

NATIONAL QUALITY FORUM

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MEDICAID INNOVATION ACCELERATOR PROJECT
TECHNICAL EXPERT PANEL IN-PERSON MEETING

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TUESDAY
APRIL 18, 2017

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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, MEd, 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

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

2 9:08 a.m.

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

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

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

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

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

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

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

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

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

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

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

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

1 about 30 years now.

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

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

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

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

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

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

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

22 So I'm very excited to be here, thank

1 you.

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

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

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

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

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

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

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

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

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

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

1 today.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 DR. WILSON: Thank you.

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

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

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

17 DR. WILSON: Thank you.

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

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

9 DR. WILSON: Thank you.

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

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

22 My passion is following the

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

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

10 DR. TERRY: Tiffany.

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

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

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

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

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

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

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

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

22 I also have an award from the National

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 And also NCQA for a dual behavioral

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

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

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

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

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

22 And in terms of external funds, I've

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

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

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

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

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

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

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

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

1 them up on the fly.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 surrounding areas in Alameda County.

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

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

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

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

1 employer or anyone who might have nominated you.

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

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

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

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

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

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

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

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

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

22 Please note the purple arrow. We are

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

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

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

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

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

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

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

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

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

22 It's a four-year commitment by our

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 So measurement development falls under

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 Set or Children's Core Set. Or maybe some of the
2 1115 efforts as well.

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

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

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

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

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

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

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

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

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

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

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

1 Committee and a number of other committees.

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

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

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

22 CHAIR RYAN: Thank you. Rich, I think

1 you had the next question.

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

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

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

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

1 concepts.

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

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

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

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

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

1 supporting behavioral health-physical health
2 integration.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 substance use disorders or co-occurring
2 conditions.

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

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

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

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

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

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

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

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

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

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

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

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

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

1 institutional care.

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

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

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

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

1 order to reduce re-institutionalization.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12 CHAIR GELZER: Janice and then Tiffany
13 and then Howard.

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

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

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

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

8 MEMBER TUFTE: Not going off Medicaid,
9 they'll be on Medicare, but it isn't that issue
10 --

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

13 MEMBER TUFTE: Thank you.

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

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

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

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

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

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

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

22 MEMBER SHAPS: Looking at all the

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

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

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

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

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

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

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

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

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

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

3 CHAIR GELZER: Thank you. Dan and
4 then David.

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

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

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

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

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

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

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

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

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

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

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

1 CHAIR GELZER: Maureen.

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

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

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

19 DR. TERRY: Can the question --

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

1 defer to Peg and Shaconna. But I think --

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

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

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

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

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

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

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

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

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

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

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

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

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

1 this project.

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

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

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

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

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

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

13 MEMBER McCOMB: Okay, thank you.

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

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

1 available measures for each of the four IAP
2 areas.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9 MEMBER BROWN: Excuse me, what is pro
10 PM?

11 MS. GORHAM: Patient-reported measures.

12 MEMBER BROWN: Thank you.

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

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

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

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

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

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

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

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

1 weighting.

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

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

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

22 Last month you received a survey

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 one of the following. So the measure or concept
2 could be excluded from the recommended measure
3 set, or the measure is recommended for inclusion
4 in the measure set, or the measure concept is
5 recommended for inclusion in the measure set.

6 Next slide.

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

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

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

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

1 can't read your name. Camille.

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

5 MS. GORHAM: Yes.

6 MEMBER DOBSON: Okay.

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

11 MEMBER DOBSON: Perfect.

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

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

22 MEMBER MOSKOWITZ: There's several

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

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

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

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

22 And the Coordinating Committee will

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

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

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

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

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

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

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

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

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

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

22 Or the second is you can take every

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

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

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

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

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

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

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

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

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

20 MS. GORHAM: Yes.

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

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

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

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

17 CHAIR RYAN: Any other questions,
18 comments? Rich?

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

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

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

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

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

18 CHAIR RYAN: We have a question,
19 Diana.

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

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

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

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

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

1 think that's a particular --

2 MEMBER McCOMB: Just wanted that
3 clarification, thank you.

4 DR. TERRY: Okay.

5 CHAIR RYAN: Jim.

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

12 CHAIR RYAN: Janice.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12 And with that, I will take any
13 questions.

