# NATIONAL QUALITY FORUM

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## MEDICAID INNOVATION ACCELERATOR PROJECT COORDINATING COMMITTEE

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**WEDNESDAY**
**JUNE 7, 2017**

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**The Coordinating Committee met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 9:00 a.m., William Golden and Jennifer Moore, Co-Chairs, presiding.**

**PRESENT:**

**WILLIAM GOLDEN, MD, Co-Chair; Medicaid Director, Arkansas Medicaid; Professor of Medicine and Public Health, University of Arkansas**
**JENNIFER MOORE, PhD, RN, Co-Chair; Executive Director, Institute for Medicaid Innovation**
**KAREN AMSTUTZ, MD, MBA, FAAP, Chief Medical Officer, Magellan Health, Inc.***
**SANDRA FINESTONE, PsyD, Executive Director, Association of Cancer Patient Educators**
**ANDREA GELZER, MD, MS, FACP, Senior Vice President and Corporate Chief Medical Officer, AmeriHealth Caritas Family of Companies***
**ALLISON HAMBLIN, MSPH, Vice President for Strategic Planning, Center for Health Care Strategies, Inc.**
**MAUREEN HENNESSEY, PhD, CPCC, SVP and Director, Quality and Population Health Solutions, Precision Advisors**

**DAVID KELLEY, MD, MPA, Chief Medical Officer, Office of Medical Assistance Programs, Pennsylvania Department of Human Services**
**DEBORAH KILSTEIN, RN, MBA, JD, VP Quality Management and Operational Support, ACAP - Association for Community Affiliated Plans**
**SREYRAM KUY, MD, MHS, FACS, Chief Medical Officer, Medicaid, Louisiana Department of Health**
**BARBARA McCANN, BSW, MA, Chief Industry Officer, Interim HealthCare Inc.**
**SARITA MOHANTY, MD, MPH, MBA, Regional Executive Director, Medi-Cal Strategy and Operations, Northern California, Kaiser Permanente***
**MARYBETH MUSUMECI, JD, Associate Director, Kaiser Family Foundation**
**MICHAEL PHELAN, MD, JD, FACEP, RDMS, CQM, Staff Physician, Cleveland Clinic**
**CHERYL POWELL, MPP, Vice President, Truven Health Analytics**
**SHERYL RYAN, MD, FAAP, Professor of Pediatrics, Chief Section of Adolescent Medicine, Department of Pediatrics, Yale School of Medicine**
**JEFF SCHIFF, MD, MBA, Medical Director, Minnesota Health Care Programs, Department of Human Services***
**JOHN SHAW, MEng, President, Next Wave**
**ALVIA SIDDIQI, MD, FAAFP, Medical Director, Advocate Physician Partners***
**SUSAN WALLACE, MSW, LSW, Coordinator - Special Communications and Projects, LeadingAge Ohio**
**JUDY ZERZAN, MD, MPH, Chief Medical Officer, Colorado Department of Health Care Policy and Financing**

**NQF STAFF:**

**SHANTANU AGRAWAL, MD, MPhil, President and CEO**
**KATE BUCHANAN, MPH, Project Manager**
**SHACONNA GORHAM, MS, PMP, Senior Project Manager**
**MIRANDA KUWAHARA, MPH, Project Analyst**
**ELISA MUNTHALI, MPH, Acting Senior Vice President, Quality Measurement**
**TARA MURPHY, Project Manager, NQF**
**MARGARET (PEG) TERRY, PhD, MS, RN, Senior Director**

**ALSO PRESENT:**
**KAREN LLANOS, MBA, Director, Medicaid Innovation Accelerator Program, Center for Medicaid and CHIP Services, CMS**
**BEVERLY LOFTON, Medication Innovation Accelerator Program, Center for Medicaid and CHIP Services, CMS**
**E. CLARKE ROSS, DPA, Consortium for Citizens with Disabilities**

*** present by teleconference**

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

9:02 a.m.

DR. TERRY: So, I'm going to open the meeting up and just welcome everybody. Oh, sorry. Can you hear me better now?

Good morning everyone. I just want to welcome everyone and thank you for joining us today as we begin our deliberations and recommendations for measures in these four Medicaid programs.

I also want to thank the public and members both in the room and on the phone for joining us today as well.

Now, I'm going to turn the presentation over to NQF's President and CEO, Shantanu Agrawal for some opening remarks.

DR. AGRAWAL: Thank you very much. It's nice to start to meet you all. I had a chance a little bit this morning. I won't take up too much time except to say how appreciative we are of all of you convening and doing this work. These four program areas are, obviously,

extremely important. The substance abuse disorder work, in particular, for me, is just something that I have been personally very interested in.

I am most recently coming out of CMS. I wasn't actually in the Centers for Medicare and CHIP Services but worked very closely with them and we did a lot of work together on substance use and abuse and what we can do to sort of intervene, including on the opioid crisis. So, it is just a topic that I feel very connected to.

Again, thank you for your work on this. You know one thing I will mention or a couple things I will mention, so one is I am going to actually apologize. I'm not won't be able to spend as much time with you today as I wanted but I have some meetings. We have got to go to The Hill this morning and have a number of meetings. And I tell you that so that you are aware NQF's funding is actually running out this year. So, we get authorized by Congress every few years and it's obviously very important. So,

we are going to do our part to advocate on our behalf but I mention that to you because, heck, if you have some time to advocate or find yourselves on The Hill, please keep us in mind. We get authorized every two to three years, depending on the last authorization cycle. And it might be that actually our authorization gets combined with the CHIP reauthorization this year.

So, I would love to spend more time with you and the varied meeting topics that you will be covering but we will be doing that.

The other thing that I will mention, which I think will impact this work down the line and a little bit indirectly but, just so you're aware, yesterday, our quality measurement department released a report that is seeking to make changes to our endorsement process that will make endorsement much more efficient, much more agile, which will allow more measures to go through -- obviously with the same standard kind of achievement but will potentially allow them to go through more quickly. And eventually, those

measures will, obviously, impact the work of this committee and of many, many other committees. So, when you get a chance, if you get a chance, please look at that report online. It is a draft. We are seeking public comment and your thoughts on that will be really helpful.

So with that, I will turn it back over and just thank everybody again for being here and participating.

CO-CHAIR MOORE: Hi, I'm Jennifer Moore, the Executive Director at the Institute for Medicaid Innovation and also on faculty at the University of Michigan Medical School in the Department of Obstetrics and Gynecology, although we're not talking about that area today. My role at the institute is very relevant to this discussion and I want to thank each of you for all the work that you did in advance of this meeting. Bill and I have been reading everything and trying to like organize it and prepare for this meeting. So I know how much work went into that and am very appreciative of that to help for

the preparation.

And I also want to thank the NQF staff. It is amazing how much work they do in preparation for these meetings and it does not go unrecognized and I want to thank each and every one of you for that.

CO-CHAIR GOLDEN: Good morning, Bill Golden, Medical Director of Arkansas Medicaid. And many of my Medicaid colleagues are here today. And I am also at the University of Arkansas for Medical Sciences and kind of an old veteran of NQF processes.

And you know metrics are critical. We are doing a lot of work these days in accountable care and the whole interface of how you pay for value and use metrics to leverage quality improvement with the financial incentives with accountable care and total cost of care is I know something that is a bit of a burning platform for many of us and these areas and topic areas that we are talking about today are critical to the Medicaid program.

Those of you not in Medicaid per se, I mean the big driver of Medicaid expense and comorbidity is mental health and substances and other issues. So, we are very pleased to be here as we being to increase our portfolio in these important topic areas.

So we are hoping that we can develop things that we can use both locally and to incentivize change and also to compare performance across states. So, we look forward to a good discussion today with all of you.

And we're all talking to each other. We have many people here in the room. And do I turn it back over for the conflicts of interest? Is that --

MS. MUNTHALI: Yes. Hello. Good morning. My name is Elisa Munthali. I am Acting Senior Vice President for Quality Measurement. Welcome.

So, today we will be combining the disclosures of interest with introductions. And you received a disclosure of interest form before

you were seated on this committee. We did ask you for a number of -- we asked you for a lot of information regarding your professional affiliations. Today, what we are asking you to do is orally disclose anything that might be relevant to the work that is in front of you.

Just as a reminder, we are not asking you to summarize your entire resume. What we are particularly interested in is anything related to consulting, grants, or research that is relevant to this work but we're not just asking for what they were paid for. We're asking also for work that you may not have been paid for like sitting on a committee like this volunteering.

Another reminder is that you are sitting here as individuals. You are not representing your employers or anyone who may have nominated you.

And one of the most important reminders is that because you disclose, does not mean you have a conflict. We do the disclosures of interest in the spirit of openness and

transparency.

And so we will start off with your co-chairs. We will ask them to introduce themselves, who they are with, and to let us know if they have any disclosures. We'll go around the room and then I will call on those that are joining us remotely.

So, Bill and Jennifer.

CO-CHAIR GOLDEN: So, as I mentioned, I'm with Arkansas Medicaid. I don't have any active consulting arrangements. I sit on a few committees here. I am the chair of the ACP's Delegation of the AMA. So, I do some work with the ACP.

And at the moment, I, aside from working with the NQF, I have just recently finished work with the HCP-LAN. But that's -- I think that's about it.

CO-CHAIR MOORE: This is Jennifer Moore. As with Bill, I don't have any active consulting arrangements and serve on the Perinatal Committee here at NQF. And I'm trying

to think -- boy.

I have some HHS appointments when I'm breast feeding, CMS with quality measures, and AHRQ involved with -- I'm on the Disparities Committee.

MS. BUCHANAN: Dr. McCann, if you would like to --

MEMBER MCCANN: Good morning. I'm Barbara McCann. I'm the Chief Industry Officer for Interim HealthCare, which provides Medicaid services in a number of states. I also serve as a member of the Board of Medicaid Partnership, which supports home- and community-based services as the alternative on The Hill and with CMS for Medicaid.

Finally, I currently serve as the chair of the Community Health Accreditation Program. Thanks.

MEMBER RYAN: Hi, I'm Sheryl Ryan. I'm a pediatrician and a professor of pediatrics at Yale School of Medicine in the Department of Pediatrics there.

I have no active consulting roles at this point but I am an unpaid contributor to a T32 training grant at Yale on training residents and fellows in addiction medicine. And I also am the chair of the American Academy of Pediatrics Committee on Substance Use and Prevention. And through that, I am the lead author on a number of publications and technical reports related to substance use, particularly marijuana in the pediatric age group.

MEMBER SHAW: I am John Shaw from Next Wave in Albany and the only current consulting that is relevant is working with the local FQHC and they do high service for the Medicaid population.

And I am also on a couple regional task forces, the Asthma Coalition and Public Health Improvement in the Albany Capital District. And that's it for now.

MEMBER FINESTONE: Good morning. I'm Sandra Finestone. I have no financial conflicts. I sit on two CalOptima committees as a volunteer

in Orange County, California.

MEMBER PHELAN: I'm Michael Phelan. I'm an emergency medicine physician at the Cleveland Clinic and I am currently the chair of the Quality and Patient Safety Committee for American College of Emergency Physicians.

I have one role for quality measure development for end-stage renal disease and emergency patients. And I'm not sure who that is with. It may be CMS or it may be NQF. I cannot recall.

And that's -- I have no other financial commitments, no current grants.

MEMBER MUSUMECI: Good morning, I am MaryBeth Musumeci. I am an Associate Director at the Kaiser Family Foundation's Program on Medicaid and the Uninsured.

MEMBER HENNESSEY: Good morning. My name is Maureen Hennessey and my current relevant activities are in the Senior Vice President and Director of Quality and Population Health Solutions with Precision Advisors and we provide

consultation primarily to life science companies, including pharmaceutical companies and device manufacturers.

In addition to that, I am also -- I volunteer my services as a peer reviewer for the Journal of Participatory Medicine and also serve and participate on the NCQA Industry Roundtable.

Thank you.

MEMBER KILSTEIN: I'm Deborah Kilstein. I'm with the Association for Community Affiliated Plans or ACAP. We represent nonprofit health plans that serve the Medicaid population, as well as other populations.

I represent ACAP on a number of NCQA Committees. We're nonvoting. I'm a nonvoting liaison member for the Standards Committee. I also sit on their Health Plan Advisory Committee and their Utilization Management Advisory Committee.

I have been on a number of expert panels, including the CMS QRS Panel that they had recently. I was on the NQF Child and Adult Core

Measure Task Force.

I got some grant money from the Open Societies Foundation to do some work with the plans around substance use disorders. And I am subcontractor on a grant from Hilton Foundation around SBIRT for adolescents.

And my husband is a former employee of a pharmaceutical manufacturer and does have -- he did receive benefits from that company.

MEMBER ZERZAN: I'm Judy Zerzan. I'm the Chief Medical Officer for Colorado Medicaid. I have no financial conflicts of interest. I have served for a number of years on the CMS HCPCS Committee and soon will serve on the HCP-LAN Guiding Committee.

MEMBER HAMBLIN: Good morning. I'm Allison Hamblin with the Center for Health Care Strategies for a nonprofit organization based in New Jersey, working nationally on Medicaid policy issues.

I have no financial conflicts to disclose. I am on a couple of advisory boards

that are relevant to the discussion, one for IHI's Complex Care Playbook and one for the newly formed National Center for Individuals with Complex Health and Social Needs.

