NATIONAL QUALITY FORUM

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MEDICAID INNOVATION ACCELERATOR PROJECT TECHNICAL EXPERT PANEL IN-PERSON MEETING

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WEDNESDAY
APRIL 19, 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 1:45 p.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, Section Chief of Adolescent Medicine, Department of Pediatrics, Yale School of Medicine, SUD Technical Expert Panel Chair

CHRISTINA ANDREWS, PhD, Assistant Professor, University of South Carolina

RICHARD BROWN, MD, MPH, Professor, University of Wisconsin School of Medicine and Public Health

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

NQF STAFF:

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

ELISA MUNTHALI, 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

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

1:54 p.m.

CHAIR GELTZER: --- social determinants measures, abuse and neglect measures. We did consider the potential for gaming the measures in all of our discussions. We had an animated discussion about the need for a robust engagement patient activation measure for Medicaid.

We discussed one measure and decided not to move it forward, but felt that that is an area of special interest and should be revisited. And we felt there was some redundancy in some of the measures.

They were, you know, either for an expansive group of a population, or the same measure for a more specific diagnosis. For example, some measures were for all mental health, and some measures might be for schizophrenia.

Lots of discussion, great days. Thank you, everybody. Pass the mic.

CHAIR RYAN: All right, I'll go next. Hi, my name is Sheryl Ryan, and I was the chair of the Substance Use Disorders TEP. And I want to thank my committee and the support staff, the support staff were great. Committee, we had a very good discussion. I think we brought a variety of perspectives that I think really helped have a good, comprehensive discussion.

We started out with 114 by the NQF staff, whittled it down to 44. So we reviewed 44, and a total of 25 were recommended finally. And four of those were concept measures; the remainder were measures.

We had started out with just three areas being evaluated, three domains: clinical care, care coordination, and caregiver experience. And there were none in the other areas of access safety and population that were available for us to discuss.

By the time we'd finished, we'd reallocated some to access, a couple to safety. So by the time we finished, we had maybe four of

our six domains covered. We still didn't have anything in caregiver experience, and we still don't have, no measures from population, population level.

A number of themes. We had a lot of, in our clinical care, there were a lot of measures looking at screening, screening for composite alcohol and other drugs, screening for separate alcohol or just tobacco. And we felt that what we were really -- and there were some that were separate for treatment after somebody had been screened.

So one of the things we felt, it was a theme, is that we would have liked to have seen was more of a coordinated group of measures that went from someone who was being screened, assessed, treatment, and then ultimately looking at outcomes of that treatment.

And we just don't have those measures. So we felt that it would have been nice to have some of these sort of cascading measures that captured the whole, you know, range of what we

might want to be doing in the clinical setting.

There were a number of gaps that we identified that I'll list. One was that we felt with our opioid use and the opioid problem, we really needed a number of more specific measures that were related to measurement.

We had problems with our denominators; we had problems with our numerators. Many items were not well-validated. And it kind of limited the validity of the measurements that we were being asked to review. And I think we were all feeling like, well, if we could have rewritten some of these, it would have been better.

So, since that wasn't our task --

(Laughter.)

CHAIR RYAN: That's, right, that's right. But, you know, but looking back on it, we realize that there's just, you know, that the domain of measures in that area is just really limited. And I think people are sort of, at each state, are sort of doing what they can coming up with their own measures.

And we felt that a lot of our denominators were just not well-defined. We tried to clarify what they were, but again, those limited what we could conclude about the measure.

Other gaps, I think, 18 year olds and up were by and large very well represented. We had very few measures for under 18 year olds. You know, there were a couple for 12-18, but by and large, most of that population is really sort of not getting a whole lot of attention in terms of measures that are being used.

And I'm coming from the perspective as a pediatrician, this is where a lot of our substance use starts. So interventions aimed at prevention and early intervention, we're not capturing that, which is important. Maybe it's not big drivers of our cost right now, but they are the ones that are going to be driving costs down the line.

