the chair of that committee. And through the American Academy, we try to reach the 65,000 pediatricians who are seeing the kids.

And I think we recognize that many of our substance abuse disorders start in adolescence. It's hard to get our pediatricians to see that there's something that they can do,

either prevention -- and we're trying to move them also to think about what to do with intervention.

And I think that's one of the major sort of challenges that we see in our pediatric provider population. So I'm honored to be here, and hope to bring my expertise, but also hope to bring back what I've learned here to our Academy. Thank you.

MS. GORHAM: Good morning, my name is Shaconna Gorham, and I just want to say welcome, thank you for coming.

MS. KUWAHARA: Hi there, everyone, my name is Miranda Kuwahara. I'm the project analyst on this project, and I'm really excited for the discussions today and tomorrow.

MS. BUCHANAN: Hi all, my name is Kate Buchanan, I'm a project manager here. And it's wonderful to put all of these faces and names together. Thank you.

MS. MURPHY: Good morning, everyone, I'm Tara Murphy. Happy to see all of you here

today.

MEMBER DOBSON: Hi, good morning. Camille Dobson. I'm a new face, invited by NQF to be a non-voting member of the LTSS TEP.

I represent -- I'm the deputy executive director for the Aging and Disability State Agency Membership Association. And our members deliver LTSS to Medicaid beneficiaries. And so I'm here to bring a state perspective about the challenges to measure development for LTSS consumers.

DR. WILSON: And before we continue with the introductions, if I may, my name's Marcia Wilson, I'm senior vice-president here at National Quality Forum.

And what we'd like to do is combine introductions with the disclosure of interest. And it's something that we always do here at NQF.

So before we go any further, let me talk about the disclosure of interest process, which is before you were seated on this committee, you filled out a form, a disclosure of

interest, probably quite lengthy -- more lengthy than you would have wanted.

But today we do oral disclosures of interest. And we are not asking you to summarize your resume. But what we are asking you to disclose is any work that you do that is relevant to those issues that are before the Committee today. And it could be paid work. It could also be volunteer work, sitting on an expert panel.

And we do this oral disclosure in the spirit of transparency, and also a way of introducing ourselves to each other. Just because you disclose something, it does not mean you have a conflict. So let me be perfectly clear about that.

So what we're going to do is we will continue with the introductions, and I would ask you to state your name, your affiliation, and then if you have anything to disclose. If there's any question in your mind, please feel free to bring something up, and we can always evaluate that in real time.

So I'm going to ask our chairs to reintroduce themselves to incorporate that disclosure. So Barbara, if I may start with you. And then we'll just go around the room and finish up with the introductions. Thank you.

CHAIR McCANN: Yes, I work with Interim HealthCare, that is a provider of Medicaid services in 41 states. And I also chair the Quality Committee on the Medicaid State Partnership with a number of groups including Managed Care.

CHAIR HENNESSEY: Good morning, my name is Maureen Hennessey, and I am SVP and director for quality and population health solutions with Precision Advisors. We provide consultation to life science and pharmaceutical manufacturers.

CHAIR GELZER: Good morning again. Andrea Gelzer, AmeriHealth Caritas. I have no other disclosures.

CHAIR RYAN: Hi, Sheryl Ryan. My main is representing the American Academy, Committee

on Substance Use Prevention. That Committee mainly works to develop clinical guidelines, policy statements, and technical reports in the area of substance use and prevention.

DR. WILSON: Thank you. And Camille, if you wouldn't mind just letting us know if you have any disclosures please.

MEMBER DOBSON: Well, NASUAD is a sponsor of the National Core Indicators for Aging and Disabilities, which is a consumer quality of life survey that is deployed for older adults and persons with disabilities. And in my role at NASUAD, I've served on several NCQA accreditation advisory committees.

DR. WILSON: Thank you. Yes, and next, go ahead and turn on your mic, introduce yourself. There's a button on the right. There you go.

MEMBER CULICA: Good morning, everyone. My name is Dan Culica, I'm with the beneficiaries of high needs and high costs group. I work for the state of Texas Health and Human

Services. We have a quality oversight unit there that -- I will call it a think tank of designing the quality strategy for the state of Texas.

And the program, it's also affiliated with the Medicaid program. And we have been fortunate last year to be one of the five states that had one of the CMS pilot projects on beneficiaries of high costs and high needs.

And one of the elements that we are trying to do in Texas is to develop the value-based payment reform with the managed care companies and also with the hospitals.

And one of the things that we did for several years -- actually going into including into the context with the managed care companies -- is for each one of them to have a project on what we call the super-utilizers, which are the beneficiaries with high cost and high needs.

So it's of main interest for us to be -- for me to be present at this meeting and be part of this national effort. Thank you.

DR. WILSON: Thank you.

MEMBER BROWN: Good morning, my name is Rich Brown, I'm a professor of family medicine with the University of Wisconsin School of Medicine and Public Health, and also CEO of a spinoff named Wellsys.

And what I mainly do with both of those positions is help general health care settings, hire coaches, and systematically screen and intervene for a variety of behavioral risks and disorders responsible for lots of mortality, morbidity, and costs.

I also am participating on various steering committees and do speaking and consulting, mainly for a variety of organizations that have federal funding to improve health services.

DR. WILSON: Thank you.

MEMBER SHAPS: Hi, good morning, my name is Howard Shaps, I'm the state medical director for WellCare Health Plans in Kentucky. I'm on the complex care needs panel as well. My main -- as WellCare is primarily a government-

sponsored managed care organization serving Medicaid and Medicare beneficiaries in Kentucky, we serve about 440,000 Medicaid lives, and I spend the majority of my day trying to work with my teams to improve quality outcomes and cost outcomes for Medicaid beneficiaries with high cost and complex needs. So thanks for having me, I appreciate it.

DR. WILSON: Thank you.

MEMBER McCOMB: Good morning, my name is Diane McComb. I work with the Delmarva Foundation, which is a quality improvement-like organization. And we do work nationally in external quality review, utilization management, disability, quality improvement work.

I also work with the American Network of Community Options and Resources, which is a national association of community organizations supporting people with disabilities throughout the lifespan. And I'm the liaison with the state associations in that organization.

My passion is following the

development of metrics in the social determinants of health and wellbeing.

Younger people with disabilities have perhaps different needs than elders in our system, and they are in fact a large part of our Medicaid and Medicare population. And I'm very passionate about looking for metrics that might define quality in their terms. I'm very glad to be here.

DR. TERRY: Tiffany.

MEMBER WEDLAKE: Good morning, I'm Tiffany Wedlake. I'm the medical director for Maryland's Medicaid Managed Care, and I'm here as part of the reducing substance use disorder workgroup.

I've been chairing the effort that's going on in the state of Maryland on tackling our opioid overdose crisis and creating the policies that Maryland's implementing right now around that.

I'm also a clinical provider in the substance use disorder realm, and I mostly do

buprenorphine in a primary care setting. I do rather primary care work, and it's all inner city Baltimore.

MEMBER McCARTY: Hi, I'm Dennis McCarty. I'm at Oregon Health and Science University and a professor in the Oregon Health and Science University, Portland State University School of Public Health.

I currently have an award from the National Institute on Drug Abuse to study the impacts of healthcare reforms in Oregon on treatment for alcohol and drug use disorders.

And in that process, am testing the applicability of the American Society of Addiction Medicine's performance standards on the healthcare systems in Oregon. And I served as a member of the steering committee for ASAM in the development of those performance standards.

MEMBER ANDREWS: Hello, my name is Christina Andrews, and I'm an assistant professor at the University of South Carolina.

I also have an award from the National

Institute on Drug Abuse to look at Medicaid Health Homes, with a particular focus on the different strategies that these health homes are using to identify and treat substance abuse, as well as the impact of treatment on use of acute care and costs related to that.

In addition, I also do some consulting with the State of South Carolina Division of Alcoholism and Other Drug Abuse Services related to their response to the opioid epidemic.

MEMBER ZELLER: Good morning, Lynda Zeller. I'm here as part of the Innovation Accelerator Project too, related to substance use disorder. My role in Michigan is the state commissioner for substance abuse prevention treatment, mental health, intellectual developmental disabilities.