MEMBER KELLEY: Good morning. I'm Dr. David Kelley. I am the Chief Medical Officer Pennsylvania Medicaid. I've served there for 13 years. I am a general internist. I oversee nine managed care plans and I am in charge of their quality improvement activities.

We work with our EQRO IPRO. I think one of their measures might be discussed today but I have no financial interests with them. We work in collaboration with them to develop quality metrics, above and beyond some of the NCQA HEDIS.

I also sit on the NQF CSAC. I have no conflicts to report.

MEMBER WALLACE: My name is Susan Wallace. I work with LeadingAge Ohio. We are a trade association that represents not-for-profit providers of elder care. So, skilled nursing

facilities, home health, hospices, et cetera.

I currently have an appointment with RTI on the Hospice Quality Reporting Program. I also have been active with the National Hospice and Palliative Care Organization for many years. And then I am on a steering committee for some research on integrating community-based supports with the Ohio State University.

There is no financial interest involved.

MEMBER KUY: Good morning. I'm SreyRam Kuy. I am a general surgeon by training and still actively practicing. I work as the Chief Medical Officer for Louisiana Medicaid. And so many of the things that people have mentioned are so relevant to what we're doing. I don't think we have a financial impact but absolutely the opioid crisis, behavioral health, looking at parity, all of these are the things that we are actually working on that take like 90 percent of my time. So, I am so excited to be here.

And around quality, that is an ongoing effort that we've been doing for the past year is trying to overhaul our quality strategy, doing Town Halls, working with providers to really find out from the provider level what is important for quality and then working with the institutions and seeing how it all comes together. So, I am excited to be here.

MS. MUNTHALI: Thank you. So, now we will go to our colleagues on the phone. We will start off with Andrea Gelzer.

MEMBER GELZER: Good morning. And first of all, let me say thank you for the accommodation to participate by phone. I wish that I could be there with you. I'm just recuperating from minor foot surgery.

I have had the honor to chair the medical -- the Beneficiaries with Complex Needs TEP for this endeavor. I'm Chief Medical Officer at AmeriHealth Caritas.

I have no direct financial conflicts.

I am a member of the Chief Medical

Officer Leadership Council and the immediate past chair of that council for AHIP. I am a member of the Board of Trustees at ACAP. I have been an invited guest and participant for the recent QRS TEP activities and I am on various other HHS CMS TEPs. And I am a standing member of the NQF Cost and Resource Use Committee.

And I am very happy to be participating today.

MS. MUNTHALI: Thank you very much. And next, Sarita Mohanty.

MEMBER MOHANTY: Yes, good morning. And again, my sincerest apologies for not being there in person. I also appreciate the accommodation for joining this morning.

So I'm Sarita Mohanty and I serve as the Regional Executive Director for Medi-Cal Strategy and Operations for Northern California Kaiser Permanente.

I am actively involved in working on redesign of our model of care for low-income populations that we serve at Kaiser Permanente

and have been also involved with Complex Care Initiative both at the region and Kaiser but also nationally.

I am also an internal medicine physician and practice at the Adult Family Medicine Clinic in Kaiser.

I do have one affiliation. I am a Board member of a healthcare company called COPE Health Solutions that is involved in strategic planning and redesign for Medicare and Medicaid, as well as population healthcare management.

And I have no active consulting activities at this time.

MS. MUNTHALI: Thank you very much.

Jeff Schiff.

MEMBER SCHIFF: Good morning, everybody. Thanks for the great technical setup. We can hear everybody very well.

I am the Medical Director at Minnesota Department of Human Services, which is the agency that serves our mega Health and Human Services Agency. We do long-term courts alcohol drug

abuse, mental health help, as well as all the Medicaid programs.

I am a pediatric emergency medicine physician and practice at the Children's Hospital part-time as well and have been involved in the development of the pediatric core sets.

And I'm on an AHRQ-funded NCQA Advisory Group that works through -- on the -- it's really the second stage, I guess development and implementation for the pediatric core set. It's called the National Collaborative for Innovation and Quality Management, which is really working on implementing some of the core measures that have been developed.

And then closer to home, I am one of the leads for our work with the SAMHSA grants on state-targeted response to opioids.

Thanks.

MS. MUNTHALI: Thanks, Jeff. And I just wanted to check if Karen has joined us or Alvia.

MS. LLANOS: This is Karen.

MS. MUNTHALI: Hi, Karen. If you can just let us know who you are and tell us if you have any disclosures of interest.

MS. LLANOS: Oh, I'm sorry. This is Karen Llanos. I think you're looking for the Karen Amstutz.

MS. MUNTHALI: Yes, sorry about that, Karen.

MEMBER AMSTUTZ: Yes, so this is Karen Amstutz. I have been just joined. I am the Corporate Chief Medical Officer for Magellan Health.

And going down the line, I also serve as an unpaid clinical assistant professor of medicine at Indiana University School of Medicine, where I co-teach a class for combined degree students, MD MBA students.

I serve on a couple of boards in Indianapolis, including those associated with YMCA's Diabetes Prevention Programming.

And finally, I have no consulting agreements and no other financial conflicts.

MS. MUNTHALI: Thank you all so much.

I just have one last reminder. If at any time during this meeting you feel that you have a conflict that you haven't disclosed, you may do so in real-time or you may approach the co-chairs or any of the NQF team.

Likewise, if you feel that one of your colleagues may have a conflict that hasn't been disclosed or they are acting in a biased manner, you may point that out in real-time. Again, you may approach your co-chairs or any of us on the team.

So, I will just ask if there are any questions of all of you of everything that you have heard from your colleagues before we proceed with the meeting.

Great. Thank you.

CO-CHAIR GOLDEN: Okay, I guess it's back to me.

So, meeting objectives; so, go to the next slide. Okay.

CO-CHAIR MOORE: Where are we?

**CO-CHAIR GOLDEN: All right, so we need to introduce everybody else who is here, who are not members of the committee. Okay.**

**So, why don't we go around and do that?**

**MS. GORHAM: Good morning and welcome. My name is Shaconna Gorham and I am the Senior Project Manager staffing this project.**

**MS. BUCHANAN: Good morning. I'm Kate Buchanan. I'm a Project Manager on this project. I just wanted to provide a couple of housekeeping announcements.**

**The restrooms are out the doors, through the glass doors to the right. Additionally, if you have to take phone calls at any time, there is a room outside, where you can do so.**

**In order to help facilitate communication, if you want to turn your name tag upright to indicate that you would like to talk for the discussion, that helps our chairs facilitate.**

Also, really important to turn your mike on and talk into it. We can only have three mikes on at a time or else we can't talk. So just also remember to turn the mike off, when you're finished.

Lastly, there is a 5:30 dinner at P.J. Clarke's scheduled. I just wanted to remind everyone. Thank you.

MS. MURPHY: Good morning. I'm Tara Murphy. I'm also a Project Manager on this project.

MS. KUWAHARA: And my name is Miranda Kuwahara. I'm the Project Analyst.

DR. TERRY: And let me just -- I didn't introduce myself. I just welcomed everybody. I'm Peg Terry, the Senior Director on the project.

MS. GORHAM: And we would also like CMS to -- our CMS colleagues to introduce themselves.

MS. LOFTON: Hi, this is Beverly Lofton. I work with CMS on the Medicaid

Innovation Accelerator Program and I am the Contract Representative over this work.

MS. GORHAM: And also Karen on the phone.

MS. LLANOS: Hi, everyone. This is Karen Llano. I am the Director of the Medicaid Innovation Accelerator Program at the Center for Medicaid and CHIP Services.

CO-CHAIR GOLDEN: All right, super. Do we have anybody else? No Uber drivers to introduce or anyone else? Okay. I had a good one coming in. So, it was nice.

So here we are at meeting objectives. So we have kind of gone over this and the bottom bullet is really the key issue is to try to help Medicaid programs develop a greater roster of measures to assist them with delivery system reform. And again for those of you not working in Medicaid programs, my colleagues we have actually a Network of Medicaid Medical Directors that issues dealing with substance abuse and complex care is really the key item of agenda for

all the meetings and we all are comparing notes on projects, innovations. And each Medicaid program is, in many ways, its own little laboratory.

So, you can talk to folks at the break or you can send Jeff all sorts of side emails, since he can multitask during the meeting. And everybody has -- it's an interesting laboratory where all sorts of interesting ways of trying to improve the health of our communities are going on with different incentives and different measures. And out of that people -- I think we had a former director years ago that said steal shamelessly to improve what's going on. So if something works in one state, it gets passed around pretty quickly to others for adoption and adaptation.

And the four bullet areas on the screen, you know substance use disorders, again, the key issue now in our programs; improving healthcare for beneficiaries with complex needs; obviously, high-cost beneficiaries in their

complexity and their diversity is a key issue; community integrity; integration of long-term care, particularly, community-based really an area of increasing importance and actually a lot of work going on that may circle back down the road. And again, today is the first bite of the apple on that in many ways. And also physical and mental health integration key to actually the second bullet. Many of our programs are facing challenges with cost and management because mental health comorbidities impact the care of people with physical ailments. And it is really a complex and difficult area as well.

Let's go to the next slide.

We have a complex task today. So we are going to be reviewing other people's work and finalizing their recommendations. Okay, I have got two different screens ahead of me here.

So before us are going to be measures that did not get to the TEPs. So, we will be looking at things that have not had the luxury of having them review it and kick the tires. And we

will be doing that work for the NQF and CMS today.

We are going to be looking also at measures that recommended by TEP measures to go to somebody else, either to be shared or to be moved to a different bucket of activity.

And then there are going to be some measures that didn't get recommended but there was a bailout option so that if a member of a TEP thought well this is really important and I really couldn't convince people but I really know it is right, we will take another look at that as well. It is sort of like I guess tweeting after the fact or something like that. We'll see. So, we can do some work in that regard.

There will be, I think, an opportunity for the group also to look for redundancies so that if we have more than one measure, we want to look the best in class. I think all of us get frustrated when you have two or three measures floating around and they are kind of related but sort of not. But that is, again, a challenge for

many programs because everybody has their own datasets and so forth. It gets kind of tricky.

Then there is an opportunity, after all of that, for the coordinating committee to look at there are many things that make a measure not ideal to be recommended. So we all have the opportunity to say you know this may not be as good an idea as was originally thought by some folks and let's have a discussion about that as well.

And then finally, we will vote about the whole thing. So that will be I guess sort of like the ribbon on the Christmas package, after we have wrapped it up and selected the gift. So, hopefully, that will be more a formality at the end because we will all be happy with what we've done.

So, there will be lots of steps. There will be discussions. There will be votes. There will be decisionmaking and there will be breaks so you can sidebar people if people are concerned about the way things are going or

confused about the process. So I'm sure the staff and everybody will be having little bits on the side to make sure we are on the right track and moving forward.

So, again, we have the measures to be looking at for, again, the concept here is for immediate use, or for additional work, or for people to try to implement in their communities.

And let's go to the next slide. And so there's the agenda. So, we're already rolling down the agenda and we have had opening remarks. We are really open really about at the stage, once we go to the next slide, to hear from CMS and their opening remarks.

And here is our timetable. And the key thing about the timetable to look at is that when we finish today's meeting you are not free to go. There will be a review of what we did. People will -- there will be, I think, moments of messiness and conversation today. And our able staff will put that altogether and make sense out of it all and send it back to us.

And so in a couple of weeks, there will be a phone call for us to review, essentially, a summary of what we've done and how we will be moving forward. And then they will go back into their cocoon and work hard and create a final report that will be delivered to CMS and we will look at that track report after it is out there for public comment. And we will be receiving those public comments for review and to identify what is really truly important comments that impact the final report, things that we may need to make adjustments for.

We will be meeting each other again by phone in very many virtual ways to finish the product and then we're done. We are done, I guess when fall starts and labor day is over. And we shall then be moving forward.

So, again, busy agenda, busy day, and a busy summer for everybody. So, I thank everybody for their continued engagement.

So, Karen, I think it's your turn. We will turn it over to you and talk about the

vision and the goals that CMS would like to see from this program.

MS. LLANOS: Okay, thank you so much, Bill. And I just want to say I am making my way there. I just had a bit of a scheduling conflict. So I will be on the line until I join you all a little before noon.

But I just wanted to thank you, Bill, and Jennifer, and certainly the NQF staff for all of their hard work in getting to today. And with that, also thanking the Coordinating Committee for spending the next two days and several previous hours on web conferences prepping for this.

As you are about to hear, this work is so important not just to the IAP program, but to our Center, that we really appreciate the time that you are spending sharing your insights.

Next slide, please.

So just by way of background, and I think we covered a little about this on an orientation call, that Medicaid Innovation

Accelerator Program or IAP, we are housed in the Center for Medicaid and CHIP Services in the Office of the Center Director. It is a four-year commitment by our agency to really focus on building the capacity, through supporting ongoing technical, ongoing innovation through technical assistance and we do that a couple of different ways.

Unfortunately, we are not a grant program but we are considered as a CMMI model. Our model is to help states through targeted technical support move towards their Medicaid delivery system reform activities.

At the end of the day, we want to have IAP have an impact on increasing the number of things moving towards their delivery system of reform goals across key program priority areas, which we will talk about in just a little bit. Next slide.