14 CHAIR GELZER: I have one logistical
15 question.

16 MS. BUCHANAN: Yes.

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

22 MS. BUCHANAN: So we will not be

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

5 MEMBER BUSH: Shall we take our name
6 tags?

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

11 (Whereupon, the above-entitled matter
12 went off the record at 10:39 a.m.)
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<p>a.m. 1:9 5:2 105:12 ability 47:15 58:16 71:20 able 25:10 58:6 102:5 above-entitled 105:11 absolutely 47:8 99:14 100:19 abuse 10:20 20:10 21:1 21:4,9,15 54:3,6 61:15,18 academic 29:10 Academy 10:14,17 11:8 14:22 25:2,2 Accelerator 1:3 3:14 21:13 31:16 35:10 acceptability 80:12 81:15,17 83:6 access 43:18 44:13,16 50:10 88:18 accessibility 83:11 accompanied 91:12 account 55:12,15 74:8 accountability 33:10 81:6 accountable 27:14 accreditation 15:13 accruing 64:1 acknowledging 49:2 ACP 25:2 acronym 35:14 acronyms 35:11 acting 32:4 activities 30:13 37:5,7 37:9,9,14 43:13 44:12 44:21 49:3 79:14 activity 41:15 ACU 23:7 acute 21:5 add 47:14 49:6 62:22 63:1 67:6,9,10 70:18 71:12 94:2 Addiction 20:15 79:3 addictions 21:20 22:11 addition 21:7 additional 8:19 70:5 84:13 87:4 92:9 Additionally 56:18 address 54:15 58:7 61:18 87:17 88:5,15 addressing 24:11 56:12 adequate 87:20 Adjourn 4:22 administer 102:5 Administration 2:20 29:13 administrative 8:5 81:2 adolescence 10:21</p>	<p>adolescent 1:18 10:4 adolescents 54:5 adult 24:2 44:22 73:3 73:13 adults 15:11 26:13,14 54:5 advantages 93:5 Advisor 2:17 Advisors 1:16 7:20 14:15 advisory 15:14 24:18 advocacy 2:5 28:9,13 affect 58:16 63:10 affiliated 16:4 affiliation 13:18 affirmative 89:2 afternoon 104:20 105:4 agencies 35:18 36:14 42:5 86:20 90:17 agency 12:7 36:1 43:13 66:9 agenda 33:3,16 103:7 Aging 2:4,10 12:6 15:9 ago 29:17 75:19 agree 99:14 agreement 91:8 ahead 15:16 AIMS 23:1 Alameda 2:12 30:20 31:1 alcohol 20:12 54:3 Alcoholism 21:9 align 30:10 42:15 45:10 58:9 alignment 43:8 83:12 86:21 89:11 Alliance 2:6 28:10 allow 70:20 alluded 39:12 alluding 41:19 aloud 102:19 ambulatory 56:9 American 10:13,16 14:22 18:16 20:14 25:2,2 30:14 79:3 Americans 60:9 AmeriHealth 1:13 9:6 14:19 amount 76:10 analysis 80:2 82:4 84:10 analyst 3:3 11:15 analytics 38:18 analyze 78:2 and/or 82:4 88:7,16 89:10,12 Andrea 1:9,12 9:2 14:19 46:17 49:13</p>	<p>61:2 Andrews 1:20 20:19,20 Angela 2:5 28:8 ANN 3:3 annotations 95:8 answer 62:16,16 anybody 45:19 53:9 62:21 67:9 applicability 20:14 applicable 42:5 95:6 97:2 applied 74:17 apply 70:21 95:3 appreciate 18:8 25:9 27:9 appreciated 63:15,19 approach 27:8 32:6,7 46:13 56:5 76:22 77:4 95:18 97:10 approached 97:8 approaches 46:12 approaching 73:8 appropriate 57:10 95:16 98:2 99:10 APRIL 1:6 area 15:4 39:11 41:1,9 53:16,18 54:18 