And the system includes services to children with serious emotional disturbances, and addictions as well. In terms of disclosing other roles, I'll volunteer I'm a board member of the National Association of State Mental Health

Program Directors, which is the association that represents state authorities.

The National Research Institute, board member there, trying to provide unbiased, results-oriented, data-driven information to improve state performance in these areas.

And then finally, I'm a board member of the Council of State Governments Justice Center, which has a particular focus right now on diverting persons with serious mental illness in particular, but also addictions, out of state corrections systems.

MEMBER LITTLE: Hi, good morning, I'm Virna Little. A couple of different roles. I'm with the Institute for Family Health as a senior manager, which is a large, federally qualified health center integrated care system in New York.

We also own and operate a Medicaid Health Home, as well as provide integrated services for the underserved there. I also do integrated care consulting work for the National Council for Community Behavioral Health

Providers, as well as the AIMS Center out of the University of Washington.

Do some independent consulting for federally qualified health centers around the country building sustainable integrated behavioral health systems.

And I'm also the board chair of ACU, Association for Clinicians of the Underserved, representing clinicians of all disciplines caring for the underserved.

And co-founder of Concert Health, which is an organization providing behavioral, telephonic behavioral health services to the Medicare population. Thank you.

MEMBER MANCUSO: Good morning, I'm David Mancuso. I'm an economist by training, and I'm the director of the Washington State Department of Social and Health Services Research Division.

We have a wide portfolio of performance measurement related projects across the spectrum of the Medicaid programs and other

social service programs, including development based on adult quality measurement and CHIPRA-related CMS projects.

I moonlight occasionally as partner of an LLC called Spectrum Informatics that focuses on primitive modeling and clinical decision support, as opposed to performance measurement.

MEMBER TUFTE: Thank you for having us. I'm Janice Tufte, and I identify as a patient partner engaged in research. I was a patient co-investigator in a project addressing the social determinants of health through a liaison project at Group Health Research Institute, which is now Kaiser Research Institute.

And I serve many roles. So just to name a few, I serve on Title XIX for the state, and the advisory committee, and I serve on a TEP for the IAP, SUD, and BCN with Mathematica for the three years, so I'm fully aware of the domains LTSS I'm not on for the development of.

And also NCQA for a dual behavioral

health concern. And I, what else? I'm on the American Academy of -- ACP, American Academy of Physicians. I'm serving this year as a public member on the Guidelines Committee.

So I can go on, but there's quite a few. So nothing is a COI, I believe, and I'm honored to be here. Thank you.

MEMBER SCHUSTER: I'm James Schuster. I also really appreciate the chance to be here, and impressed by the group, and happy to be able to spend a couple days with you all.

I'm a psychiatrist by background, from Pittsburgh. I'm a clinical professor in the Department of Psychiatry in Pittsburgh, and also serve as the chief medical officer of three not-for-profit insurance entities that are part of UPMC.

One's focused on behavioral health services, one's focused on physical health services for individuals with Medicaid, and the third's a forthcoming product focused on MLTSS.

And in terms of external funds, I've

mainly, I think probably the only significant one is I've been the lead investigator on a couple of PCORI-funded projects focused on engagement of individuals with a serious mental illness, especially around physical health and wellness issues. So thanks.

MEMBER SCHREIBER: My name's Rob Schreiber, I'm a geriatrician internist. I was previously the chief medical officer at Hebrew SeniorLife in Boston, Massachusetts. And I've been involved with really trying to integrate community-based programs and services on LTSS in the care of older adults.

But in particular, older adults that have health inequities or, you know, are in specifically poverty areas that are forgotten.

There's the Healthy Living Center of Excellence. I'm the medical director, which is really working to develop evidence-based programs in communities and really targeting those with health inequities in Medicaid populations to really help individuals change health behaviors

that go along with social determinants of health, and trying to integrate that into healthcare systems.

Massachusetts is where I'm from. I'm part of Hebrew SeniorLife. And I work also at Harvard Medical School, I'm a clinical instructor. And really trying to change the approach, but it's been very, very challenging. So I really appreciate the opportunity to be part of LTSS.

I've been working with LTSS for 33 years. We're getting closer to integrating it. And in the state Medicaid, we now have an accountable care organization where LTSS is going to not only be recognized along with behavioral health, but also paid for.

So the LTSS providers that will be going in with the state will actually be at-risk, and they have developed measures. But I think the measures that will be coming out of this group will be very influential in helping steer the boat differently, because they sort of made

them up on the fly.

So I'll be very interested to see what we come up with and what they're using. But I'm really honored to be here and thank you for having me.

MEMBER KIMBALL: Hello, thank you. I'm new to NQF, I'm on the TEP for physical and mental health integration. My name is Angela Kimball, I'm the national director of advocacy and public policy for NAMI, the National Alliance on Mental Illness.

So I'm here representing a patient perspective, advocacy perspective. And prior to working at NAMI, I did spend three years in my home state of Oregon, so I'm delighted to see a fellow Oregonian across the way here.

As Oregon embarked on its Medicaid integration of health, mental health, dental, and substance use disorders, and I'm very interested in the integration efforts here. Thank you.

MEMBER OLAH: Good morning, I'm Judit Olah. And thank you for the opportunity to

support this work. I am currently with the University of Colorado Health transformation and information and innovation department, which is a cross-functional department supporting population health and primary care transformation.

And in terms of outside awards, we are currently recipients of the Comprehensive Primary Care Transformation Award coming out of CMS.

Before healthcare, I was a full-time academic at CUNY, the City University of New York, Queen's College. And I continue to teach at the graduate level at Regis University in the Healthcare Administration program currently. Thank you.

MEMBER BUSH: My name is Jim Bush, and for many years, I was in private, solo practice with internal medicine. Ten years ago, I became Wyoming's Medicaid medical director. Wyoming is a 100 percent fee-for-service state, so there is no managed care there.

However, I've been sort of tasked with developing our high-value care model, the first

step of which was developing our Patient-Centered Medical Home Program, which is now statewide and has over half the primary care physicians in the state. Our second phase was the development of our Superutilizer Program in the State of Wyoming.

We're now in phase two out of three. Our final step will be developing regional care organizations around that. So we've been very involved in how do we align our quality measures between meaningful use, our PCMH program, and then our medical neighborhoods.

Other potential activities with the American College of Physicians, I've been on the National Health and Public Policy Committee, as well as their Coding Committee. And for the Medicaid Medical Directors Network, I'm on their executive committee.

MEMBER MOSKOWITZ: Hi, my name's Dave Moskowitz. I'm a medical director at Alameda Health System, which is the public hospital system serving Oakland, California and

surrounding areas in Alameda County.

I'm in charge of implementing and overseeing our complex care management program serving super-utilizers, as well as a primary care physician proving care for a large number of those patients.

In California, we are implementing our Medicaid 1115 waiver, which has several large components that bear directly on the high cost, high risk patients. And so I'm seeing sort of the interface and interplay of the various measures and measurement requirements for these programs at sort of the implementation level.

MS. LLANOS: Good morning, everyone, my name is Karen Llanos. I'm the director of the Medicaid Innovation Accelerator Program at the Center for Medicaid and CHIP Services at CMS. And I'm very happy that you are all here, and to be working with the National Quality Forum.

MS. HAMMERSMITH: Okay, I would just remind everyone that you do sit on this committee as an individual, you do not represent your

employer or anyone who might have nominated you.

If at any time you feel like you have a conflict of interest, or someone else has a conflict of interest or is acting in a biased manner, please bring that up in real time. You can approach any of your chairs. You can certainly approach any of the NQF staff.

What we don't want you to do is just sit in silence if you think there is a potential conflict of interest. So having heard my remarks and having heard from each other, does anyone have any questions at this time?

All right, thank you so much, and Peg do I turn it -- I want to introduce Elisa. Pardon me, just stabbed you with my hand.

DR. MUNTHALI: Good morning and welcome, my name is Elisa Munthali, and I'm vice-president for quality measurement. Thank you for being here.

MS. HAMMERSMITH: And Peg, do I turn it over to Karen for comments, or is Barbara going to cover meeting objectives?