So this is just a visual representation of our program at large. You know our North Star is Medicaid delivery system

reform. So because of that, how we get there are taking program areas in what we call functional or foundational areas to help states move towards their delivery system reform goals.

The program areas are the topics of the populations that you all discuss as part of your introduction. So it is fantastic to hear that there is so much relevant experience and that these are priorities and interest areas of all of you. Certainly, we picked these because we heard from our states our stakeholders that these were the big, critical points or challenges. And certainly as we think about how a state and Medicaid move forward in delivery system reform across these areas, we know that quality measures or having the right quality measures is critical.

So when we think about all of our program areas, we think about those functional levers and that's where quality measures comes in.

In addition to that, having the right

access to data, thinking about performance improvement or improvement science, and certainly value-based payment all have a role to play but we feel quality measurement is so critical and this is why this project is really, really important.

Next slide.

So again, Bill did a great job about talking about our program areas. So no need to go into detail. Obviously, these are important areas. You all know this. We know this as well.

We work with states in IAP in these areas across a variety of different ways but we know that there is still a need for access to really good measures in order to really think about how to drive change in these populations or target groups. Next slide.

So I want to spend a little bit of time just framing how we think about quality measurement in the IAP portfolio. We have a variety of different quality measurement activities that we tackle through IAP and some of

them, I am sure, come to mind when you are thinking about what are the right measures for our program areas. Certainly, gaps, how to fill critical Medicaid relevant measurement gap is something that comes up a lot.

We have a quality measurement development separate project from NQF, from this particular project that is looking at gaps and we actually help share some of that information as part of the environmental scan for this work. But just know that when it comes to the development or the pipeline of some key issue-specific measures, we are handling that in a separate activity.

What you see in bold is this project here. So we know that there is a need to support states in selecting or identifying what are some standardized quality measures that exist today that could help drive their effort. And this is why we thought collaborating with the National Quality Forum to help us identify sets of existing standardized measures for states and

even for our agency to use was so critical.

In addition to that, we have two other projects that are separate from NQF. We're looking at what are some challenging measurement issues, benchmarking to non-HEDIS measures, small numbers issues. Those are more internal-facing so that we can just be better informed about the key challenges that our states and that we face when we think about quality measurement.

And then finally, how do we share best practices and innovations in quality measurement issues? And that actually hits all of the different activities that we have in our quality measure portfolio.

So I just wanted to give you a sense of how this particular activity through NQF fits as part of the other IAP quality measurement portfolio activities.

Next slide.

So finally, the goals for the project and the measure sets that come out of this project, I think that is probably a question that

is burning, particularly for those that have been part of our child-adult core sets. This is a little bit different.

What we wanted to be able to do is to have available a listing or a set of measures that states and we can use that reflect a variety of different quality domains across our IAP program areas. We want measures that are of value to our Medicaid agencies, which is why we are working with NQF to pull your expertise in. Again, focused on measures that are standardized and that can be collected by states tomorrow, as opposed to having them undergo changes or tweaks or what we don't want to do is identify too many concepts because we want things that are actionable for say tomorrow.

And we want to reflect a wide range of stakeholder perspectives. Again, we could have done those projects internally but we really didn't think that would be as valuable as leveraging our partnership with National Quality Forum who has access to a variety of expertise,

as reflected by the coordinating committee.

And then, finally, considering measurement alignment is really important for all of our work. So we wanted to be able to have measures that are available tomorrow that reflect a wide variety of perspectives and that are thinking about measurement alignment across a variety of different pairs and settings.

Next slide.

So, when we think about how to think about each of these sets, I know I think about our CMS quality measures domain framework and that is what we are going to ask of you as well. And just based on a program area, we know that we can't hit all of these but this is just a really nice way of guiding, of having guiding frameworks in terms of how you think about substance use disorder measures, or a grouping of community-based LTFS measures or physical-mental health integration. You know are we looking at access or clinical care, care coordination, safety, patient/caregiver experience, and prevention and

population health?

Again, some of these will have more in one area than the others. Ideally, we would like to have the measure sets reflect all of these but we are in the real world and we know that there are certain gap areas that exist. But this is just something helpful for you all to keep in mind.

And then next slide, please. I wanted to end with just refreshing what we are going to do with this project with the outputs of this project.

So what states are the audience for these measures? And I base these on common questions that we get.

So, as I said our ideal scenario is that the recommendations that we get from you all we will share publicly and they will be available for both our staff, as well as any state, whether they are part of IAP or not, health plans, other stakeholders, that they have access to just a good starting set of measures to think about.

We often get asked what are the right measures for these program areas. And we know that this might not be the whole answer but why reinvent the wheel or why ask for everyone to be doing the same kind of research in identifying the starting point of these measure sets, when we can just share this with a broader audience?

Who will have access to the measure sets, I just said we will post online. So, hopefully, everybody.

How can states use these measure listings? Any way they feel is most valuable. As I said, we are doing this because we have been often asked what are the right integration measures or what is a good starting point for physical mental health integration measures and in our other areas as well. Again, this is just to create efficiencies and having some good, smart thinking around the table and helping us think through what are some listings of measures around these areas that are representative of care?

And the finally, how is this project different from federal measure sets? So, this will not be part of a requirement, a reporting program but you need to be thinking about or we ask you to think about aligning with other measure sets that are out there. So we have heard folks who represent or have been part of the AHIP or the Child and Adult Core, bring all of that experience into your thought process over the next couple of days. That's what we want to leverage.

So be thinking about that. We want to align with those measure sets. Generally we don't want to be creating measure sets that are different or completely outside of that realm.

And again, this is a helpful resource. This is not going to be a statute. It's not going to be a requirement. We just think that this is a need that we have and because of that, probably most likely a need that other states have as well in terms of what are some good measures for these program areas.

With that, I think my next slide is just questions. I'm happy to take any questions now or when I make it in there.

CO-CHAIR GOLDEN: Comments or questions for Karen?

I was ready to turn it over to the next stage, to Jennifer. Tara.

Okay, so I gather Alvia has joined us. So before we go to the next discussion point, Alvia, why don't you introduce yourself and mention if you have any conflicts of interest or disclosures of note for the committee and the staff?

MEMBER SIDDIQI: Sure. Good morning, everybody. My name is Alvia Siddiqi. I am a family medicine physician and Medical Director at Advocate Physician Partners. My only disclosure is really that I am employed by them and my spouse is employed by CVS Health. But otherwise, those are the only disclosures that I have.

And I have had the opportunity to serve on the Medicaid Pediatric and Adult Core

Set in the past as well. So I really appreciate that presentation and I am sorry that I couldn't be there in person for meeting with all of you this time.

CO-CHAIR GOLDEN: Super. So, Karen, we hope to see you soon on your way in.

MS. LLANOS: Yes.

CO-CHAIR GOLDEN: So, I will turn it over -- we have another member who just joined in. Okay, welcome.

MEMBER POWELL: Hi, Cheryl Powell with Truven Health Analytics. My apologies. Traffic was horrible from Baltimore this morning. I understand why Karen didn't make it down.

And I think the only disclosure I have is that I do work at Truven on TEFT projects related to some of the HCBS measure surveys, things like that. Otherwise, I have been at Truven since October and before that 16 years at CMS. So, here I am.

I'm going to try to find my name tag. I'm not sure where it is.

CO-CHAIR GOLDEN: Super. And again, we have no other Uber drivers joining us, right? I keep looking for them under the table, I guess.

All right, Tara, it is now your turn.

MS. MURPHY: Good morning, everyone. I'm going to take us through a quick overview of the project goals and some key points from the literature that staff conducted.

As you well know, the goal of the NQF-Medicaid IAP Quality Measures project is to identify and recommend measure sets for the four program areas of CMS's Medicaid Innovation Accelerator Program. As you are well familiar now, these four program areas are: reducing substance use disorders -- we will call them SUDs; improving care for Medicaid Beneficiaries with Complex Care Needs and High Costs -- we refer to this as BCN; promoting community integration -- community-based long-term services and supports -- we will call this LTSS, usually; and supporting physical and mental health integration, which we will sometimes refer to as

PMH.

The recommended measure sets will support states' ongoing efforts related to delivery system reform.

The measure sets should consist primarily of measures that are ready to be immediately implemented by states. Further, the measure should represent the full continuum of care. All state Medicaid agencies, regardless of whether they participate in the IAP will be able to use these measures and the measures will not be mandatory. Rather, they will serve as a menu from which state Medicaid agencies can voluntarily adopt measures that fit their needs.

On this slide, we break down some key NQF terminology. The first definition we call out is that of a performance measure. NQF defines a measure as a fully developed metric that includes detailed specifications and may have undergone scientific testing. Clear specifications of measures allow for replicability across states, health plans, et

cetera.

This definition has been revised since the TEPs met in April. The previous version of the definition required scientific testing of the measure; that is, testing of the measure's reliability and validity. This change comes as part of our responsiveness to CMS, TEP members, the public, and other concerned stakeholders who felt that the original definition didn't adequately represent the measures that were in use by state Medicaid agencies.

We revised the definition to be more inclusive of those measures currently in use in the Medicaid population, many of which have not undergone full scientific testing but which can be replicated and have results.

This revised definition requires that in order for a metric to be considered a measure, it must be fully specified, meaning that it includes all key components of a measure to ensure that it is repeatable by many users. These required components include the measure's

title, numerator, denominator, exclusions, data source, level of analysis, care setting.

The change to this definition is reflected in the immediate use question of the decision logic we will use during our measure deliberations later today.

The next definition we called out on this slide is that of a measure concept. A measure concept is an idea for a measure that includes a description of the measure, including a planned target or numerator, a population/denominator.

The difference between a measure and a measure concept is that a concept may not be fully specified with all necessary components and, therefore, may not be ready for immediate use.

During the TEP in-person, another designation arose for those measures that showed particular promise for potential adoption. We call these metrics promising measure concepts. Both the LTSS and PMH TEPs identified promising

measure concepts during their review at their meeting in April. As we have mentioned many times over the life of this project, our goal is to recommend measures that are ready for use in states tomorrow. Ideally, our final recommendations would include no more than about 20 percent measure concepts.

The next definition on this slide is that for tools. A tool is an instrument that can be used for screening and is not a measure but can be used within measures. An example of this is the PHQ-9 depression test questionnaire or the BASIS-24 tool, which is referenced in one of the SUDs measures that we will discuss later as a reconsidered measure.

And finally, we also note that surveys are not performance measures but that they can have measures in them. An example of this is the CAHPS survey, which is made up of 19 individual performance measures, each fully tested and NQF endorsed.

And here are those examples I just

mentioned. In the first bullet, you see the NQF-endorsed measure Depression Remission at Twelve Months. You see that from the description that the change in the PHQ-9 depression test is used to calculate this outcome measure but that the tool itself is not the measure.

The second bullet references the CAHPS survey I mentioned on the previous slide. As you can see, the CAHPS survey is made up of 19 performance measures which have all undergone reliability and validity testing. Many surveys have undergone psychometric testing but the items within this survey have not been fully tested.

We will now briefly take you through some background information on the four program areas. Our first program area is the reducing substance use disorder program area, which focused on Medicaid beneficiaries who experience significant impairment such as health problems, disability, and failure to meet major responsibilities as a result of substance use disorders.

According to CMS, two of the top reasons for hospital readmissions are substance abuse, in particular, alcohol and substance use diagnoses. And of all Medicaid beneficiaries, 12 percent of adults and 6 percent of adolescents have a substance abuse issue.

Compared to patients on Medicare, private insurance, or even dually-eligible patients, Medicaid-only beneficiaries have the highest combined rate of both illicit and prescription drug use. Lock-in programs, which limit patients to filling prescriptions at one location in order to manage patient's prescription use are again being considered as a mechanism to address opioid misuse.

Measures in the reducing substance use disorder program area will focus on the CMS quality domains, as will the remaining three program areas. To date, one theme that has arisen when considering SUDs measures is the identification of people with substance use disorders or co-occurring conditions.

Of the 114 measures in this program area that NQF staff collected, 69 of those measures were characterized as clinical care, followed in second by care coordination, which identified 27 measures.

The next program area is promoting community integration through community-based long-term services and supports, LTSS for short. This program area focuses on Medicaid delivery reform for beneficiaries living in the community and using home- and community-based services and social supports. This program area does not include institutional care.

Measures in this set will focus on the CMS quality domains. Some themes that have arisen to date are finding the right measure to address this program area, which is changing and growing all the time and looking for ways to align measures that are already in use in multiple states.

Of the 66 LTSS measures collected by NQF staff, the largest domain represented was

clinical care with 21 measures after that care coordination was identified for 16 of those measures.

Living in and participating in the community are important parts improving life satisfaction. As individuals with the need for long-term services and supports look to rejoin the community following institutionalization, mental health disability, difficulties with family members before transition and a lack of choice and control in one's daily life are often predictors of re-institutionalization. We can look to these predictors as areas for possible intervention in order to reduce re-institutionalization.

I will now turn it over to my colleague, Kate Buchanan, who will provide an overview of the remaining program areas.

MS. BUCHANAN: Great. Thank you so much, Tara.