Another big gap that we felt was there was virtually nothing about pregnant women or any kind of recommendations for obstetrical care

related to substance use disorders. Absolutely nothing, not even in the 114. I don't think I saw anything when we viewed the -- and we really feel that this is a huge gap, especially with our neonatal abstinence syndrome.

You know, just use, what we know about use of substances, all substances throughout pregnancy. So we felt that that was another real gap that was there.

Let's see, and I think, you know, we also felt that a lot of our measures were very much process-oriented, and that we really didn't have a whole lot of outcome measures.

So maybe, you know, it's like we're providing treatment. So, taking the step beyond that, is that treatment? Really, do we have any evidence about whether the treatment is resulting in any kind of positive outcomes, either decreased use of emergency services or re-hospitalizations, or decrease in the behaviors that we're trying to intervene about?

We really don't have real good outcome

measures, those were lacking. You know, how well our patients are doing in some of the interventions that were being measured as part of the process. So we felt that there were a number of criteria that you could use to assess success, but these really were not represented at all in the universes of measures that we were asked to evaluate.

So I think that pretty much covered it.

CHAIR McCANN: Thank you. This is Barbara McCann, and I had the privilege to chair the Community-based Long-term Services and Support, and I'll do my best to represent the incredible brilliance of our group.

We had 28 measures. And it may sound like the easy thing to do, but boy, it was a stretch. It was a stretch. There are at least five major populations in this, in HCBS, in Home and Community-Based Services. We didn't come close, as I'm hearing with the rest of the chairs, to even any measures for those

populations.

We found ourselves often looking at medical measures, health care measures, and trying to adapt them to their benefit in home and community-based services. So you're happy that they're going to get a once a year visit, and we are hopeful that in that visit, needs will be identified.

So the stretch was significant in many areas. In others, we are looking for structure because there is no standard of practice. We're just looking for how you begin. So if you want to go to an outcome, you have to make sure that the issues were ever assessed to begin with, to do that.

We also have proxies, but we also found an interesting thing that could be positive. And that is, we needed definitions to speak to each other.

So as an individualized plan of care evolves in medicine to be patient-centered and goal-oriented, folks who were not in medicine

thought, 'No, well, that's not a patient-centered plan.'

So we had to get to the point where going forward, we need a definition of what each of us is talking about, because it's not understood the same within the populations that we serve. So that was, I mean, we had to bridge just to be able to explain it in the process.

As we also, I think, have highlighted, many of the measures were Medicare. However, such as, screening for falls at home is a big deal, and that's for all ages, not just Medicare. So we have the same issue there on an ongoing basis.

We have several measures that need additional validation. So we came down to six measures we would go forward with, five promising concepts, and two concepts that we would go forward. This is clearly an element of Medicaid that's going faster than we can possibly imagine, but we have almost nothing, almost nothing to look at.

And we started rewriting all of our measures, I don't know what your problem was. So it was a challenge, but I think at the end of the day, we were able to bridge a great deal, but we have a long way to go, long way to go.

DR. TERRY: So I'm going to just take us through the next steps of what's going to happen after this. And before I begin, I just want to say, this may change slightly because of this meeting. So whatever I say, don't hold me totally accountable for what I say.

But as we designed it, there were five steps. The first is to review the measures that come forward.

The second is to vote en bloc of all measures recommended by each TEP, and that does not include those that the Coordinating Committee pulled out as something they wanted to look at from the main list that were recommended, and those not recommended, where the Coordinating Committee actually could identify some they wanted to still look at.

We have a lot of what we call save measures throughout this process, just because we're, you know, the data is not always perfect in this world, and we want to make sure that it reflects, you know, what's going on in each of these TEPs.

The next part would be that the Coordinating Committee will vote en bloc and everything that just go through without any discussion. Then for those that are pulled out for discussion, they will vote on each measure. There are some guidance that we have for them to use, a little bit like the guidance we had for the decision logic, just a little bit shorter.