MS. BUCHANAN: Hi Peg, so Barbara's going to take us through the meeting objectives and the agenda. So Barbara, if you just want to say next, we'll move forward.

CHAIR McCANN: I ask you to look at the meeting objectives carefully. Look at the verbs. Reducing, improving, promoting, supporting. So we're looking at measures I am honored to be with you as we initiate accountability for populations who have not had a voice, if ever. And that's the work before us.

And to also understand that the recommendations that we put forward today are for the states to take the next step and for them to utilize. Next, please.

The agenda, we've had a good introduction, but we will go forward with understanding CMS's goal today as we begin. But also to spend the majority of our time actually looking at the measures and reaching recommendations. Next, please.

Please note the purple arrow. We are

at the beginning of this process. There is ongoing plans for public input, comment, and review. And there will be many more opportunities for you to read many more pages of information as we go forward over the next several months. Next, please.

With that, it's my privilege to ask Ms. Llanos to please present your perspectives from CMS.

MS. LLANOS: Thank you, Barbara. So I am very excited to give you some good context about this. And I know that many of you have been on some of the prep calls, so some of this might be a reminder.

But I've been working on this program for three years, and context is always helpful for me, particularly when there's a lot of work going on in similar topic areas. Next, please.

Before I describe our program at large, I just want to take a moment and thank you all for coming and focusing your attention over the next two days on this work, and certainly to

our National Quality Forum partners, who this work could not happen with.

And I'll give a small shout-out to Beverly Lofton, who's our contracting officer and is on this team as well. This work couldn't happen without her.

So how does this work fit into our Center for Medicaid and CHIP Services? Let me start there and then work my way down. So the Medicaid Innovation Accelerator Program, or IAP, we use a lot acronyms as you'll hear over the next couple of days. The program sits in the office of the center director at CMCS, which is our acronym.

However, we are an innovation center-funded model. Our intent is to test the most effective way of providing technical assistance to state Medicaid agencies, with the ultimate goal of moving states towards their Medicaid delivery system reform efforts. That takes a bunch of different ways, as you can imagine.

It's a four-year commitment by our

agency to build states' capacity, our own capacity, and to support ongoing innovation. Tons of innovation has been happening across the states way before there was even the inkling of an IAP program.

So this is to support and to facilitate that work, and to make sure that Medicaid has a role and a spotlight in the broad delivery system reforms that are happening across the country.

We cannot give states grant funding because this is all around technical assistance. And for this particular work, it's around tools and resources for state Medicaid agencies. Next slide.

So this is our big visual, this is the way to think about how we visualize IAP. So there, certainly the top of our structure is the ultimate goal, which is to support state Medicaid delivery system reform.

We have things called program areas, or areas of focus, and those are contained in the

areas that you're going to be thinking about today as well as it relates to quality measures.

But within each of these different buckets or areas, there is a whole range of other activities going on. We're working with states and learning collaboratives, in one-on-one technical support activities that range from six to twelve to sometimes longer in trying to put activities or promote activities across these different areas.

So I'll talk about our quality measurement portfolio, but just know that when we use these terms or these populations, as Barbara said, there's a bunch of other activities that flow within that.

We identified these areas through a multi-stakeholder state listening sessions with our stakeholders. That happened before we launched our IAP program, so this is reflective of the big struggles and challenges in terms of how our states think about and how we think about the areas that we can target to improve.

So we could pick one of these areas for four years and make a small dent. We're trying to pick multiple areas across a variety of different dimensions, so this is the exciting part of this work.

So improving care for beneficiaries with complex care needs or super-utilizers, promoting community base or community integration through long-term services and supports, supporting physical and mental health integration and reducing substance use disorders.

Within that, we know that there are different delivery system reform levers. So in order to do good work or to move states within those areas, states and ourselves need to know what the data are around that.

So we have a whole other portfolio around data analytics. Quality measurement, this is where this work falls in. We need better measures, we need to help our states understand which measures are available, performance improvement or improvement science. And then

finally, how do you pay for the change that's happening? Next slide.

So this is just recap of there, just to emphasize again there's a variety of different ways that we're working with states across these areas for the focus of this work. It's around the quality measurement portfolio. Next slide.

So our quality measurement portfolio within IAP has four big buckets, and I bolded the work that we have with the National Quality Forum. The first area, as a few of our Technical Expert Panel members have alluded to, is quality measurement development.

That's not the goal of this particular work, but we have a contract with Mathematica Policy Research on beating some critical needs across those different four program areas.

So where there's nothing, or where there's some good measures, what can we develop de novo or refine and put out there for our states and stakeholders to use?

So measurement development falls under

that other bucket. We also know that there are existing measures out there that are NQF-endorsed, or that our state partners use or that health plans use. And we want to get our hands around it.

We want to better understand what that universe looks like. Is it small, is it large? Within our different program areas, what could a state use tomorrow if it had to? And we are often faced with that question here at CMCS, and I'm sure our state partners are as well, right.

We're doing a health program on physical mental health integration. How do we measure that, where do we start? We don't want to keep reinventing the wheel, and we want to help our state partners not have to reinvent the wheel, and have a starting point where they can kind of pull out and point to.

It might not be everything that they use, it could be just a few things. But that's the purpose of what we want to produce as part of this work.

Our third area is what are some challenging measurement issues. And we're working with another portion of Mathematica Policy Research on that to help us understand how does one set benchmarking targets, how does one think about small numbers issues. So those are the types of issues that are happening as part of that.

And then the fourth area is how can we push everything that we're learning, whether it's individual with states, or as part of our other areas, to states. Because that's the ultimate goal.

So that's our project, and that's how this particular activity fits in. So let me just put a couple of grounding points of view forward. You can move it.

So what do we want at the end of this? And I started, I think, alluding to some of this. A listing or a set of measures across those different four program areas that reflect a variety of different quality domains across our

program areas. And we use the CMS measurement quality domains, and that's in the next slide.

Ultimately, we want the listing of measures, the sets of measures, to be really applicable to state Medicaid agencies. That's our ultimate target audience for this. Again, what measures can be used tomorrow, understanding that we picked the hardest populations, and there might not be a perfect one-to-one?

But what can there be out there, what is existing out there, that states can take and use, understanding there's development efforts and understanding there are good concepts that still need to be developed?

And then how can we align, and how can we reflect input from a wide range of stakeholders and perspectives? And I'll say this is a hard one, right. This is the reason why we partner with National Quality Forum.

We could research and pull these together, but we want your smart thinking on this, particularly because as you just heard,

your fellow TEP members reflect a variety of different perspectives much larger than Beverly or I at CMS.

So we want broad input, the state perspective, the researcher perspective, developer perspective all in there to make this really robust and a good product that states can use. And then I already mentioned alignment. Next slide.

So I mentioned the quality measurement domain. This is how we think about our organizing framework across all of our measurement development activities at the agency, and I thought it would just be helpful to emphasize it here.

And it's supposed to hit every part of a person's health or the healthcare continuum: access, clinical care, care coordination, safety, patient-caregiver experiences, prevention, population health.

Again, I am realistic about the fact that we may not hit all of these within each of

the populations, but let's be thinking about that as you think about the measures that are already out there.

And then my final slide, next please, what will we do with this. And I'm sure that's a big question that you all have. So our ultimate audience is states, whether they are or are not participating in IAP.

As I said, ultimately, we're working with more than half of the states, and we have reached all states as part of different IAP activities. So all states are IAP states. Who will have access to the measure sets? We want to push this information out and post it online so states, interested stakeholders will all have access to this, and ourselves as well, at CMCS.

How can states use these measure listings? It's a resource or a tool, it's not part of a requirement. As you can imagine, some of these measures might already be baked into other measurement activities at CMS, like the Health Plans Core Set or the Medicaid Adult Core

Set or Children's Core Set. Or maybe some of the 1115 efforts as well.

So we already know there's going to be some natural overlap, but we want this to be a resource for states to take and use.

And then finally, how does this project differ from other federal measurement sets? Again, it's not part of a requirement, there's no payment, so it's different. But we want to align where relevant with other measurement sets.