So here we can see the improving care for beneficiaries with complex care needs and

high costs, also referred to as BCN. BCN focuses on supporting Medicaid delivery reform for beneficiaries who experience high levels of costly yet preventable services. They are a small portion of the Medicaid population, making up just about five percent of all beneficiaries but they account for more than half of the total Medicaid expenditures. This group also includes one percent of beneficiaries who account for 25 percent of total Medicaid expenditures.

This group is very heterogeneous, with beneficiaries experiencing different medical, behavioral, and psychosocial needs. Patients in this group often have multiple chronic conditions. Eighty-three percent of the most costly one percent of patients have three or more conditions and sixty percent of that group have five or more conditions.

Federally Qualified Health Centers are one approach to improving care and reducing costs in this population. Research has shown that in areas served by FQHCs, there are lower rates of

emergency department use and lower rates of hospitalizations for ambulatory care-sensitive conditions.

More broadly, however, there are many challenges for addressing the needs of this population. Care management interventions often vary in design, focus, and setting, which makes the comparison of results challenging. Consequently, best practices have yet to be identified for wide implementation.

Additionally, there is a lot of churn, which we define as consumers transition between different types of coverage and/or becoming uninsured among individuals characterized as high utilizers. This characterization of high utilization can often be temporary, as individuals often return to normal levels of care utilization after a brief time. Researchers attribute this churn to changes in illness, the impact of care, and mortality.

Once again, you can see the six CMS quality measure domains. And of the 69 measures

identified by staff, the majority fell into the safety and care coordination domains. Staff identified no measures within the access domain.

An example of themes and issues raised to date in this project are the complexity of identifying people with complex care needs, promoting care coordination, and identifying types of social services or supports appropriate for this population.

The last area that we will discuss is supporting physical and mental health integration, also known as PMH. This program area focuses on supporting Medicaid delivery reform for beneficiaries with both mental and physical health conditions. Among these beneficiaries, the top two most common diagnosis for re-hospitalizations among Medicaid beneficiaries are mood disorders or schizophrenia, as well as other psychotic disorders. Individuals with mental health needs often experience comorbid physical conditions as well. Over half of all Medicaid enrollees in the

top five percent of expenditures had asthma or diabetes, as well as a behavioral health condition.

While there is evidence of effective integrated care models, they are not widely used as a result of the many various integration, including payment, project cuts, workforce issues, and EHR capabilities.

With regards to payment, 24 states have limits on same-day Medicaid billing for behavioral and mental health services. Budget cuts in many states often result in reductions in state mental health services.

In the workforce, significant workforce shortages exist in many parts of the country. An estimated 91 million Americans live in areas without enough mental health professionals.

Limited EHR capabilities prohibit providers from documenting relevant behavioral and physical health information, as well as limit communication among integrated teams.

As with the other three program areas, focusing on the CMS quality domains, of the 63 measures identified by staff in this area, the majority fell within care coordination or the clinical care domain. Staff identified no measures within the population health and prevention domain.

And some examples of themes of and issues raised during the project are knowledge that integration is occurring; enhanced coordination, as well as enhanced collaboration; the question of whether care is occurring at the primary care physician's office or remotely; and the question of is care coordination the same as integration.

And with that, I will turn it over to Jennifer to facilitate any questions or discussion.

CO-CHAIR MOORE: AT this time, we want to open it up to the committee for any questions.

Anyone on the phone with questions?

MEMBER GELZER: Hello, can you hear

me?

CO-CHAIR MOORE: Yes, we can.

MEMBER GELZER: Hi, it's Andrea Gelzer.

So we have changed what we are defining as a measure and what was are defining as a measure concept. I just wanted to ask the staff, did you go back and then reclassify measures that each TEP put forward?

MS. GORHAM: Hi, Andrea. This is Shaconna.

So we did not do that. As you remember, we initially used the definition of a measure for an endorsed measure. And so as a result of feedback from CMS, as well as some of our TEP members and the public, we are now using the measure definition that NQF uses for our framework projects. And this project falls under one of the framework projects, which is really in line with CMS's desire and some of what we need really to explain the measures in the Medicaid population.

So, we would like for the Coordinating Committee members, as you all review the measures today, to, if you, based on the definition, notice a concept with the TEPs recognized and appointed as a concept, if you think based on the definition it should be a measure, then as we review the measures, then we will note that. And so then the final report will move forward that way.

So the staff did not change designations made by the TEP but we are asking the Coordinating Committee to do that today.

MEMBER GELZER: Okay, thank you very much.

CO-CHAIR GOLDEN: So I have a follow-up question. One thing that has always been a challenge, when you talk about measures, very often it gets pretty detailed, I know. So, I will not talk about NQF. I will talk about NCQA for a second. And they get very twitchy about the fact that people play with their specifications. But I can tell you that if you

go to Pennsylvania, Colorado, or Arkansas, everybody has slightly different code sets so there are adjustments that need to be made.

Have NQF or others begun to assess that, while alignment is critical, that implementation often requires tweaks to the coding? Because otherwise, you'll end up injuring the validity of the local implementation.

MS. MUNTHALI: Okay, there were too many mikes on. Hi, this is Elisa.

Yes, we actually started a project about two years ago on variation in measurement specs to look at that exact issue. We are trying to resolve it but we do recognize that because of the limitations of what may be happening on the ground with different states, different collaboratives, people that may pick up our measures anywhere, they may need to vary it so they can use these measures. It is not the right thing to do. We always say that we endorse the measures for the level of analysis or the intent

for which they are specified but we do also recognize that folks are doing this.

So this first project was to identify the what, where, and why. And we are hoping to do additional work to see how we can mitigate this going forward. But we do -- we have done some work on it.

CO-CHAIR MOORE: And I have a clarifying question for CMS and I don't know if Karen is still on the phone. But the framework looking at access, clinical care, care coordination, safety, patient care, caregiver experience, prevention, and population health, wanting us to frame our discussion around those areas and as they were going through the different measure sets that we're looking at, there are some areas where there are no measures identified.

So as we move forward, help us understand what our task is in that space, recognizing that some of them have like 60 percent of the measures are in like one bucket

but there is only one or two in the other areas.

So, if we are using these areas as a framework for our discussion and there is a measure's that is missing or a very low number, what is your expectation from us as we use that framework?

MS. LLANOS: Right. So, it's a great question.

As I mentioned, I think of it as a guiding framework and to help organize folks on thinking in terms of what are the different types of measures that should be there. But as I said, we certainly know that there are some where there is going to be more in one category or the other. I think you just acknowledge it.

But it's more let's be thinking about these measures in a broader continuum and that framework is to help think about that broader continuum.

CO-CHAIR MOORE: Thank you. Go ahead.

MEMBER PHELAN: And just to get a better understanding of the framework that we're

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CO-CHAIR MOORE: Introduce yourself.

MEMBER PHELAN: Oh, Mike Phelan.

Just to get a better idea, an understanding of what we're trying to do here, are there basic measures of churning or high utilizers that are currently being used that are standardized across all the Medicaid programs?

So, we're looking at patients with complex care needs, patients that are high utilizers and there is no standard definition of what these specific group of patients are that programs like Arkansas Medicaid can look across each other and say oh, you have a rate of X number of high ED utilizers across all the programs, so there's no such measure like that. Or you have X number of high complex care patients that aren't getting the coordinated care that they need. There is no current measure that looks at those specific, like the hierarchy above, rather looking at the end product what the Medicaid programs are currently trying to look at

internally.

CO-CHAIR MOORE: Yes, I think that's a great question and I will have Karen answer also but within the institute we have a great interest in understanding the concept of churn. Frequency, disparities, equity issues. We have not found a measure. We also find it difficult when we look at databases to be able to capture that transition from the different -- and even when we reach out to health plans, they are unable to know where they are churning from and to. So, there is an absence of that information from what research we have done. So, I will defer to Karen, in case she knows something from the CMS side.

MS. LLANOS: No, it's the same thing. So I think that is just an area that I don't think we've been able to identify measures by either.

CO-CHAIR MOORE: And please identify yourself for the benefit of people on the phone.

MEMBER KELLEY: This is Dave Kelley,

Pennsylvania Medicaid.

I will say that Bill mentioned that we have a Medical Directors' Network for Medicaid. And actually one of our projects that we are going to be taking on in the next 2017 is to actually have multiple states come together and work to identify these individuals with complex needs and look at similarities and differences. And we actually are planning to look at our Medicaid data sets over multiple years, to look at one of the points that was made, some folks will be very high cost for a while and then their needs are met or they have an episodic illness, or they're homeless and their costs go way up. So we are going to actually be looking at that and probably have, I would say, at least 20 states that are right now interested in participating in that. It's more of a data initiative, not necessarily a metric development.

And we are hoping that some of the work that comes out of this will also help to inform us as that project moves forward.

MEMBER KUY: And I assume you are working with Academy Health on that, just as do their group?

MEMBER KELLEY: Yes, they are enabling partners.

MEMBER KUY: Yes, that's helpful.

MEMBER POWELL: Cheryl Powell from Truven.

I just want to go back to the earlier issue about measures versus measure concepts and sticking to the tech specs. I think having developed both for a state, for Maryland, as well as for CMS, tech spec for quality measures and looking across just the great variety not only of coding but programs and how programs are set up, I think this is an issue that we should actually consider tackling in the introduction and really trying to encourage states to take measures and use them as measure concepts within their states.

Often, a measure specified at a provider level but it may be very helpful for a state Medicaid agency, which is unique, to look

at that at a program level or to look at it in multiple program levels but you can't take the pure measure and apply it to the program level because of the way it was configured for a different program.

And so I actually think that encouraging states to look at the measures and think how they could apply those even as measure concepts within their program so that they work for them is a good thing because that may lead. That then gets you some similar measures which may then later be endorsed at a say Medicaid program level or across fee-for-service and managed care for states.

And so I wouldn't want the purity of the tech specs to be a limitation. I actually think that encouraging experimentation with that to fit the needs of Medicaid because there are so few measures that help Medicaid agencies see at the program level or across different HCBS programs, for example, or across different types of programs for other parts of the population you

know what is really going for specific populations or their entire Medicaid population.

So, I would just encourage us to think in that terms. And I think that may be some of why CMS is trying to put together a family of measures. Here are things that are very much worth measuring, we think, and here are some measures that are available but also that experimentation of those concepts in different ways and applying them to programs in different ways I think may be very helpful and helpful to other states.

CO-CHAIR MOORE: Thank you for that. I think maybe one of the resources that might be developed at some point is helping states to make those adjustments but maintaining the validity and reliability of the underlying measure. I think that is the crux of the issue to sustain the quality of the quality measure as these changes are made because we have seen some really interesting adjustments that call into question the quality of the quality measure and what is

being reported. So I think that there is a balance to be made but a good point.

I know that we are way behind on time. So, I am going to take these two and then we'll turn it back over to Bill.

MEMBER SHAW: Hi, John Shaw.

Speaking of balance, what struck me was there is value of having consistent technical specs to do comparative benchmarking. That's good. We should have that.

There is also value in targeting the use of a metric to the actual population locally in your state or local area. That is a value, too.

I'm a systems guy. I would say do both and there is value in both. But from a transparency perspective, we need to just specify that.

So have here is the standard specs that the intent is to be able to benchmark across populations and then each population can customize the specs to their best use and maybe

state that as a go forward.

CO-CHAIR MOORE: Maybe the next phase of a quality measure after it's endorsed is to look at the variation that is occurring in the field and then seeing if there is consistency. I mean we all think we have a unique population but there is probably like five buckets in which the variation is occurring in which we could provide resources on how to make that adjustment.

MEMBER SHAW: And I think the NQF is in the process of moving more into --

CO-CHAIR MOORE: Correct.

MEMBER SHAW: -- the implementation side of things.

CO-CHAIR MOORE: Yes.

MEMBER SHAW: So this is a perfect fit for the direction we are going forward.

CO-CHAIR MOORE: Yes, like the Disparities Committee looking at risk adjustment, as an example. Yes, okay.

MEMBER ZERZAN: So this may be a bit controversial but in looking at the measures,

there were very few, if any, that I was like aha, this is the measure I've been searching for.

For the most part, these are well-trod. They are not super exciting. We all wish they were a bit better. And my view of looking at this, especially because the purpose of the Innovation Accelerator Project is sort of, and these are optional, is that this is grassroots so that this is a place for states to sort of figure out what works best and then the next step might be the Child and Adult Core Set or figuring out oh, well this is the way the measure specs were but here's how states are using them and they are not exactly following measure specs; so perhaps we should recommend some change to the measure specs based on this.

So that made me, I think, a little more comfortable with some of this of like this is just dipping our toe in the water and there is a deep ocean we are going to have to wade through. And this is sort of the beginning.

**CO-CHAIR GOLDEN:** So you know Jennifer

said that we have to move along. So we are going to, I'm sure, after listen to the conversation, instead of moving thing to the parking lot, we'll have happy hour areas to move things to. So, there's lots of discussions for later on today.

So, let me turn it over to Shaconna. Now, this next part is important because it is going to tell you what we need to be doing for the rest of the day.

MS. GORHAM: Yes, it is important and it is a lot of information. So, we thought it would be helpful to give an overview of the measure selection process, starting with the TEP review. Barbara, Sheryl, Maureen, and Andrea have been gracious enough to join us for both the TEP and the Coordinating Committee meeting and they will help us to relay the messages and the measures recommended by each TEP. We'll go to the next slide.