55:3 57:4,6,15,18,22 58:7 59:5 79:13 84:17 86:13 88:7,19 97:17 areas 5:11 22:6 26:16 31:1 34:18 36:21,22 37:1,4,10,16,22 38:1 38:3,15 39:6,17 40:8 41:12,21 42:1 48:3,6 48:16 49:19 50:9 53:15 54:20 56:7 58:22 60:10 67:19,21 74:7 76:12 77:2 88:11 103:22 areas' 77:6 arena 100:11 arisen 54:21 57:7 58:5 60:18 arose 99:22 arrow 33:22 ASAM 20:17 aside 48:4 asked 83:20 asking 13:4,5 66:10 assign 77:18 assigned 77:20 78:10 80:13 84:9 assignments 103:11 assistance 35:17 36:12 assistant 1:20 20:20 association 2:4 12:7 18:18 21:22 22:1 23:8</p>	<p>associations 18:21 assume 96:16 assuming 75:10 assuring 61:19 asthma 59:16 at-risk 27:18 101:15 attend 103:7 attention 34:21 99:9 attributed 57:2 audience 42:6 44:7 authorities 22:2 availability 47:4,16 available 38:21 67:13 77:1 award 20:9,22 29:8 awards 29:6 aware 24:20</p> <tr> <th data-bbox="235 695 527 724"></th><th data-bbox="548 695 841 724"></th><th data-bbox="862 695 1154 724"></th><th data-bbox="1175 695 1464 724">B</th></tr> <tr> <td data-bbox="235 730 527 1892"></td><td data-bbox="548 730 841 1892"></td><td data-bbox="862 730 1154 1892"></td><td data-bbox="1175 730 1464 1892"> <p>back 11:8 67:20 68:14 69:10 76:15 79:19 94:4 96:8 104:20 background 25:12 baked 44:20 Baltimore 20:3 Barbara 1:10,16 6:21 6:22 7:2 14:3 32:21 33:3 34:10 37:13 Barbara's 33:1 barrier 60:3,12 barriers 59:21 base 38:8 based 16:11 24:2 79:11 82:22 basic 6:15 71:8 bathrooms 5:18 BCN 1:13 24:19 55:5,5 56:6 57:4 62:20 72:15 72:16 101:16 103:13 bear 31:9 beating 39:16 began 7:10 beginning 7:5,15 34:1 behavioral 2:15,19 7:21 17:9 22:22 23:6,12,13 24:22 25:18 27:15 50:1 55:18 59:17 60:5 60:14 61:6 64:21 65:1 97:6 behaviors 26:22 believe 25:6 47:12 50:18 belongs 98:14 benchmarking 41:5 beneficiaries 12:8 15:21 16:8,18 18:2,6 38:6 53:18 54:4,9 55:4,7,11,15,17 57:19</p> </td></tr>				B				<p>back 11:8 67:20 68:14 69:10 76:15 79:19 94:4 96:8 104:20 background 25:12 baked 44:20 Baltimore 20:3 Barbara 1:10,16 6:21 6:22 7:2 14:3 32:21 33:3 34:10 37:13 Barbara's 33:1 barrier 60:3,12 barriers 59:21 base 38:8 based 16:11 24:2 79:11 82:22 basic 6:15 71:8 bathrooms 5:18 BCN 1:13 24:19 55:5,5 56:6 57:4 62:20 72:15 72:16 101:16 103:13 bear 31:9 beating 39:16 began 7:10 beginning 7:5,15 34:1 behavioral 2:15,19 7:21 17:9 22:22 23:6,12,13 24:22 25:18 27:15 50:1 55:18 59:17 60:5 60:14 61:6 64:21 65:1 97:6 behaviors 26:22 believe 25:6 47:12 50:18 belongs 98:14 benchmarking 41:5 beneficiaries 12:8 15:21 16:8,18 18:2,6 38:6 53:18 54:4,9 55:4,7,11,15,17 57:19</p>
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C E R T I F I C A T E

This is to certify that the foregoing transcript

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Project TEP In-Person Meeting

Before: NQF

Date: 04-18-17

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