And then I can't emphasize this enough, we just want this to be a helpful tool for states and for our staff at CMCS.

So that's my big overview. Hopefully, that connected some of the dots that you might have. And I think my next slide is just questions if you have any.

CHAIR RYAN: Anybody have any questions, or is there any discussion? I think we're supposed to -- yeah? Oh, okay. How do you want us to, did you say you want us to put the --

put your -- if I could just ask for -- okay, but I do see Jim, you had a question there.

MEMBER SCHUSTER: Thanks. I know one question that often comes up these days looking at quality measures is pulling information only from claims data, versus trying to get extracts from electronic records.

Just personally, it always feels like kind of a little bit of a shot in the dark to depend on information from electronic records. But different organizations have different approaches to that. And I was just wondering if you all had kind of an approach, a philosophy. Like, is that a good thing, are you trying to stay away from it, or not?

CHAIR RYAN: Do you want to respond to that, Andrea?

CHAIR GELZER: Sure. I don't know why I'm blinking, but I'm blinking.

I will tell you from the NQF perspective as I know it, and NQF should pile on, but I've been on the Cost and Resource Use

Committee and a number of other committees.

And as we look at measures from a technical perspective, one of the things we always are now looking at is the availability of those measures and the ease of collecting those measures electronically.

So I think, you know, what you say is absolutely right. You know, you have to wonder about the veracity of the information you're getting. It may be easy to collect, but is it right or is it wrong? But certainly we want to move in that direction, and I believe that would be the path we're all on.

MS. LLANOS: Yeah, I'll just add from a CMS perspective, certainly the states' ability to collect and availability of the data plays a huge a role in the data source. So just keep that in mind, and I would rely on your state representatives on the panels to give you some insights on what some generalizations are on data sources.

CHAIR RYAN: Thank you. Rich, I think

you had the next question.

MEMBER BROWN: It's blink -- oh, there we go. As folks have said, these four areas of healthcare have long been sort of pushed aside. So quality metric development really is not as mature as in other areas.

So I'm wondering if we feel that there are not sufficient validated metrics out there to recommend. Is it our role to also recommend measurement concepts for states to develop metrics from, or do we just stick with validated measures?

MS. LLANOS: That's a great question. So I can kick it off. I will say, I think because we have a development contract underway looking at those exact areas and identifying concepts, it's okay to have a shorter list.

I would say I think that, I give our NQF colleagues the 80/20 rule. Be nice to have 80 percent of the recommendations from each set focused on measures that states could use tomorrow, and 20 percent that gives a nod to

concepts.

But just acknowledging that I think across our different activities across CMS, we are working on identifying concepts already.

DR. TERRY: I don't have anything to add to that. But one thing, we are in measure concepts, some of them are undergoing testing. We know that, and those are certainly rise to the top for measure concepts that are undergoing testing right now, especially in the Medicaid population.

If there's no other questions, I can probably move to the next slide. Andrea, thank you.

CHAIR GELZER: I think the next slide, yup. So the goals have really been stated already, and I'm just going to reiterate.

We're trying to identify measure sets related to the four identified areas: substance use disorders, individuals with complex care needs and high costs, community-based long-term services and supports, community integration, and

supporting behavioral health-physical health integration.

And the measure sets are to support states' ongoing efforts to move to delivery system reform and value-based care.

The measure sets should include measures that can be implemented immediately, so existing measure sets that represent the full continuum of care, and all those areas from access to care coordination that are on CMS's list.

And this ends up being a voluntary process, so we are making recommendations. CMS hopefully will codify those recommendations. But it is, at the end of the day, it's up to the states to make the decision as to whether they will implement.

But I honestly believe they will, because they're looking for good information, and there are lots of powerful brains in this room. So I hope we will come up to land in a rational place.

DR. TERRY: Thank you. I'm going to just do a little, I know we've talked about this already, I just want to do a quick little review about what this isn't, and maybe what it is.

And people here probably, some people have been on some of our, what we call our CDP projects, where we evaluate measures rigorously and recommend them for endorsement. I just want to say, this is not a CDP project. So just you have that perspective, it is different.

Secondly, this is a program to recommend measures for use in one of the programs, possibly, actually, a starting point. So we're really looking for what we call here at NQF performance measures, which is a fully developed metric that includes detailed specifications that has undergone scientific testing, reliability, and validity.

We also will look at today measure concepts, which is, as we define it, an idea for a measure that includes a description of the measure, including a numerator and denominator.

So when we were doing our search, we found tools.

There are a lot of screening tools out there, but those are not measures, although they can be used in measures. And we've also found surveys, and surveys are not performance measures, but they have measures in them. I just want to give you two quick examples. Next slide, thank you.

So an example of a tool within a measure is -- the tool is actually the PHQ-9, which is a depression scale, many people are familiar with it.

But it's actually in a measure, it's an NQF-endorsed measure, and it's a Depression Readmission at Twelve Months is the title. And you can read the rest of the measure. So it's a tool that's actually used in a measure.

The second one is, so the first is a tool in a measure, the second is a measure in a survey, so. Surveys in and of themselves are not measures, but there can be measures in the surveys. And so I happened to choose the CAHPS

HCBS survey that has 19 performance measures, and they've been tested.

So again, surveys as well as tools may have some psychometric processes, properties when they are developed, but they are not developed as measures. And I just want to take a minute to clarify that, I think, so everybody's sort of on board as to what we're looking for.

And so does anybody have any questions on either, any of what I just said? Great. So with that, I'm going to turn it over to Tara.

MS. MURPHY: Hello again, everyone. Again, my name is Tara Murphy. I'm going to briefly take us through some of our program areas.

Our first program area that we'll look at is reducing substance use disorders. This program area focuses on Medicaid beneficiaries who experience significant impairment, such as health problems, disability, and failure to meet major responsibilities, as a result of substance use disorders.

According to CMS, two of the top reasons for hospital re-admissions are substance abuse, in particular alcohol, and substance use diagnosis. And of all Medicaid beneficiaries, 12 percent of adults and six percent of adolescents have a substance abuse issue. Next slide.

Compared to patients on Medicare, private insurance, and even duly eligibly patients, Medicaid-only beneficiaries have the highest combined rate of both illicit and prescription drug use.

Lock-in programs, which limit patients to filling prescriptions at one location in order to manage patients' prescription use, are again being considered as a mechanism to address opioid misuse.

The measures we'll look at in the reducing substance use disorders program area will focus on the CMS quality domains, as well as the remaining three program areas. To date, one theme that has arisen when considering SUDs measures is the identification of people with

substance use disorders or co-occurring conditions.

Our second program area is improving care for beneficiaries with complex care needs and high costs, or we'll call them BCN. BCN focuses on supporting Medicaid delivery reform for beneficiaries who experience high levels of costly yet preventable services.

These superutilizers are a small portion of the Medicaid population, making up about five percent of all beneficiaries, but account for more than half of total Medicaid expenditures.

This group also includes the one percent of beneficiaries who account for 25 percent of all Medicaid expenditures. This group has a lot of variation, with beneficiaries experiencing different medical, behavioral, and psycho-social needs.

Patients in this group often have multiple chronic conditions. Eighty-three percent of the most costly one percent of

patients have three or more conditions. And 60 percent of that group has five or more conditions.

Federally qualified health centers, FQHCs, are one approach to improving care and reducing costs in this BCN population. Research has shown that in areas served by FQHCs, there are lower rates of emergency department use, and lower rates of hospitalizations for ambulatory care-sensitive conditions.

More broadly, however, there are many challenges for addressing the needs of this population. Care management interventions often vary in design, focus and setting, which makes the comparison of results very challenging. As a result, best practices have not yet been identified for wide implementation.

Additionally, there's a lot of churn among the individuals characterized as high utilizers. That's to say that the characterization can often be temporary, as individuals return to normal levels of

utilization after a brief time. This churn can be attributed to the changes in an illness, the impact of the care, and mortality.

The BCN program area will focus on the CMS quality domains. To date, within the program area, some examples of themes and issues that have arisen are the identification of people with complex care needs, promoting care coordination, and identifying types of services or social supports appropriate for the population.