So the measure selection process is really a standardized approach for selecting the best available measure in each IAP program area.

Each TEP met. They used the standardized approach to discussing vote on measures. They were separated into program area-specific breakout sessions in April to decide on the measures that will be discussed today.

Using a similar process, you, this committee, will discuss the TEP's recommendation and the outcome of this two-day meeting will be finalized for four finalized measure sets in each program area to recommend to CMS.

So this pretty graphic on your screen really represents the six steps in the TEP measure selection process. The first step, staff scan universe of measures; capture those measures, step two; assign ranking on the specific measure criteria, step three; assign an overall score to each measure in step four; step five, conducted an initial review of the list of measures and removed measures by measure score; and finally, the last step, analyze remaining measures using a decision logic to recommend to this committee. Over the next several slides, I

will walk through each of these steps quickly.

So, again, the step number one, NQF performed a comprehensive search using relevant measure sources. We searched more than 75 sources, many of which were recommended by members of this committee, as well as the TEP. Sources included NQF repository of measures, CMS measure inventory, American Society of Addiction Medicine, et cetera. We also searched many state sources, 17 states to be more specific. To name a few, we looked at Minnesota, New York, Colorado, Ohio, Arkansas.

We identified measures based, again, on feedback from CMS and multi-stakeholder experts regarding the goals of each program area and the current measurement activities of the states' delivery system reform efforts.

Step number 2, we captured measure details on each of the IAP program area measure summary sheet. So, as part of your pre-work, you received those kind of big, bulky Excel sheets. We won't torture you and ask you to pull those

out today. But we used those sheets as a way of capturing the measure information in detail. So, included on those sheets, you have the numerator, denominator, measure type, the steps basically for the measure. All of this information was housed in the fourth separate Excel sheets.

As stated earlier, we used the CMS quality measurement domains as an organizing framework.

Step number 3. So staff ranked the measure specific criteria as part of the collection of measure details, using four measure-specific criteria. We looked at feasibility, usability, scientific acceptability, and evidence, assigned a ranking for each measure criteria.

Each measure criteria, the feasibility, usability, scientific acceptability, and evidence has its own definition for the high to low rankings. If we could not find information to support one of the criteria, then we mark that as unsure. Of course, you know it

is very easy for us to find information on NQF-endorsed measures but not always as easy to find information for concepts in those measures in states.

Okay, so you see on your slide some of the designations for scientific acceptability and evidence. So, let's go to the next slide.

Okay, Step number 4, after the criteria were ranked and translated into a numeric score, staff calculated an overall measure score based on the rankings and rating.

Bullet two on your slide describes the weight of each of the four criteria in the overall measure score calculation. So you will see that feasibility and usability each made up 30 percent of the measure score; scientific acceptability made up 25 percent and then evidence made up 15 percent.

Feasibility and usability were weighted the highest because, considering reporting burden, accessibility of data, alignment with other measure sets, et cetera, is

particularly important to the Medicaid population.

The overall measure score was used in the culling down process.

Step 5, the initial review and removal of measures by measure score. So TEP members conducted an initial review of the measure universe. We wanted to make sure that the process is well-vetted. So, along the way, we have often asked for feedback from CMS, from our chairs, we had an Advisory Group, and then TEPs, and then also from yourself.

So before the TEP meeting, the TEP members received a survey soliciting feedback on the measures captured to date. Their feedback was very instrumental in helping staff search for more measures and find additional information about the measures already included in the measure summary sheets.

Once the summary sheets were promulgated and measure scores assigned, staff conducted an analysis to determine the mean. The

mean is the threshold or cutoff to determine whether a measure or a concept would be considered for additional consideration.

Prior to the meeting, TEP members received measure summary sheets with overall measure scores and mean scores for their particular program area.

Again, the measures or the concepts with scores under the mean were not considered unless the TEP members identified the measures or concepts that scored under the threshold that they wanted to retain. We gave TEP members the option to propose up to three measures or concepts below the threshold that they wanted to retain.

So on this next slide is really a visual of the information that I have shared thus far. So, the measures were assigned a score based on the measure's feasibility, usability, scientific acceptability, and evidence. We found the mean score of all the measures in the program area, which became the cutoff.

So, here in your diagram you will see that the cutoff in this case for the program area was 0.92. The top blue box demonstrates all measures equal to or greater than the mean automatically selected for further TEP discussion.

The TEP members were able to select up to three measures below the mean to be retained for further discussion. So in the bottom box, we see that a low-scoring measure retained by TEP member moved to the decision logic review.

This allowed the TEPs the option to -- or allowing the TEPs the option to retain a measure below the threshold was important because scores were determined by information the staff could find. So, again, we easily found the information for NQF-endorsed measures but the TEP members, being boots on the ground, having an expertise in the areas, knew more information about concepts and so they were able to retain those concepts.

CO-CHAIR GOLDEN: Can I stop you for

a second to ask two questions on the scaling?

Do you know what the scale was? So was it like zero to three? Is that the usual with these measures?

MS. MURPHY: So actually based on the weighting that we calculated, the maximum score was a little odd. It was a 2.7, I believe. And there was a good amount of variation among the four program areas on the maximum score. The highest was the integration of physical and mental health, which I believe had a high cutoff score of 1.7.

MS. BUCHANAN: Yes.

MS. MURPHY: And the lowest was the substance use disorder, which was a 0.92.

MS. BUCHANAN: Yes, in that program area, we did find a lot of poor developed measures but we also found a lot of measures with little information.

CO-CHAIR GOLDEN: With weighting -- I'm sorry, the scale in substance abuse was zero to --

MS. MURPHY: So the scale -- the formula used to calculate the measure score was consistent across all program areas. But the variation of the scores that we found, based on the measure information varied.

CO-CHAIR GOLDEN: And I'm sorry to be technical but I looked at the scale. So something that had a low like you know, we thought poorly feasible would have gotten a one. But if you are unsure, it got a zero. Is that right?

MS. MURPHY: That's correct.

CO-CHAIR GOLDEN: So people were -- so you could, technically if you weren't sure, rate something lower than if you thought it was terrible.

MS. MURPHY: Yes, I think we were thinking that low didn't mean terrible. That wasn't quite the translation in our mind.

Shaconna or Peg, do you want to add anything?

DR. TERRY: So the ratings that we

came up with, and by the way, when we saw the ratings for each program and they were different, then we used a cutoff point, as you know, differently for each program.

So when we came up with the original high, medium, low, and unsure, it was because we really couldn't find enough information usually. That was really the biggest problem, especially with measures that weren't NQF-endorsed or weren't out there really enough in the public view. It was a bit of a struggle and that's what we did, if that helps.

MS. GORHAM: All right. And so the final step, Step 6, describes the work the TEP completed during the in-person meeting. Steps 1 through 5 was all pre-work. As you know, we love to give our committees pre-work because you all had a lot to do.

So, 1 through 5 was pre-work and Step 6 was the actual in-person meeting activity or happenings.

So, the remaining measures, those

above the threshold and those that TEP members retained were evaluated initially against the criteria and the decision logic. Each measure was considered against the specific criteria or questions using the following indicators of high, medium, and low.

The next slide is a great illustration of this step, albeit very small. So really tiny diagram but keep in mind that it is very similar to the decision logic that you have at your table and a few tweaks have been made, based on feedback received during the TEP meeting. Again, feedback is very important throughout this process. And so we made tweaks and Peg will further elaborate on this on the decision logic question about immediate use that also goes back to the tweak for the definition as well.

And just a clarifying point, really the major change for the definition is whether or not the measure has been tested. And so we know that a lot of great measures used in Medicaid will never actually come to NQF for endorsement.

And so we can't say that just because it is not suitable for endorsement or does not have that testing, it is not a measure.

And so we look at the measures. We are not asking you to change the specifications or anything like that. You are looking at what the measure is before you. You just will look to see whether or not -- well, maybe this measure was considered a concept because it didn't have testing but it really is a measure because it has been fully spec'd out.

So the next slide.

So finally, the decision logic results for each measure or concept will yield the following. So either the measure or the concept will be excluded from the recommended measure set, the measure is recommended for inclusion in the measure set, or the concept is recommended for inclusion in the measure set. Again, just to reiterate, we are looking for, CMS is looking for measures ready for immediate implementation and they have allowed us to have some concepts but we

do not want more than 20 percent.

So just to quickly review the voting that the TEPs actually partake in and you will also partake in the same voting, for the most part, the TEP members utilized hand votes. Today, we will do a mixture of hand votes and the actual clickers but because we were in breakout sessions, the TEPs used hand votes.

Consistent with NQF voting, votes require at least a 60 percent -- greater than 60 percent agreement. All decisions to support or not support were accompanied by one or more statements of rationale as to how and why each decision was reached. And so we will ask you to do the same today as you vote. We just want to make sure we record why we are voting a certain way.

So I know that was a lot. I will turn it back over to Bill to facilitate any discussion or questions.

CO-CHAIR GOLDEN: You're not off the hook yet.

MS. GORHAM: Okay.

CO-CHAIR GOLDEN: So okay, that's terrific and after our break or comments, we are going to get back together and we'll start our work.

How are we voting? Are we voting on the measure as a totality or on subsections?

MS. GORHAM: So our voting system is we have been very strategic about it. So both. So we will start with program area, the BCN program area. So we will vote and we will look at that program area and you will be voting first on the new measures. Did the BCN have new measures?

MS. KUWAHARA: No, we did not have new measures -- oh, I'm sorry. I thought I clicked it.

We will not be voting on any new measures submitted after the deadline because there were no measures submitted after the deadline but we will conduct votes on measures referred to from other program areas. We also

will get to measures that were identified for reconsideration by coordinating committee members.

CO-CHAIR GOLDEN: So again, so a measure shows up, a percentage of people who still have their hat check at the end of dinner, at the restaurant, what elements of that are we going to be voting on, the whole measure, the global score, the components, the different elements, I just want to know the process.

MS. GORHAM: So you will vote on the individual measure. And when we get there, we will definitely go through the process step by step. But you will vote on the individual measure. At that point, we will have you open your discussion guide so that you will see all of the measure specs.

CO-CHAIR GOLDEN: Right.

MS. GORHAM: You will see the preliminary analysis completed by staff. We will, if it is, for example, an NQF-endorsed measure, if we have information from the Standing

Committee about the measure and where it is in the endorsement process, we will share that information if it is a concept or something that we have been able to get in contact with the state about, if we have more information about that measure.

So, you will review all of the information about the individual measure.

CO-CHAIR GOLDEN: So Measure X comes up for discussion. We have the different elements of that measure. The discussion is open on all of that and then we have one vote on the measure. Is that correct?

MS. GORHAM: Yes.

CO-CHAIR GOLDEN: So, it is a global vote but we can discuss all the different aspects of the measure for the global vote.

MS. GORHAM: Yes.

CO-CHAIR GOLDEN: Okay.

DR. TERRY: Yes, I just -- and thank you for the questions. I am going to cover some of this in the next part.

CO-CHAIR GOLDEN: Okay.

DR. TERRY: And then that's a good time to jump in and really ask additional questions.

CO-CHAIR GOLDEN: Okay because Jennifer and I weren't sure if that is what we would be discussing.

DR. TERRY: It's a lot. It's a lot.

CO-CHAIR MOORE: And if we are leading this group, we had better know.

(Laughter.)

CO-CHAIR GOLDEN: Okay, other comments or questions about the TEP process and our compass for the future here, I guess?

Anybody on the phone? Okay.

MEMBER SIDDIQI: This is Alvia. I'm sorry, just a quick point.

So I know one of the things was trying to do the pre-work to cull out measures but will there be opportunity to do more of that in the future between this meeting and the next meeting or, at this point, most of that work has been

finalized and so there won't be that opportunity to select new measures again?

DR. TERRY: I'm just --

CO-CHAIR GOLDEN: She wants to know whether more measures can come in after today.

DR. TERRY: At this point, I think we have the measures in whatever we talk about today. I don't think we are going to add measures that come in to this project for this project but we will share a little bit about how this is seen.

And this is considered sort of the beginning. I'm not going to say starter sets but that's been talked about. So, this is not the end. This is the beginning of recommended measures.

MEMBER SIDDIQI: Okay, thank you.

CO-CHAIR MOORE: So what we're voting on then is just recommendations to CMS to figure out what the next steps are. Because some of the early conversations, and Andrea, I think that you brought this up on one of the first calls is the

issues with gaps; gaps in evidence, gaps in knowledge, and if we are recommending measures, we have to acknowledge those pieces. And there was a desire to focus on that piece first but for the objectives and purpose of this project, we are not able to do that.

But putting that forward is the purpose of that and to take it to the next level.

MS. GORHAM: And towards the end of Day 2, you all will notice that we do have a final overall look at all of the measure sets and, at that time, you can make suggestions to CMS for future iterations of the measure sets.

CO-CHAIR GOLDEN: Yes, did somebody else have a question on the phone?

MEMBER SCHIFF: Hi, Bill. This is Jeff. Just one general comment, I think, and then one specific one.

The general comment is I think we have to look at these measures as sort of guidance and tools for Medicaid programs so that how they get used is really sort of a living piece of work

that we will just have to see over time.