And when they're completed that, they will look at all the measure sets, and they will vote on each measure set as a whole. When I say they look at it, they'll be looking at issues such as, you know, how many domains are represented. It's a little bit of what came out of the discussion today, actually.

And then they will vote on each

measure set to recommend to HHS or CMS. So just to tease that out just a little bit, next measure, next slide I mean. Great.

I think I sort of said this, but the objectives really are to review any new information that we receive that can go to the CC, there may be some new information.

I know there were some, in the group I was in, BCN, we're going to look to see if there's anything additional here, there may be other groups with that, to evaluate measures submitted from the TEPs, you know, through an additional process of what we call reconsideration, and then to finalize it.

We do not want this Coordinating Committee to be really duplicative of what we did in the TEPs, that's not the goal. But to really look from a broader view or broader lens. I mean, some of the work has already been done for them.

So they'll have a smaller set to look at, and you know, and they'll have comments from

what is going to be passed on to them from the work here. So it won't be the level of depth, although maybe for some areas and some measures.

These measures we want to be a resource for all states, and we want to make sure they're available for quality improvement and maybe someday payment activities.

So onward to the next one. Just to, again, a little bit more delineation the way this is going to work. So, and I've alluded to this. The CC will be provided with two lists. Those that, measures that measure concepts that were recommended and those that weren't.

And for those that, and they'll have a process, as the TEPs did, to do pre-work. So they'll be provided with these lists, and they'll look at them to see if there's any they want to pull out for further discussion of those that were recommended.

And for those not recommended that they want, they get two choices per person to recommend others for further discussion. So,

again, that's how we're going to do that.

They will, from the list, from both activities, they will actually reconsider the measures that were already looked at. And I also mentioned they'll vote en bloc. So the next part is they'll vote en bloc for everything that just moved forward. Next slide.

So three, four and five gets into the details. Three involves the review of the -- I'm sorry, three involves the voting individually on the measures and measure concepts.

Four involves the review of the entire measure set for each program area for balance as I said, type domains, measures that are immediately ready. And then five is the final vote.

And with that, I'm going to turn it back over to -- any questions on the next steps? Yes?

MEMBER BUSH: So on that last slide, it looked like point three means they're going to vote on everything we just voted on, because they

vote for the ones we approved and vote on the ones we didn't approve?

DR. TERRY: So they're going to vote on those that move forward without discussion, just to look at them and vote on those. They can pull out individually any that they want to discuss that have been approved or recommended.

And then they can pull out up to two of those that weren't recommend. And they'll discuss those -- the purpose for that is for them to take a deeper dive into those.

MEMBER BUSH: So not all of the ones that we didn't approve, just up to two each?

DR. TERRY: Up to two per person.

MEMBER BUSH: Okay, thank you.

DR. TERRY: It's called the save, as we keep calling it. Yeah, thank you, yeah. All right, there are no other questions. So I'm going to pass it on to I think Maureen, no?

CHAIR HENNESSEY: Oh, yeah.

MS. KUWAHARA: Hi there. We will now take this time to hear from any members of the

public that would like to offer comments. If you are not connected via phone, you can use the chat function at the bottom of your screen to submit a comment. Operator, can you please given instructions to the participants.

OPERATOR: Yes, ma'am. At this time, if you would like to make a public comment, please press star then the number one. And there are no public comments from the phone line.

MS. KUWAHARA: Thank you.

CHAIR HENNESSEY: So we may have juxtaposed the agenda a little bit, just want to check and verify. Are there any other questions, discussion that anyone else would like to have with regard to the discussions we've had today? Yes, James?

MEMBER BUSH: Just, yeah, so a couple of quick comments. One of the things that we brought up at the end of meeting is ever since CMS expanded our 1915(c) subassurances, we've become aware of there's a large gap around quality, around the 1915(c) DD and the home and

community-based services waivers.