I'll now turn it over to my colleague Kate Buchanan to take us through LTSS and MPH.

MS. BUCHANAN: Thank you very much, Tara. So as Tara mentioned, we were referring to the program area of promoting community integration through community-based long-term services and supports as LTSS.

This program area focuses on Medicaid delivery form for beneficiaries living in the community and using home and community-based services and social supports. Importantly, this program area does not focus on those in

institutional care.

Measures in the set will, as previously stated, focus on the CMS quality domains.

And some things that have arisen to date are ensuring that we are able to find the right measure to address this program area that is changing and growing all of the time, as well as looking for ways to align measures that are already in use across multiple states.

Living in and participating in the community are important parts of improving life satisfaction. As individuals with the need for LTSS services look to rejoin the community following institutionalization, there are many factors that will affect their ability to stay in the community.

Those include mental health disabilities, difficulties with family members before transition, and lack of choice and control in one's daily life. We can look to these predictors as possible areas of intervention in

order to reduce re-institutionalization.

And lastly, we'll talk about supporting physical and mental health integration. We refer to this program as the PMH program, and this program area focuses on supporting Medicaid delivery system reform for beneficiaries with both physical and mental health conditions.

The top two most common diagnoses for rehospitalizations among Medicaid beneficiaries are mood disorders with schizophrenia and other psychotic disorders.

Individuals with mental health needs often experience co-morbid physical conditions as well. Over half of all Medicaid enrollees in the top five percent of expenditures who had asthma or diabetes also had a behavioral health condition.

And while there is evidence of effective integrative care models, they are not widely used as a result of the many barriers to integration.

These include payment, budget cuts, workforce issues, and EHR capabilities. An example of a payment barrier is that in 24 states, they have limits on same-day billing for behavioral and mental health services in Medicaid.

Further, budget cuts in many states often result in reductions in state mental health services. An estimated 91 million Americans live in areas without enough mental health professionals.

And an example of an EHR barrier is that they can often prevent providers from documenting relevant behavioral health and physical health information, as well as limit communication between integrated teams.

And some examples of themes that have arisen to date are the knowledge of whether or not integration is occurring. Is there enhanced coordination, enhanced collaboration?

Is care occurring at the primary care physician's office or remotely? And is care

coordination the same as integration? And with that, I'll turn it over to Andrea to deal with any questions.

CHAIR GELZER: Thank you very much, Kate. I would just note another issue on the behavioral health/physical health integration side, especially in Medicaid obviously, is the state-to-state variation in benefit structure. And with that, James.

MEMBER BUSH: I was hoping if you all could clarify what -- there's going to be a lot of overlap between our four subjects here. Eighty percent of our complex care cases have a co-existing mental health disorder. A lot of those will have a substance abuse disorders.

So as we're into our four groups, and like I'm in the complex case group, do we not then address mental health or substance abuse, assuring that those would be going to those groups?

Or what do they do? Because there's a whole spectrum with those, some of which are

not in the complex case. So do they limit themselves to non-complex care cases, or how do we prevent overlap?

DR. TERRY: So let me start with saying we had this conversation as a team as we looked at these measures, and what we tried to do is we've tried to put measures in the right what I would call TEP.

We will sort this out if we don't totally sort it out at this point and the measure moves on, we'll sort it out when it goes to the Coordinating Committee, where they will really begin to look at measures across all of the four TEPs.

So I know that's not a specific answer, but it's sort of a general answer to how we hope to deal with this.

As I said, it wasn't a perfect, especially with integration of physical and mental health in the BCN, beneficiaries with high cost, it was a lot of overlap. So does anybody on the team want to add anything? Kate?

MS. BUCHANAN: Sure, I'll add something very quickly. And so Jimmy mentioned that there was, will you deal with other issues occurring, especially in the beneficiary with complex care needs.

And measures that deal with substance use disorder, mental health conditions, are encapsulated within this measurement discussion, so that the beneficiary with the complex care needs will look at issues that affect this population.

CHAIR GELZER: Janice and then Tiffany and then Howard.

MEMBER TUFTE: Thank you. I just want to say that I really appreciated one statement in here, it really popped out at me when I read the slide regarding the individual's opportunity to exercise control and quality of life. And I appreciated that.

I just had a question about churn. If the churn in this context meant that rolling off of Medicaid and onto Medicare, and therefore

accruing bills, or if it meant they were actually out of this system, like not going to their doctors, or --

MS. MURPHY: So in this instance, we are referring to churn as those designated with the characterization of a beneficiary with complex care needs and high costs.

MEMBER TUFTE: Not going off Medicaid, they'll be on Medicare, but it isn't that issue --

MS. MURPHY: Right, it didn't have to do with the Medicaid status.

MEMBER TUFTE: Thank you.

MEMBER WEDLAKE: I just had a follow-up question on the overlapping of measures. If we do find in our TEPs that we have a measure that might be better suited to one of the others, can we just refer it over there, or are we going to be deciding on it?

Because I know in the substance use disorders, some of them were very much behavioral health measures. And they might be really good

behavioral health measures, but it may not be as relevant to substance use disorder prevention as specifically.

But are we going to just keep them wherever they're at right now, or are we going to refer them to the other group to look at?

MS. GORHAM: Sure, we would ask that if you find such a case, that you make note of that. And at the end of each day, you will have an opportunity or the chairs will have an opportunity to summarize the conversation and the measures discussed.

And then at the end of the second day, we'll take those summarizations and report out to the larger group, so that the other chairs and the other TEPs can also hear the discussion.

And then when the Coordinating Committee meets in June, then they'll have an opportunity to look at all of the measures, all of the sets in the discussions, and then they will finalize the sets to recommend to CMS.

MEMBER SHAPS: Looking at all the

measures before we got here, there are a lot of them. And speaking from experience, we can get overwhelmed as a provider, we can get overwhelmed as a company with all the different measures that are out there.

So when this is all over in September, is there going to be a defined set of measures that we're going to recommend? Because I can just see going to my state Medicaid agency and asking them to incorporate ten or fifteen or twenty measures, and they're going to look at me like, you know, this seems a little too much.

But just wondering what your thoughts were from an overall measure perspective and how many there will be.

DR. TERRY: So there are a lot of measures. And the use is not -- of course it's voluntary. I just wanted to mention that. We had many more measures before we did our first rounds, as many of you know. And the goal is really to hopefully get it down to reasonable numbers. What that is will vary.

And it's just, for each group, it's a little different. It's hard to respond, but you know, it can also go to the Coordinating Committee, who can also take another look.

And you know, and anything that they find that they want to either add, hopefully, maybe not, or change, or not move it forward. So I think there is another option there as well. Anybody want to add anything?

MS. GORHAM: Sure, can I just add in a few minutes, I'll do a presentation on the measure selection process, and that will really help the TEPs decide on the best available measures, if you will.

Once you have your measure set at the end of the second day, then the Coordinating Committee will look at those recommendations, and they'll have all of the recommendations for each of the four areas.

And they're going to step back, take a broader look, and look at the four areas. And then they're going to also call down the

measures, so that we can have a discreet number of measures that we'll recommend to CMS.

CHAIR GELZER: Thank you. Dan and then David.

MEMBER CULICA: Yeah, I was just wondering that, I know that this four groups of measures or domains have been introduced mostly related to the change of the delivery of care.

But now, as we move on towards the pay for value, and I know the CMS is starting looking at the new programs, IAP at least into the, bringing into the value concept, I wonder whether, in our entire discussion, should we use a filter? Or just keep it in the back of our mind in the selection of these measures of how much or to what extent they would be related to this future direction in the pay for value.

MS. LLANOS: Yeah, it's a good question, Dan. So the question is: how do you connect the dots between this work and how the state might think about Medicaid delivery reform in light of value-based payment?

I think that is something to think about, right. I think that's why we wanted to think about measures that are ready tomorrow, that have been through a standardized review process. Because those tend to hold up a little bit stronger when you tie it to payment.

So it is something to think about in terms of how a state would think about operationalizing different types of measures. So I would definitely keep it in the back of your mind.