The specific thing, I guess I am just cautionary in that I noticed, for example, that in the feasibility, surveys automatically got a lower score, which is true because they are less feasible to do. However, I worry. I think as we look at this we have to be careful that the raw score is sort an averaging of unlike categories. So I just want to be cautionary about that because I think in some situations, especially things like care coordination for complex patients, some of the things that may not be feasible instantly may produce the best information. Thanks.

CO-CHAIR GOLDEN: All right, other comments or questions?

Now, I apologize for jumping ahead.

DR. TERRY: No, no.

CO-CHAIR GOLDEN: I was looking at my slide deck in my hands and your material was missing. So, I was getting concerned. So, I will turn it over for -- I'm sorry, was there

something else?

MS. GORHAM: I just wanted to take a pulse in the room. We are scheduled for a break right now but we are also behind time. So, just to take a pulse in the room, if you want to take a five-minute break?

CO-CHAIR GOLDEN: Five minutes would be great.

(Whereupon, the above-entitled matter went off the record at 10:36 a.m. and resumed at 10:53 a.m.)

DR. TERRY: Okay, I know people are coming back but we are a little tighter on time, of course. So, I think I should get started. And what I'm going to do herein the next few slides is talk about a few things. The measure selection process, we have begun talking about that but I am going to go into it in a little more detail; the voting procedures; and the decision logic steps.

I just want to make sure everybody knows we are not going to take every one of the

measures there through the decision logic. Some of the measures that were recommended by the TEPs will just move forward.

But we have so many other what ifs, what ifs, what ifs, and those are that if there are new measures or measures that are newly submitted -- we have some; or measures that were moved from one TEP, one program to another; measures that we, I call them, saved or recovered from what the TEP did, the pre-work; and also measures are related, we will take a look at those, take another look; and the one other types of measures we will look at are those that people here want to pull from the measure set and really talk about and decide whether we want to keep that. So, those are the ones we will have an in-depth look at. So I just wanted to make sure we all understand where we are going with this.

So, go to the next slide. And so this one I'm just -- would you go to the next one? Just go to the little more detailed one. Thank you.

So here we have the process for -- and I just said this so I am going to do this real quickly. This is the process for selecting the measure set. The first one is to evaluate newly submitted measures. I think there is only program that has it, the PMH program. And also measures that were moved from one -- suggested to move from one particular program to the other by the TEPs.

The pre-work that was done, those measures we will look at separately and that will be the next step. And I just want to let you know we had ten measures that were selected from all the programs to kind of look at to see whether this group wants to include those measures.

The best in class for, again, the related measures.

And the last one is really to remove measures -- what I just talked about. So the ones that this group feels should not be in.

And then we will vote en bloc.

So, again, here is a little bit more detail. I'm going to try to go through this quickly because I think we have just said it but I do want to say that for each of the measures that are either new or those moved from one program to the other, we will take those through the decision logic and they will need to have more than 60 percent vote for the measure to be retained and added to the measure set.

For the next one, it is the measures that in the pre-work were recovered. And I mentioned that we allowed people to save some measures. And what we will do -- what we have, there are ten measures; two for LTSS, two for BCN, three for PMH, and three for substance use disorder. And we will also take those measures through the decision logic as well. And we need, again, more than 60 percent.

For those that are actually measures that have been pulled prior to the meeting, we would expect that those who pulled them will be able to speak to their rationale and some of

these measures have two people or three. So, those are the popular measures that people felt we needed to reconsider again.

So going to the next slide, I think I just did the reconsideration one. So, the next slide.

And this is the best in class. I do just want to let you know why we did this. You know we, if anybody's been part of a CDP process here at NQF, we do look at related measures. It's part of what we do but we're not trying to harmonize them here. So I just want to make sure you really are aware of that.

We are just -- it's another look. And when you have them in tables, it is really easier to see whether they are similar or whether they're different, or whether there is one that is broader. Really, the goal is to find parsimony is the word to find the broad measures if it captures what needs to be captured.

So again, the purpose of this is, again, just to look at this. The staff will go

through the measures in terms of the numerator, which is the target or what the measure is about and the denominator is really the population. So, just so you know, and you don't, the other part is if you don't want to remove anything, so be it. It's just another way to look at it.

And then when you get to the elimination, we are asking on this one, this is somebody here in the room or on the phone who says ah, I really don't know why that measure is on that measure set and I want to really look at it again, so they need a rationale and they need a second. So they can talk about the reason and if somebody seconds it, then we will review that measure and we will take it through the decision logic as well.

And then the last is just at the end we will look at each measure set and, based on everything we've just done, we will remove, we will discuss, we will second, whatever, and then we will need to vote more than 60 percent to approve that set.

And then I want to just take a minute and just talk about voting procedures. You know the voting procedures at NQF are always a little complicated. So, some of it we are doing electronically and some of it we are doing by hand, just so you know.

So electronically -- and you will see this as we go along, so I don't need to spend a lot of time on this. But the evaluation of newly submitted measures, those moved from one program to another, those recovered by a member, and then they vote en bloc. And then the ones that are related, we are just doing a hand vote. And measures pulled from the block for further discussion, we are also doing just a hand vote.

And I just want to say we will work with the people on the phone to make this work. Just so you know we are very experienced at that.

So, here is the decision logic. And I just wanted to really walk you through this a bit because this is really the core of what everybody will be doing in each of the groups,

led by the chairs of those groups. So, we will look through these measures.

But the first thing I just wanted to go through and, again, this begins with the first part of this. And I know this is a little hard to see. I will just getting my piece of paper here, so I have it in front of me. Here we go.

So the decision logic begins with the extent that the measure addresses a critical quality issue. And that critical quality issue we have high, medium, and low as the kind of issues here that they need to address.

I am just going to kind of let you see this. I think if something gets a high/medium, high/medium, it moves, moves, moves to the next, except that when you get to the extent with the measure concept or measure concept is ready for immediate use and there we have a divide. And if it is a measure, it goes in one track. If it is a measure concept, it goes in another and you will see that.

So, let's go and just take a little

bit of a walk through the decision logic. And the first one starts with is to what extent does this measure/concept address critical quality objectives of CMS quality measurement domain or key concepts that we have. And so the high is measure addresses a quality measure domain or all of the key concepts; medium is addresses the quality domains but maybe not address the key areas and concepts.

So the key areas and concepts are what we did early on with I know input from this group because we had a call just to share with you what we were doing. And we also had input from CMS on what those key concepts and key words were. And so we're using that. We use that as a way to make sure it addresses those.

And then the low is that it does not address domains or concepts.

So, it gives you a sense of how we walk through that. And what we will do is we need to get 60 percent vote for that to go through.

And can I just say this? This is really what we did in the TEP. So this is not new to the people who were in the TEP.

The next one that we have here is does it -- to what extent does this measure or concept address an opportunity for improvement and/or significant variation in care by quality challenges? Again, we want to get at whether this is something that shows opportunity to improve or there are some things that can change.

And so we have high, addresses quality -- multiple quality challenges and opportunities for improvement; medium measure has potential to address variation in care and quality challenges; and measure does not address is low.

So we have kind of gone -- and I don't need to read all of these because you will hear all these later. I just wanted to give you a sense of how we did high, medium, and low.

So the next one is the alignment one. And so this is -- I think this is always a bit of a hard one but this is one that we really -- to

what extent does the measure or concept demonstrate efficient use of measurement resources and/or contribute to alignment of measures across programs, health plants, et cetera, et cetera?

So here, we wanted to get at the fact that we want measures that we think are not duplicative of other measures but they have some ability to be used across programs and health plans. And of course, the issue here, of course, is also whether it is specified to do that, too. So that's the next one.

The next one we get to is to what extent is the measure ready for immediate use. And you have heard this probably five times already here, if not more today. And so it is key and it is key for CMS. I see Beverly smiling at me as I say that.

And so here we have high is a fully developed measure that includes detailed specifications and may have undergone testing that is currently used or planned for use in

states. And so that is high. That is for a measure.

For a concept, a measure concept that includes a description, numerator, and denominator is currently in use or planned for use in states. So it is a little bit -- if it is a measure concept and it goes to what is the medium and low is a measure or concept not in use.

So, when you look at this diagram that you all had, you will see that on the diagram there is a little different movement for measures that are high -- measures that are concepts -- measures that are measures and measures that are concepts.

And then the last question is to what extent do you think this measure is important to Medicaid agencies and other stakeholders, including consumers, families, Medicaid managed care organizations, and providers?

This is based on your knowledge, based on your expertise, based on your background. So,

high is important to state Medicaid agencies and beneficiaries and families; medium is important to two stakeholders, including state Medicaid agencies; and low is important to only one stakeholder.

It is a bit of a judgment here but the goal is to know that this is something that is considered an important measure to look at.

So --

CO-CHAIR MOORE: Can I clarify that?

DR. TERRY: Yes.

CO-CHAIR MOORE: So the high says state Medicaid agencies and beneficiaries/families and then medium it says two stakeholders. So high is also just two stakeholders. So is high those two plus?

DR. TERRY: Right.

CO-CHAIR MOORE: Okay.

DR. TERRY: So there can be -- yes, the first can be more and the second one, we don't really -- we didn't put in important to consumers. We left it at others. It can be two

others.

CO-CHAIR MOORE: Got it.

CO-CHAIR GOLDEN: And a quick question. Looking at this, the notion of the measure feasibility, does that fit in any of these boxes? Is it in box 3? Is it in box 4?

DR. TERRY: Well, we did look at feasibility already.

CO-CHAIR GOLDEN: Okay.

DR. TERRY: Remember as we were looking at and rating the feasibility, knowing basically that the data and where you get the data from is really accessible. So, we have looked at that initially. We don't have it here in this decision logic.

I kind of think it is implied here, as you ask the question. I'm just thinking about it but I don't think so. I think we've already addressed it and it is certainly something you can talk about. Feasibility is I think something that can be an issue when you discuss this.

Okay, I know I did that kind of

quickly but I know we are short for time. Any other questions?

Okay, so next is -- oh, Miranda?

MS. BUCHANAN: Isn't it time for public comment?

DR. TERRY: It is.

MS. BUCHANAN: Thank you very much. So we will now open the lines for public comment. Any members of the public can either participate via teleconference or type their questions into the chat box and a member of the staff will read it.

Operator, if you wouldn't mind opening the lines now.

OPERATOR: Okay. At this time if you would like to make a public comment, please press * then the number 1.

And you have a public comment from Clarke Ross.

MS. BUCHANAN: Okay.

MR. ROSS: Hi. This is Clarke Ross. I work for the American Association on Health and

Disability and a member of the National Quality Forum Work Group on Persons Dually Eligible for Medicare and Medicaid and the Medicaid Adult Measures Task Force.

And this is really a comment for tomorrow afternoon's discuss but I am going to be an hour late in joining the call tomorrow afternoon.

This concerns the concern of home- and community-based service advocates in the aging and disability field. So that is two coalitions, the consortium of citizens with disability and the disability and aging collaborative, about how modest and incremental the proposed measures are for home-and community-based services and that our practice is farther ahead than the draft slides indicate.

And that the attention should be much more on community inclusion than transition from institutions. And there are three or four different examples we could cite but I want to encourage your committee to carefully review

these tonight before tomorrow afternoon's discussion, the recommendations from the National Quality Forum Committee on home- and community-based services and their vision of what is important and what is being done in selected states and program like the National Core Indicators that you are going to hear from later at this meeting and the personal outcome measures that we heard about last month at the Medicaid Adult Measures.

So, I just wanted to plant the seed that we have this commissioned work by the National Quality Forum on home- and community-based services and there is concern by a number of home- and community-based advocates that what you are dealing with is quite modest and there is more happening in the country that should be considered. So, thank you for your consideration and we look forward to your work. Thank you.

MS. GORHAM: Thank you, Clarke, for your insightful comments. We share your sentiments. And again, thank you for your

comment.

MR. ROSS: Okay.

MS. BUCHANAN: And we also want to invite anyone sitting in the public in the room to come up to the microphone and ask any questions, if they have any.

OPERATOR: And at this time, there are no public comments from the phone line.

MS. BUCHANAN: Okay, thank you very much.

MS. KUWAHARA: All right, so we can dive right into our first program area.

We will be assessing measures for the improving care for Medicaid beneficiaries with complex care needs and high costs.

So I know you all have seen this list of criteria -- I'm sorry, this list of events that will be taking place today but I will just provide an overview specific to BCN.

First we will go through and evaluate measures referred to from other program areas. Then we will evaluate measures that were

identified for reconsideration by members of the Coordinating Committee.

There were no related NQF measures identified through the NQF staff preliminary analysis, so we will not be conducting voting on related measures for BCN. Then you all will have an opportunity to remove any measures that were recommended by the TEPs from the final recommendations.

And then, finally, we will cast a vote on the overall measure set. Next slide, please.

Andrea, are you on the line?

MEMBER GELZER: I am.

MS. KUWAHARA: So, I will invite you to provide an overview of the TEP deliberations.

MEMBER GELZER: Thank you. First, I would like to give a shout out to my other colleagues on this TEP and they were James Bush, Dr. James Bush, who is the State Medicaid Medical Officer for the State of Wyoming; Dan Culica, Dr. Dan Culica, who is the Senior Research Specialist for the State of Texas HHS; Dr. David Moskowitz,

who is the Medical Director of Hope Center at Alameda Health System in Oakland, California; and Howard Shaps, M.D., who is the Medical Director for WellCare of Kentucky. And kudos to their hard work that got us to this place and really the brilliance of all their minds in the discussion.