And I didn't really, and of course, it may not have been in our group, but I don't know if you saw any in your group, but that is an area with a lot of need for further measurement. So that was one comment that I would like to see addressed, because that was an area we had not been looking at until very recently, and there's way too much problems there.

The second problem that I just had with some of my discussion was apparently in the long LTSS group, there's some question about the role of med reconciliation. And apparently there were several med reconciliation measures in that group that were voted out.

And my understanding from speaking to some of the members was they thought that might have been addressed in other areas. But we only addressed those of inpatient and emergency room.

And so is there anything about med reconciliation in the purely outpatient setting? Because that's an area where we see a lot of

problems as well. So those are my only two comments.

CHAIR McCANN: We did address med reconciliation. We went through the measures. Our challenge was that the measures that we looked at didn't take it back to the home. That med reconciliation was upon discharge from the hospital, that's great, and then when they got to the physician's practice.

But actually we brought up med reconciliation from our perspective needs to occur in the home. And our rejection, if you will, or our lack of wanting to push those measures forward, based on the scope of the measure, is that it didn't address reconciliation in the home and community, which we thought was the most important.

We also rejected a measure regarding adherence that was limited to the pharmaceutical claims for a refill, which we thought did not address adherence, which is a huge issue in the community. So it was not because of an issue of

a lack of understanding the importance of medication reconciliation. We couldn't get anything that moved it to the home at that point.

MEMBER BUSH: Great, I appreciate that. And then, and again, we had several things that we thought we wanted to bring to the Coordinating Committee as well about some gaps. So I appreciate those comments, and I'm sure those will be carried forward as well.

CHAIR HENNESSEY: Any other comments? Thank you for those? Any other comments, questions from the group today? I think I would like to echo what's already been said in terms of thanking not only this total group, but the TEP that I worked with today, and then also the team Kate and everyone from the NQF staff. It's just a great job of organizing and preparing, so thank you.

DR. TERRY: And I will say the final thank-yous. So I first want to thank our chairs for their work they've done, for all the calls we had in advance, for leading these groups, and for

their expertise. So I really wanted to thank each person for what they brought to the table.

And I also want to thank the TEP members. People were really very engaged and very knowledgeable, very, very knowledgeable, on these topics. And we asked you to do pre-work and you all did pre-work, and I think that's great.

So thank you very much to everybody for the hard work over two days, and for the results of what we have now. And you'll certainly hear the end result as we move forward. And please don't hesitate to email staff if you have any questions in between.

And I also want to thank the team, I'm sorry, I want to thank our team, the NQF team. They really worked hard to put this together. I want to thank the CMS for coming here, for supporting us to clarify all those things they did over the last two days. Really, it's been very, very helpful.

This is our partnership on this that,

you know, we talk to them every week, so you know that. And they give us guidance, and we ask them questions, and we move forward, and we try to come to an understanding. So it's been great.

So, again, thank you to everybody for this work, and hopefully you'll make all your trains and airplane connections, and --

MS. GORHAM: Before we run out the door, we just want to go over next steps to give you all some kind of direction of where the project is going.

DR. TERRY: Oh, I'm sorry, I jumped in too soon.

MS. KUWAHARA: So I have spoken with my colleagues, and it's our understanding that all measure deliberations were finalized today. So we propose cancelling the May 3rd meeting. We are seeking an affirmative hand-raise from you all if you are in agreement.

(Show of hands.)

MS. KUWAHARA: Seeing many enthusiastic hands, we will cancel that meeting.

Up next, we will be publishing our draft report for public comment. That'll include all the TEP and Coordinating Committee measure recommendation results. And that'll be posted no later than August 21st.

Then on September 14th, we will be submitting our final report to HHS. All right, thank you very much.

DR. TERRY: And I think that does conclude the meeting, so thank you again.

(Whereupon, the above-entitled matter went off the record at 2:17 p.m.)

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C E R T I F I C A T E

This is to certify that the foregoing transcript

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

Before: NQF

Date: 04-19-17

Place: Washington, DC

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

Court Reporter