MEMBER MANCUSO: This may fall a little bit outside the bounds of kind of existing measure concepts, but I do think it would be of huge value to have standardized definitions for the key concepts here -- mental health needs, substance use disorder, risk, beneficiary with complex needs. What HCBS settings this measurement's focused on.

If we have well-defined population definitions related to those special populations, those target populations, those populations that

have been less focused on in other measurement, we can take existing measures and use those population definitions to define strata and calculate measure disparity and differences in ways that really generate huge additional value from existing measures where we have co-morbidities across these populations.

Much of the measurement that we do in Washington State is focused on disparities and difference across a population served in different Medicaid silos, quote unquote silos, or delivery systems.

And using exiting measures on the physical healthcare side, utilization side, and trying to understand whether we're moving the dial in the trajectory across populations.

So I would encourage folks to think of this, potentially not just about let's add more measures to the set, but let's develop population definitions that allow us to take our existing toolkit of measures and apply them to understand disparities and differences across groups.

CHAIR GELZER: Maureen.

CHAIR HENNESSEY: Two questions. The first is, is that -- following up on David's question, is that part of the scope of what we're doing, to define, develop those kinds of definitions?

DR. TERRY: It's not really part of the scope. We have some kind of basic definitions that we have and we have used in what we are looking at. But to go beyond what we have already done, not really in the scope. I don't know if Karen wants to add to that.

MS. LLANOS: No, and I don't think it's possible in a two-day meeting, either. But I think, you know, David's point is what existing measures can be stratified by the different target populations. I think that is a good question for the TEPs to consider.

DR. TERRY: Can the question --

MS. LLANOS: The ability to actually, like, sit down and define, I don't think you guys probably have enough time to do that. I would

defer to Peg and Shaconna. But I think --

CHAIR HENNESSEY: So that then in the course of our discussion, if we're looking at a measure and considering its merits, one possible consideration would be: is this a measure that would lend itself well to stratification, is that what you're saying?

MEMBER MANCUSO: Maybe just a quick follow-up. I think that may naturally fall out. I know there's at least one measure in our --- in the physical and mental health group, the denominator of which could define a population criteria that could be deployed across other measures.

I'm imaging the BCN group has to define what a BCN is, and the LTSS group may have to define what service settings qualify a Medicaid enrollee for that measure. So I think some of this may fall out of what the groups would be developing.

CHAIR HENNESSEY: Thanks, and I had one more question, which was following up on the

question about measure sets. So is the intent here really to have a measure set similar in some ways, for example, to the Medicaid adult core set of measures?

Or is really the intent more to create a menu of measures that we think have some degree of reasonable rigor, or measure concepts that are approaching perhaps rigor, so that really a state can select from that menu depending on their population and needs and so on?

MS. LLANOS: Yeah, it's definitely more on the menu side. So this, I mean I used to run the children and adult core set portfolios. It's not comparable. Those are tied to a voluntary reporting system that has to be reported out.

This is more on the resource side. This is a listing of measures. That's why I used the term resource. But menu is a good way of thinking about it. So the list could be longer, but you guys probably need to be manageable so you don't go insane over the next two days.

But it is something for states to take and choose from, and for us to better understand what's out there that's probably more on the essential side for states to be thinking about, what our understanding that these populations could be defined, particularly complex ways.

What are some good key areas that should be taken into account when thinking about a measurement strategy?

CHAIR GELZER: So we are really all going to be efficient over the next day and a half. And Diane.

MEMBER McCOMB: My question is for Karen. How widely do you think states will look at this resource and use these measures going forward? Do you have any data on how the work that you're doing is applied throughout the states?

MS. LLANOS: So this is, we've not done this before. I will say, though, that in the context of our daily work with states outside of IAP, this comes up a lot. This is what drove

this project.

So if a state comes in and wants to do a waiver on SUD or something broader than that, the question is always: what are the right measures, or what are some good measures for us to be thinking about?

And that happens on our staff side, and it happens on the state side. So we know that there's a need. How broad the need is, I think we're assuming that it's pretty broad, because these are tough issues or tough target populations to think about.

MEMBER McCOMB: And then I'm also curious. How do you intend to integrate the work of the TEPs developing metrics with the work of this group reporting out on existing measures?

MS. LLANOS: Our measurement work is -- so we started last year, about a year and a half ago. So we're not in the -- we wouldn't meet Peg's criteria of a concept that's almost hatched enough to be integrated as part of this conversation.

MEMBER McCOMB: And what's the time frame that you think that measures under development would then be introduced to the states for consideration? Just trying to get an idea of the time frame.

MS. LLANOS: Well, we're trying to get through NQF endorsement, so I think we're probably a year out for our first round. It's only three, a contract total of three years. And it's a very small amount of measures, no more than 12 measures. So this is on the much smaller side in some key gap areas.

MEMBER McCOMB: Okay, thank you.

CHAIR GELZER: So if there aren't any other questions, I'm going to turn it back over to Shaconna and Kate to guide us through the measure selection process.

MS. GORHAM: Thank you. Again, my name is Shaconna Gorham, and I am the senior project manager staffing this work. So I'm going to review the measure selection process, and it is a standardized approach for selecting best

available measures for each of the four IAP areas.

Each TEP will use the standardized approach to discuss and vote on measures. The measure sets decided on today in the program areas' specific breakout sessions will be recommended to the Coordinating Committee, as we mentioned earlier.

Using a similar process, the Coordinating Committee will discuss your recommendations during their in-person meeting in June. The outcome of that meeting will be finalized sets to recommend to CMS.

So, on this slide, you see the six steps of the measure selection process. So step one, we scan the universe for measures. We then capture measures on your measure summary spreadsheets. We assign rankings on the specific measure criteria.

Step four, we assigned an overall score to each measure. Step five, we conducted an initial review of the list of measures and

removed measures by their measure score. And finally, step six, we will analyze the remaining measures using decision logic to recommend to the Coordinating Committee.

So over the next several slides, we will walk through each of these steps, and the steps of criteria included. So you will notice that you are very familiar with the first couple of steps, because that is pre-work, homework that we assigned.

And we are very grateful for your participation. It makes our job a lot easier when we have dedicated committee members. So we'll recap, I'll recap some of those steps that have already been completed, and then I'll go over the last step.

All right, so step one, the process in the search for measures. So we performed a comprehensive search using relevant measure sources. So we searched more than 75 sources, many of which were recommended by yourself and Coordinating Committee members.

So some of those sources included NQF's repository of measures, CMS measure inventory, American Society of Addiction Medicine, and I could name many, many more, but those are just a few.

Then of course we wanted to look at the states. So we looked at 17 states. To name a few, Minnesota, New York, California, Massachusetts are just a few of the states that we looked at.

We identified measures based on feedback from CMS, and then of course yourself, regarding the goals of each program area, and the current measurement activities of the states' delivery system reform efforts.

So step two, we captured measure details on each of the IAP program measure summary sheets. So you'll recall the Excel sheets that we sent kind of went back and forth via email.

This step was performed by NQF staff. We completed this step, and staff captured

details including things like numerators, denominator, measure type level of analysis. And that information, again, was housed on the measure summary sheets.

Okay, step three. So this next step in the measure selection process is the ranking of the measure-specific criteria. So as part of the collection of measure details, staff collected information pertaining to the four measure-specific criteria.

We looked at feasibility, usability, scientific acceptability, and evidence. We assigned rankings for each of these measure criteria. And each criteria has its own definition for high to low rankings.

Each criteria could also be marked as unsure if no information was found to support a ranking.

So just as an example, I won't read all of them, but as you can see for both feasibility and usability, you have four different rankings. So high, medium, low, and

unsure. In the case of feasibility, if a measure uses administrative claims or registry data, the measure received a high ranking.

In the case of usability, if a measure is in use in a federal program or used in multiple states for accountability and quality improvement, that measure received a high ranking.

MEMBER BROWN: Excuse me, what is pro PM?

MS. GORHAM: Patient-reported measures.

MEMBER BROWN: Thank you.

MS. GORHAM: So the last two of the four criteria in the set, scientific acceptability and evidence.

In the case of scientific acceptability, if a measure is currently NQF-endorsed, or there was some evidence of reliability and validity testing in the Medicaid population, that measure received a high ranking.