So with that, with regard to review of the Beneficiaries with Complex Needs TEP discussion of the 69 or 70 originally surveyed measures, the TEP actually reviewed and discussed 43 measures or, at the time, what were deemed measure concepts and recommended 14 measures to move on, as well as six measure concepts to go on to the Coordinating Committee. And you will hear also that two additional measures were retained after this process and will be considered retained by members of the Coordinating Committee.

So throughout our deliberations, as we discussed, there were really several themes that kept coming out. And first of all, there really

is some ambiguity surrounding who is a complex beneficiary. And that really posed some degree of challenge and opportunity in identifying best-available measures. And we kept having the discussion as to okay, are we talking about super utilizers who are really not the five percent who drive 50 percent of the cost individuals but really the half a percent that are at the top of the pyramid, or are they individuals that aren't quite the super utilizers yet, they are really people that have a number of chronic conditions and are in danger of really falling off that cliff to exponential cost and health care needs?

We also had quite a discussion about whether we were going to consider doing specific measures or measures that really encompassed multiple conditions. And we, you know after lots of discussion, decided that we would favor, in most cases, measures that encompassed multiple conditions, rather than a single condition.

And then I would just note that many of these measures -- and it's not just for my TEP

but for all of our TEPs and the whole previous TEP discussion, many of these measures can be considered cross-cutting measures. I mean if you look at medication reconciliation measures, cost and resource use measures, I mean I think it's important that all of the measures that we discuss with regard to this TEP are pertinent to beneficiaries with complex needs but we have to remember that they are also pertinent to other populations in other subject areas that we will discuss later today.

And with that, I turn it back over. We're not going to go over each of the measures at this time. Is that correct?

MS. KUWAHARA: That's correct.

MEMBER GELZER: Okay.

MS. KUWAHARA: So, if we move on to the next slide, please.

Before moving on, we did want to make one note. During the TEP in-person meeting, a few TEP members identified several measures that were specified for the Medicare population.

After the TEP in-person meeting, NQF staff and CMS determined that in order to maximize the potential of the BCN measure set, these seven measures outlined on the slide were inappropriate for the BCN population. As such, they are removed from consideration and they will not be included in the final measures that we ask you all to vote on later today. Next slide, please.

So, as I mentioned previously, there were no late submission measures for consideration but TEP members recommended four measures from other program areas. We will take each of these four measures through the decision logic and vote through them individually.

We have included a handout at your desk, if you are joining us in the room. It is the decision logic handout and guiding questions. We will be using that to inform our votes today.

For individuals joining us remotely, we sent out an email over the break that has the exact same handout. So, please use that to your advantage.

So, I would like to ask everyone, remote and in-person, to please open up your discussion guide. It's an H channel file and it is located in one of two places. It was sent out yesterday via the calendar invitation for this meeting and it is also included on the NQF web page for this project.

As you load that up, I will be providing a very brief guide, an overview of the discussion guide.

So everyone should think of this tool as a continuous very long web page. And the agenda synopsis serves as a shortcut to all the different points within the web page.

So, as you will notice on the left-hand side, right now we are in the Review of BCN Measures stage. And directly to the right of that section, we have our measures and measure concepts for reconsideration, as well as new and referred measures for Coordinating Committee review. If you click on either of those links, it will drop you down, if it is working

correctly. Hopefully, everyone in the room, it is working for you all. If it's not, please flag us down and we'll try to sort something out. This may be a single computer issue.

Once you do drop down or you scroll down, you will notice that we have an overview of the measures. So, if it is an NQF-endorsed measure, it will have the NQF number, as well as the description. And for measures that were identified for reconsideration, the lead discussants are also made available there.

You'll notice that there is a section with measure specifications and staff preliminary review. If you click on either of those links, it should drop you down to the measure specification section, which is found below. This will include fields such as data source, description, numerator, denominator, as our staff preliminary analysis.

There is also a field labeled status. That will let you know if the measure was recommended by the Technical Expert Panel, if it

was identified for reconsideration by a member of the CC, if it is a related measure. And if it is a related measure, it will let you know which measures it is related to.

If you scroll all the way back up, or use your back space arrow at the top left-hand corner of the screen, you can access the measures -- all the way at the top in the navigation bar, once you click on "Measures," it will provide you with a comprehensive list of all measures that fall under the program areas. So, they are listed out for BCN, PMH, LTSS, and SUD.

We also have links to the measure repositories for each of the program areas and that gets you to the Excel spreadsheets that were distributed several weeks ago.

And I just want to get a pulse check for those in the room. Are you able to utilize the links?

Okay.

MS. BUCHANAN: I think it is our computer.

**MS. KUWAHARA: That is excellent news.**

**All right, so we can begin with your first measure slated for review. This is not an NQF-endorsed measure. This is Adult Access to Preventive and Ambulatory Care 20-44, 45-64, and 65+. I will read out the description and the numerator and denominator for everyone.**

**This measure is used to assess the percentage of members 20 years and older who had an ambulatory or preventive care visit. The organization reports three separate percentages for each product line: Medicaid and Medicare members who had an ambulatory or preventive care visit during the measurement year; commercial members who had an ambulatory or preventive care visit during the measurement year or the two years prior to the measurement year.**

**The numerator is Medicaid and Medicare. One or more ambulatory or preventive care visits during the measurement year. For commercial use, one or more ambulatory or preventive care visits during the measurement**

year or the two years prior to the measurement year.

And the denominator: members age 20 years and older as of December 31 of the measurement year.

And with that, I will turn it over to Jennifer to facilitate discussion.

CO-CHAIR MOORE: At this time, do we have any comments or questions about this measure? Deborah.

MEMBER KILSTEIN: Just a quick question in terms of where there is a carve-out or where there are situations where a plan is not responsible for all the services -- I'm sorry. Did you have a question?

MS. KUWAHARA: No, we're just trying to --

MEMBER KILSTEIN: Oh, okay. Do we need to make any comment on this or exception on this, where there may be cases were a plan is responsible for some services but doesn't have access to whether or not the primary care visit,

preventive care visit was done because it was paid for by Medicare and they may or may not have access to that data?

DR. TERRY: So, I just so I can understand the question is could we change in some way the requirements here on the measure?

MEMBER KILSTEIN: No, I was thinking more in terms of at least noting limitations in some cases. And some of those decisions are made by the state and how they put their program together.

So in some states, this may be perfectly appropriate. In other states, it may be difficult to report, depending on who is involved in different aspects of -- coordinating different aspects of the person's care.

DR. TERRY: So you know these are not -- will never be mandatory, these are --

MEMBER KILSTEIN: No, I understand.

DR. TERRY: Okay.

CO-CHAIR MOORE: Yes, so Bill and I were having a conversation during the break about

that because there were a couple of measures that we quickly identified that these issues definitely exist and the question about what are we voting for. And can we add clarification and caveats and like this package around what our vote really means. It doesn't mean like we are endorsing it and everyone has to apply this and that the vote is a recommendation not for CMS to then continue the process. It is not for purposes of endorsement.

DR. TERRY: I think what we're doing here is we're recommending measures or concepts that we think are ready. What CMS has told us, and they have said they are going to do, nobody is -- this is open to any state but these are not required. These are not any -- there are no requirements. But I think to your point, I think we will be able to take -- if we want to say something and basically, if you want to make a statement and just tell us that you know the caveat here is we will be able to capture that. And I think but we just want to make sure we know

clearly that is what, generally, people are saying.

CO-CHAIR MOORE: Yes, I think that is important to be able to capture for all these for contextual information because a lot of times when things come out of NQF, states will just take it for face value and think this is NQF. This is what we have to do and not take into account --

CO-CHAIR MOORE: Does that work --

DR. TERRY: Yes, okay, good. Thank you.

MS. GORHAM: And then if I could just add just a clarifying point, I think that Jennifer definitely touched on it, this is not an endorsement project. And so we are not endorsing measures here.

Oftentimes in endorsement projects the reason why a measure is endorsed because we have all of the information; the developer has provided details about the measure and we can say and we have evaluated. The Standing Committee

will look at the measure and make sure that this evidence is good and that we have reliable and valid testing. And so we don't have all of that level of detail for some of the measures, especially those measures that are concepts or those measures -- especially concepts and those measures that are not NQF-endorsed.

But Deborah, you bring up a really good point. Whether or not this measure or concept can be actually implemented in a state, if some states can do it but other states can't, those are the things that you want to consider as you move through your decision logic. So that will influence your vote because, again, we are looking for this measure set that states can use. But if you know, because of your expertise, that this concept will run into certain problems in states because of X, Y, and Z, that is something that we want to know and we want to include in the report. But also you want to really consider that as you vote and consider every step in the decision logic.

CO-CHAIR GOLDEN: Okay. Three comments, I guess, is: A) I'm surprised we don't have a pediatric version as well because there are high-cost complex pediatric patients; B) I was concerned preventive visit codes are complex but if we are accepting preventive and/or ambulatory, that is pretty reasonable; and then C) perhaps down the road having a denominator directed toward a high-risk population would be more useful than having -- this measure is for all patients in the program. It's not for high-risk patients. But we might get more mileage out of looking at it if we can define a high-cost population.

Otherwise, it is fine.

CO-CHAIR MOORE: Someone on the phone?

MEMBER GELZER: Yes, this is Andrea Gelzer and I do have a comment.

So this didn't come from as a TEP. It was referred in. But I just have to say, personally, I'm responsible for Medicaid managed care quality programs in multiple states and we

would consider this a well person measure, as a measure of access and not pertinent to this specific group.

The other point I would make is that in trying to move these measures, because the denominators are so huge, you won't see a lot of significant performance improvement from year to year or I would not expect that across the board.

So, I think it's important that we all be on the same page with this.

CO-CHAIR MOORE: So Andrea, with that comment, was there a discussion within the TEP about the value of having this measure, then?

MEMBER GELZER: See, I don't even remember.

CO-CHAIR MOORE: Oh, okay.

MEMBER GELZER: But I don't remember the discussion about this measure or I would have made those comments.

CO-CHAIR MOORE: Okay.

MS. GORHAM: So I will say that this was a measure that was initially discussed in the

LTSS TEP and the LTSS TEP thought that it was suitable for some of the other program areas.

But with that, Barbara may speak more.

MEMBER MCCANN: Actually, a point of clarification and I want to thank you for accepting our dump online.

From the perspective of the LTSS group, when measures were presented that clearly related to health plans, we did not, as a whole, support them.

So in construct, the measure, if you take out the references to health plans because that is what this was developed for product lines, et cetera, could be valid with the modification discussed about over complex as a denominator and could actually occur. But that may be something that you will see come up over time is that we didn't feel we could, if you will, mess with the specifications and in Medicaid, we are not going to have commercial. Right? I mean it is measure exchange and you take exchange or whatever.

So that was a key factor in ours as to why we, if you will, did not take that on.

CO-CHAIR MOORE: Can you clarify what you mean by not commercial? So Medicaid managed care has private insurance.

MEMBER MCCANN: Well, this is a health plan and we understood our task to address fee-for-service or Medicaid outside Medicaid managed care.

CO-CHAIR MOORE: Oh.

MEMBER MCCANN: And commercial, for instance, I wouldn't think would be defined in Medicaid managed care but the idea of duals, et cetera, was valid. And we would agree with the comment on the huge database this would be to look at.

CO-CHAIR MOORE: Allison?

MEMBER HAMBLIN: Thank you. Yes, I guess this may be sort of a half-ass question in that -- well, maybe some specific, some process. And that is, so the concept of an access measure here, an access to preventive care measure I

think many of us would agree is a critical measure, a critical concept, whatever the right terminology is, to include for a complex need population.

And I guess my question is are there -- I'm sort of scanning the list of other measures that are included in the BCN category. And there are some follow-up after hospitalization measures but this appears to be the only one on the list that relates to this notion of are high-need populations getting you know ongoing access to primary and preventive care.

And so I guess my question is, I think from the discussion there are clearly some limitations associated with this measure but are there other options in any of the other groups to consider or would anyone else, based on their expertise -- I know we are not introducing new measures but there is sort of like a baby in the bath water issue here of is there value in including the least imperfect measure on a

construct that is important and not knowing this measurement area particularly well myself, were there other options considered, given that there don't seem to be other measures addressing that on this list?

CO-CHAIR MOORE: Okay, thank you.

SreyRam.

MEMBER KUY: Well I was just going to add that we, in Louisiana, actually have been developing a measure that is similar to this and we have been using it since around July when we did Medicaid expansion to prove that having just access to health insurance showed a substantial increase in people getting preventive care or something that would actually move the needle on health care.

And it is has been phenomenal what we have seen. You know like we had half a million people who enrolled in Medicaid expansion and among that, about 90,000 or so got some sort of preventive care service. So, I love this measure. That is just my standpoint.

I am a general surgeon but I see the end result of people who don't get preventive care service and end up with complications of diabetes. So this is just my two cents about how much I love this measure.

CO-CHAIR MOORE: Okay.

Andrea, I want to make sure that, because you are not in the room, that you have an opportunity to speak after a couple of comments, in case you have anything to add.

MEMBER GELZER: Thanks. No, I have already I think said my piece.