The ranking for evidence are slightly different. So rather than a high to low scale,

we used the options of yes or no. A measure received a yes for evidence if there is evidence of data or information resulting from studies and analysis of the data evidence and/or scores for a measure as specified, or a measure is NQF-endorsed without exception to evidence.

A measure received a no is there is no evidence of importance to measure. And if the staff couldn't determine, the measure was marked as unsure for evidence.

After criteria was marked high, medium, low, or unsure, the rankings were translated into a numeric score. A high ranking is equal to three, a medium equal to two, and low equal to one, and then unsure equal to zero.

In the case of evidence, a yes was equal to one and no or unsure equal to zero, as indicated in the parentheses on your slide.

So step number four. After the criteria were ranked and translated into a numeric score, staff calculated an overall measure score based on the rankings and the

weighting.

So you'll see bullet two describes the weight of each of the four criteria in the overall measure score calculation. So feasibility and usability will make up 30 percent of the measure score. Scientific acceptability made up 25 percent, and evidence made up 15 percent.

So feasibility and usability were weighted the highest, because considering reporting burden, accessibility to data, alignment with other measure sets, etc., is particularly important in the Medicaid population. The overall measure score was used in the culling down process.

All right, step five was the initial review and removal of measures by score. So TEP members conducted an initial review of the measure. We wanted to make sure this process was well vetted, so we have often asked for feedback along the way.

Last month you received a survey

soliciting that feedback on the measures captured to date. And again, thank you for completing the survey. Your feedback was very instrumental in helping staff search for more measures, and also helping us find more information for the measures that we already had on the sheet. You can turn to the next slide.

Once the measure summary sheets were updated and the measure scores assigned, staff conducted an analysis to determine the mean. The mean is the threshold or the cutoff to determine whether a measure or concept would be considered for additional consideration.

Prior to this meeting, you received your measure summary sheets with the overall measure scores and the mean scores for your particular program area. So the measures or the measure concepts with scores under the mean will not be considered unless one of you elected to retain a measure.

So you have the option to retain up to three measures or concepts, and we'll discuss

those measures and the measures that were above the threshold when we talk about the decision logic.

So this just really illustrates the point of step five. So you see in the top blue box the threshold score for substance use. You have measures that equaled or were above the threshold score. The bottom blue box you have measures that were below the threshold score.

And then if a TEP member elected to save a measure that was below the threshold score, you all could do that. And all of those measures would move to the decision logic review. Next slide.

Okay, so step one through five of the measure selection process was all pre-work. So all of that was done before you came today. Step six describes the work you will begin in your individual groups momentarily.

So the remaining measures, those above the threshold and those that were saved by TEP members, will be evaluated individually against

criteria in the decision logic. So each measure will be considered against the specific criteria or the questions using the following indicators.

So we have high, medium, and low. And you will vote on the measures or concepts through the criteria in the decision logic. So the next slide is a really good illustration of that. That is the decision logic that we will follow.

So you will use the decision logic to evaluate the remaining the measures and concepts. There's five steps in the logic. If each measure or concept passes the step, it will be recommended for inclusion in the program area measure set.

So it is important as you consider your vote just to reiterate some of the things said earlier, that you focus on choosing those measures or concepts most ready for immediate use and those of most value to the state Medicaid agencies in their delivery system reform efforts. Also, consider measure alignment across payers and settings.

NQF also provided a list of guiding questions, so when you move to your breakout sessions, you will have a handout with the decision logic, as well as additional questions to help you move through the logic.

All measures and concepts will follow the same path until you get to the question in the logic that says, To what extent is the measure ready for immediate use.

Then you will begin to evaluate measures and concepts separately. This merely helps you distinguish a measure from a concept when we recommend the set to CMS. Next slide.

The next four slides detail the criteria of the questions and the definitions of high, medium, and low indicators of the decision logic. The TEPs will address each question for the remaining measures and concepts and vote high, medium, and low.

So if a measure receives an adequate vote, it will move to the next criteria in the decision logic. If the measure does not receive

the necessary votes, then of course it will be excluded from the measure set.

So the first two questions in the decision logic, the question one: to what extent does this measure address critical quality objectives of the CMS quality measurement domains, and/or identify program area key concepts.

And those key concepts are the same as search terms. We use those terms in order to find measures relevant to your program areas. This question must receive a high or a medium vote or ranking to move forward.

The second question: to what extent will this measure address an opportunity for improvement and/or significant variation of care, evidenced by quality challenges? So for example, re-admissions access to care for each program area. This question must receive a high or medium ranking to move forward as well.

You will vote the measure or concepts through each criteria or question in the decision

logic. It is important to note that you will need at least three affirmative votes in order for a measure to move forward.

And then we want to retain quorum that's necessary, so you need at least four members of your TEP to vote on each measure. Okay.

All right, so question three: to what extent does this measure demonstrate efficient use of measurement resources and/or contribute to alignment of measures across programs, health plans, and/or states?

The measure is not duplicative of existing measures within the measure set, captures a broad population. This question must receive a high or a medium vote to move forward.

The next question: to what extent is this measure ready for immediate use? For this criterion, a measure will move forward if it receives a high or a medium ranking. If the measure receives a low ranking, it will move to a separate track within the decision logic.

And that is where you would decide what a measure -- if you decide that a measure is not ready for immediate use, it will continue to be evaluated, but can only be recommended as a measure concept.

We received some really promising concepts, so we didn't want to eliminate them simply because it was a concept and we didn't receive instructions from CMS, as Karen said earlier, for sort of a 80/20 split.

But we do want to reiterate the fact that CMS is looking for measures that are ready for implementation tomorrow.

So all items will then move to question five, the last criteria in the logic: to what extent do you think this measure is important to state Medicaid agencies and other key stakeholders? This question must receive a high or a medium ranking to move forward. Next slide.

Then you will decide whether or not the results of the measure will actually yield

one of the following. So the measure or concept could be excluded from the recommended measure set, or the measure is recommended for inclusion in the measure set, or the measure concept is recommended for inclusion in the measure set. Next slide.

So again, you will require 60 percent agreement, which will be at least three TEP members, and you will utilize a hand vote in your breakout sessions.

It is really important that each decision to support or not support be accompanied by a rationale so that we can include that, one, when your chairs report out, and also so that we have good information for the report that will be due in September.

Again, quorum must be maintained, so you need at least four voting members. And with that, I know I said a lot, I'll turn it over to Sheryl to facilitate questions or comments.

CHAIR RYAN: Okay, anyone have any comments, questions for the group? I think, I

can't read your name. Camille.

MEMBER DOBSON: Hi. Just want to clarify, the key concepts, will they be provided as well in our breakouts?

MS. GORHAM: Yes.

MEMBER DOBSON: Okay.

MS. GORHAM: So you'll receive a handout, and that handout will include the decision logic, the additional guiding questions, as well as the key concepts and search terms.

MEMBER DOBSON: Perfect.

MS. GORHAM: And just to reiterate, the voting is only for TEP members. So you will have presenters such as Camille and Linda in the SUDs group. Linda will be in SUDs and Camille in LTSS. They are welcome to participate, but they will not be voting.

CHAIR RYAN: Let's go with David then Rich then James. I missed what order people put them up. Oh, and then, oh, Maureen. And then Maureen. Okay, go, Dave.

MEMBER MOSKOWITZ: There's several

measures that really get at the same construct with slightly, you know, different definitions of how it's constructed.

And it seems to me this methodology advantages measures that you review first in terms of looking at, there was language on one of the slides around measures not being duplicative of existing measures.

Was that purposeful in terms of the higher score gets the prioritized decision? Or is there a process to, if you're reviewing down that list, you get to this measure that you think is better than this other measure for getting at that same construct. How do you deal with that discrepancy? Does that make sense?

DR. TERRY: So we talked about this too. What, well, I will say is, if both of them get through, we will have information that the, you know, committee, the TEP I mean, felt that these were quite related or they were similar measures.

And the Coordinating Committee will

look at that and make that final decision. So do you want to add anything?

MS. GORHAM: Just to kind of piggyback on that, so that again goes back to my statement about making sure that there is a rationale for why you included and why you did not include.

Because if you get to that point where you have measures such as that, you'll have a rationale. And so when the Coordinating Committee looks at that, then they'll see you voted these measures through or concepts through. But there are related measures, if you will.

And so they'll look at that, because they have a piece in their process where they will really look at those related measures.

CHAIR RYAN: Rich, why don't we go, then Jim, then Maureen.

MEMBER BROWN: I see that some of the measure specifications gave specific information about the populations or settings they were intended to, and others were more general. And if I were in a Medicaid program, it seems it

would be helpful to me if there were some kind of notes about what populations or setting measures might apply to.

And as we're reviewing measures that are specific to one population or setting, we may realize that they're applicable to other populations and settings. So I wonder if there's room for those kind of annotations that could be passed on to Medicaid, because I think that would be helpful to them.

DR. TERRY: Yes, that's a very good point. And we're taking all this information down. It will be part of public record, and we will make sure to include the comments about specific populations that the committee feels will be appropriate or somebody suggested.

MEMBER BUSH: So there are two ways you can approach your decision tree. One is you take each measure and you run it through the decision tree and see if it falls out or makes it through the gamut.

Or the second is you can take every

measure through the first decision point, then the second decision point, leading to a smaller and smaller pool as you go through those. So which one did you all want us to follow here?

MS. GORHAM: The first. So we want you to evaluate each measure completely through the decision logic, and you will come up with a decision. Then you'll go back and do the other measures. So we'll look at measures by domain, by CMS domain.

Your measures have already been grouped in those domains, and you'll look at each individual measure or concept in that domain, and then you'll do the same for the next domain.

CHAIR HENNESSEY: So just following up on that question, so I would assume then that when one reaches a point with a measure in a specific domain where that measure falls out as a no, at that point we stop reviewing it, we don't continue. Very good, thank you.

The other question that I have is that theoretically you could have a measure that meets

a yes to all those questions, but may not necessarily be applicable to the TEP that you are working on.

So for example, one might say that a measure that only pertains to treatment by a behavioral health practitioner does not involve integration. One might say that. So if that's the case, how does that get approached if a TEP runs into something like that? How would you like us to approach that?

MS. GORHAM: So I would say that if that happens, then again, you will want to note it. So we would just really need rationale for the reason why it was not ultimately recommended.

CHAIR HENNESSEY: Okay. Or it could come through as a yes, yes, yes on all of those things, but the note would be, This is an area of concern or noted by one or more members of the panel. Okay, thank you.

MS. GORHAM: Yes.

CHAIR RYAN: I have a question. When I was reviewing, it seemed like some of the

measures in a domain, one domain, actually seemed more appropriate in another domain. Do we have the flexibility to switch from one domain to the next?

MS. GORHAM: So, I would say yes, because you're really looking at the individual measure. And you as experts might say, NQF staff put it in this particular domain, but we think better, you know, we think it would be in a different domain better.

The key is you really want to review the individual measure, and then again, we do have rationale and notes, and so as you as experts think it belongs in another domain, make a note of it, and we'll take that in consideration.

CHAIR RYAN: Any other questions, comments? Rich?

MEMBER BROWN: Yeah. It seemed, as I was reviewing measures, that some might be more susceptible to gaming and creating sort of unintended perverse consequences than others. Is

that consideration covered by one of those five concepts, or is that a separate issue?

DR. TERRY: It is not at this point, but I want to say one thing. You're the experts around the table here, and that's why people here at the table, bringing that expertise.

And so if that's an issue that you want to raise, then it should be raised and it should be brought to the attention of everybody. And if you think it's not appropriate because of the gaming potential, that needs to be discussed, and you know, handled that way. So thank you.

CHAIR GELZER: Yeah, I would absolutely agree. I have been on numerous of these before, and we have to discuss it. I mean, it doesn't necessarily discount it, we may not throw it out. But it should be on the table.

CHAIR RYAN: We have a question, Diana.

MEMBER McCOMB: Yeah. In the criteria for the efficient use of resources in another TEP that I was on, a question arose.

If we're looking at quality indicators for long-term services and supports for people with disabilities, and specifically people with intellectual disabilities, a face-to-face interview is considered critical to get valid information from the user of the services.

And yet that's not necessarily perceived by many to be an efficient use of resources because a face to face interview takes more time, and so forth. However, those of us in that arena don't feel you can really get valid information from that individual unless you do a face-to-face interview.

Is there room for some variation to the understanding of that definition of efficient use of resources, given the objectives that we might want first-hand information from the users in the system?

DR. TERRY: Absolutely. In LTSS obviously, the patient-reported outcomes are important. And so I think the people on that committee, as well as you, understand that. So I

think that's a particular --

MEMBER McCOMB: Just wanted that clarification, thank you.

DR. TERRY: Okay.

CHAIR RYAN: Jim.

MEMBER BUSH: Just to quickly respond to Rich's comment. As a Medicaid medical director, anything that I think is liable to gaming is not going to be important to me, so I think you could discount it on the last decision measure.

CHAIR RYAN: Janice.

MEMBER TUFTE: I just want to touch on the efficiency of resources. I've worked extensively with at-risk youth and homelessness populations and SUD and BCN, and so I realize that a lot of time, it's definitely, there should be a face-to-face, at least for sure in the first couple of, you know, meetings.

But often they're unable to sit down long enough to come in for surveys, whatever, measurements, and don't want to sit through them,

you know. And so one thing I noticed is, or I've learned through this process of TEPs, is your all qual or the whole qual.

I don't know, their quality of life, or they're able to administer to themself, sit there for a half hour, do it. And I just think it's something we should think out within some of these populations, because some of them, that is going to be the only way we're going to derive that information from them. Thank you.

CHAIR RYAN: If there -- oh, wait a minute, I'm, okay. Any more questions? If not, I'll turn this over to Kate to public comment.

MS. BUCHANAN: Thank you very much. We will now hear from any members of the public who would like to offer comments. If you are not connected via phone, you may also type the comment into the chat box, and staff will read them aloud. Operator, can you please give instructions to the participants?

OPERATOR: Yes, ma'am. At this time, if you would like to make a public comment,

please press star, then a number one. There are no public comments at this time.

MS. BUCHANAN: Thank you very much. So with that, we will move on to the breakout session logistics. So all information on streaming information location is all found in your agenda. The public is welcome to attend the breakout sessions, either in-person or via the phone.

As you can see, we have the room assignments for each TEP. Two TEPs, the SUDs and LTSS, will remain on the ninth floor. And two TEPs, PMH and BCN, will go down to the NQF offices on the eighth floor.

TEP members and members of the public will need to be escorted by NQF staff to the eighth floor, as it is locked. And Peg and Miranda will escort the beneficiaries of complex care needs to their meeting room, and I will escort the PMH TEP to our meeting room.

There are restrooms at designated areas where TEP members can take calls on both

eighth and the ninth floor. Further, lunches will be served on both the ninth and the eighth floor for ease. On the next slide, we will review the teleconference and streaming information.

So here you can see the dial-in and streaming information for each of the technical expert panels. Important note for the members of the public that this information, the streaming link, will change for day one to day two, so please use the ones on this slide.

And with that, I will take any questions.

CHAIR GELZER: I have one logistical question.

MS. BUCHANAN: Yes.

CHAIR GELZER: So we're going to be deliberating, the TEPs are going to be deliberating the rest of the morning and into the afternoon. So will we be coming back to this room today?

MS. BUCHANAN: So we will not be

reconvening together today. So tomorrow morning we will have breakfast up here, and then break out into our sessions, and then reconvene in the afternoon of the second day.

MEMBER BUSH: Shall we take our name tags?

MS. BUCHANAN: Yes, please. And we are now going to take a 15-minute break, and then we'll meet up here to go down to the eighth floor, or stay on the ninth floor.

(Whereupon, the above-entitled matter went off the record at 10:39 a.m.)

C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Medicaid Innovation Accelerator Project TEP In-Person Meeting

Before: NQF

Date: 04-18-17

Place: Washington, DC

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Neal R. Gross

Court Reporter