I just think we, as a group, I mean if you are looking at the different subject matter areas and you are looking for drivers for individuals, those individuals with complex needs that may have fallen off that cliff or may not quite be there, is it really that access measure or even whether they got their preventive visit or not? Is that really what is driving the care? And I think that that is a matter of some debate.

That said, if the majority of the

Coordinating Committee feel that it is important that this measure be included somewhere and this is the best place to put it, I would not object to that rationale.

CO-CHAIR MOORE: So that goes back to Allison's point about do we include the measure even though it's not perfect, with a goal of having some type of access measure versus having nothing at all.

So, CMS representative Beverly or Karen, if they are on the line, can you give us some guidance and if that would be a valuable response of the committee?

MS. LLANOS: Can you guys hear me? This is Karen.

CO-CHAIR MOORE: Yes.

MS. LLANOS: I think the earlier conversation about feedback or caveats, I mean this falls right into it. So this may not be the best measure but I think you could have some sort of feedback in the final report that says this measure, you know the majority of the committee

members agreed that this measure hit on certain aspects that were not captured in the other measures. I think something like that could be helpful and then make the case for what were some of those aspects that were uncovered, with the caveat that the measure might not be the best for purpose.

But I think that kind of feedback we wouldn't to get lost in the report.

CO-CHAIR MOORE: Great. I like this idea of having additional context for each of the things that we're voting on, like these little stars, asterisks, we voted for but.

And when you flip over your tags, because I don't know everyone, if you could make sure that your name is up so I can see it. So that says Kelley but you're David.

MEMBER KELLEY: Hi, this is David Kelley, Pennsylvania Medicaid.

I would actually support adding this metric. It can be used across populations. I think the NCQA spec does include lower age bands,

I believe. It includes both not just primary care but any outpatient visit. So there is a whole host of codes.

You can, in a long-term care support service program, you can couple Medicaid, you should be able to couple Medicaid plans but you're not doing coordinated care well if you are not looking at Medicare claims. This is mainly a claims-based measure.

So I know that we struggle with this because when we looked at people with complex needs, unfortunately, these folks are seeing all kinds of specialists, PCPs, 15, 20 times, 30 times a year.

So it is a very basic process but it doesn't get to measure kind of that quality of the coordination of care. But I think it is, at least, a nice proxy and I think folks parse out subpopulations. You could start to look at utilization that goes up pretty high but doesn't necessarily translate into better care.

So I think it is a reasonable

specification to include in this population and it applies to Medicaid in general, all populations, you know pediatrics, adults. I do believe there are pediatric age bands. And it can be applied to the dual eligible population. And it can be applied to both managed care and fee for service.

And I just want to go back to kind of a question and comment that I'm hoping that these measures aren't meant just for fee-for-service Medicaid because now the majority of folks are actually in Medicaid managed care. And even though we don't want to necessarily say these measures are geared for managed care because they can be taken down the various subpopulation levels. But hopefully, as we go through this, we're thinking in terms of individuals that are covered under Medicaid, whether it's fee-for-service or managed care.

CO-CHAIR MOORE: Thank you. I have been informed that there is someone on the lines who has a comment or question.

MEMBER MOHANTY: Yes, hi. This is Sarita Mohanty. I appreciate the comments here and I do feel that this measure could have relevant -- I guess I'm trying to think of it going back to the definition of beneficiaries with complex care needs and you know looking at the definitions that were outlined in the deck.

And you know we talk about how they are likely to experience high levels of costly but preventable service utilization and these care patterns our costs are potentially impactable.

So when I try to look at measures in my space, this measure is I think important just to understand their overall rates of engaging with, in this case, primary care, ambulatory care, and I think also to be able to use this measure to see if there is a correlation between access to preventable ambulatory care services and reduction of preventable service utilization of high-cost utilization.

So I try to look at the measure not

only as an independent measure of access but also how is it correlating to how it impacts, in this case, preventable high-cost service utilization like emergency department visits.

And I wanted to get kind of a sense from the group, as we are thinking about these measures, our approach to looking at how it correlates to other measures we may be collecting.

I don't know if that makes sense but I'm trying to go back to the definition of complex care when we look at these measures.

CO-CHAIR MOORE: Sheryl.

MEMBER RYAN: I appreciate Bill's comment about the pediatric population because I think it is sort of lost in a lot of these measures.

But I think the 20-year-old, I think to look at that lower of an age range is really important in terms of being able to measure whether kids are transitioning out of pediatric care into adult care. And I think that group in

their 20s, particularly when they have complex needs, really drops out of the healthcare system and they resurface in emergency settings because they haven't been able to make that.

So this is a really good measure to capture that aspect of transition that is so important for all young adults but particularly those with the chronic medical or mental health conditions.

CO-CHAIR MOORE: Cheryl.

MEMBER POWELL: I think noting that we think this is a great base measure and one that would provide valuable insights for Medicaid agencies, particularly if they stratified it based on things that they were particularly interested, whether that is age, duals -- I love the duals. I would do duals. I highly recommend duals but also by different types of you could even like get chronic conditions and things like that. So I think as a base measure, it might be a little vanilla but it's a great start and states could really do a lot with it to learn

about their programs, figure out where to focus and see where there is quality.

CO-CHAIR MOORE: And I can't see your tag but you're next.

MEMBER HENNESSEY: Hi, Maureen Hennessey.

CO-CHAIR MOORE: Okay, Maureen.

MEMBER HENNESSEY: So my question was for those entities that have used, could anybody speak to what actions they have taken as a result of reviewing data on this measure?

CO-CHAIR MOORE: So maybe going back to Srey.

MEMBER HENNESSEY: Yes, that would be great. Thanks.

CO-CHAIR MOORE: Can you use the microphone? Thank you.

MEMBER KUY: So in terms of what we've doing with the data, we are actually able to run the data on a continuing cycle, like every two weeks. So we actually see cycles on like influenza vaccinations going up, or, in this

case, preventive services will go up that have a seasonal variation, we are able to drill down to the parish level, or in other states you call it county level, and really see where are the counties where people are getting these great preventive services, and where are they not getting it, and where do we need to do better outreach.

Other things that we're able to see is the divide by gender and demographics. So, it's really telling when you see like there is this huge use among say women and particular in the Medicaid expansion population. These are women who didn't have health insurance before. And Louisiana being a state that had been ranked one of the worst in the country for women's health, that shows almost a justification which you kind of need during this climate for why it is so important to have access to preventive health care.

So I see it as, 1) being able to help us do interventions; and 2) to even justify our

existence of providing this health care.

MEMBER HENNESSEY: So it sounds like it helps to promote health equity and address disparities in care for some subpopulations.

MEMBER KUY: Absolutely. You phrased it so much better than I do.

MEMBER HENNESSEY: Okay, thank you.

No, this has been very helpful information. Thank you.

CO-CHAIR MOORE: I want to be cognizant of the folks on the phone. I know that we have someone who would like to jump in. It's easier when you're in person to jump in. So, I want to go back to the phone.

MEMBER SCHIFF: This is Jeff. I just had a question about the numerator. Is this any ambulatory visit that would come about, like if someone went to their pulmonary specialist for something like that?

CO-CHAIR MOORE: David's nodding his head, yes. So, David, do you want to comment?

MEMBER KELLEY: To answer your

question, Jeff, this is Dave Kelley, if this is the HEDIS spec, it looks at a whole host of outpatient visits and it can be primary care. It can be specialty care. I think it includes FQHC visits as well. There is a whole host of codes that are thrown in there.

So, it really looks at the total of number of -- it looks at whether or not a person has gotten access to care at any of those venues.

To answer the question about how can this be used, we did expand in Pennsylvania, 700 and some thousand new people. So we used this as a sub-metric to look at. Not only did they get an insurance card, but they actually got access to care. And how often do they actually get access to care?

We also look at regional variation in our urban versus our rural areas. And we also drilled down and actually have looked at race and ethnicity. This is one of the measures we require our health plans to actually measure and look at race as well as ethnicity in the region,

regional differences.

So we also look at it in the context of emergency department visits, as well as in-patient stays. NCQA bundles the three kind of together. So, we like to look at them in that kind of overall context.

So, it is a fairly useful basic measure that can be really sliced, and diced, and parsed to look at the various populations. It's not perfect, though.

CO-CHAIR MOORE: So I just want to reach around back to the person on the phone, just to make sure that they were able to follow through with their thought on their question.

MEMBER SCHIFF: Yes, I think the real question, obviously, is what's the purpose of this because I think what you're saying, David, makes perfect sense.

I think in terms of advocating a firm measure or folks with special needs, I think the challenge is then if somebody just has a pulmonary problem and they go to their pulmonary

doctor, are they getting their other preventive services and is this a good enough measure of that.

So, I guess the question I just have is a little bit for the group, is how do we approach the purpose in that context?

CO-CHAIR MOORE: All right, any other thoughts? It is what it is, yes.

So, I had my HHS hat on, even though I'm not there anymore, in running review meetings for measures and for research grants, and recognizing that the first proposal, the first measure that comes to the table, you always give a little extra time because you're storming and your norming, right, where we're trying to get to a point where we all come together and we work out some of the bugs and some questions we spent some time talking about voting again. And I wanted to give us a chance to be able to do that.

For subsequent measures, we're going to move a little bit quicker but I just wanted to give that opportunity for us to come together as

a group on this.

I think that is we're all comfortable, we are ready to move -- okay.

MS. KUWAHARA: All right, so we will be using the clickers at each of your stations for voting. When we call for the vote, you will submit your vote and if the number you select shows up on your screen that means your vote was cast. However, if you see a horizontal line, that is potentially problematic and we will want to get you a new clicker.

For those of you joining us on the line, please submit your votes via the chat function at the bottom left-hand corner of your screen and the staff will cast your votes.

All right, shall we get to it?

MS. GORHAM: Just remember that we are voting for each step in the decision logic. So you will be voting multiple times on the same measure.

MS. KUWAHARA: And for those of you joining us remotely, please refer to the handout

that we sent over the break. That will give you the definitions of what constitutes high, medium, and low throughout.

So for the first vote, to what extent does this measure or concept address the CMS quality measurement domains or program area key concepts? Please note that this is for Measure Adult Access to Preventive/Ambulatory Care 20-44, 45-64, and 65+.

Polling is now open and you may submit your votes.

MS. BUCHANAN: Can you tell us what we're voting --

MS. KUWAHARA: I apologize. If you would like to select high, please press 1; if you would like to select 2, please -- I'm sorry, if you would like to select medium, please press 2; and if you would like to select low, please press 3.

High is addresses a CMS quality measurement domain and program area key concepts. Number 2 is medium, addresses CMS quality

measurement domains but does not address program area key concepts. And 3 does not clearly address CMS quality measurement domains or program area key concepts.

It is also on the screens for those of you in the room and this is also included in the handout for those of you joining us remotely.

MS. GORHAM: So, Miranda will direct this. You can direct your clicker to Miranda to cast your vote. And we have had a lot of discussion about the measure but definitely as we go through each step in the decision logic, if you feel need more discussion or clarification then just let us know but voting is open for this measure.

CO-CHAIR GOLDEN: So, has the first vote gone through? So now we go to the second vote?

MS. BUCHANAN: We are waiting for two more responses from individuals.

CO-CHAIR GOLDEN: Okay.

MS. BUCHANAN: So we are now waiting

on one vote.

Allison?

MEMBER HAMBLIN: Hi, is there a place we can reference the key concept?

CO-CHAIR MOORE: So if you open the sheet that I was referring to, the text on the --

MEMBER HAMBLIN: Am I missing the key concepts?

MS. GORHAM: So if you look in your discussion guide, under the measure information, so you have a number of measure specifications. So where your key concepts will be your key words.

So if you go down, you will have NQF number, description, status, numerator, denominator, and then key words, that is synonymous with the key concepts.

MEMBER HAMBLIN: Oh, they've been crossed off.

MS. GORHAM: Exactly.

MEMBER HAMBLIN: Okay. Is it internal?

CO-CHAIR GOLDEN: So do we know who is missing? Which number is missing?

MS. KUWAHARA: We're missing a vote from someone -- we have too many mikes on. We're missing a vote from someone on the phone but I don't think she's available to submit her vote right now.

CO-CHAIR MOORE: Got it.

MS. BUCHANAN: We still have a quorum.

CO-CHAIR MOORE: Okay.

MS. BUCHANAN: I believe we can still meet our criteria.

CO-CHAIR MOORE: Okay, yes.

MS. KUWAHARA: Seventy-four percent of the 19 voting members voted for high; twenty-one percent of the 19 voting members voted for 2, medium; and five percent voted for low.

So, we'll move on to the next step in the decision logic. This is the second step. To what extent will this measure or concept address an opportunity for improvement and/or significant variation in care?

If you would like to select high, addresses multiple quality challenges and opportunities for improvement within a program area, please select 1. If you would like to select medium, the measure has the potential to address variation in care and quality challenge, please select 2; if you would like to select low, measure does not address quality challenges or opportunities for improvement within a program area, please select 3. Polling is open.

Okay, we captured all 20 votes. Sixty percent of the 20 voting members selected high; forty percent selected medium; and there were no votes for low.

We will continue on the decision logic. For step number 3, to what extent does this measure demonstrate efficient use of resources and/or contribute to alignment?

If you believe this measure demonstrates an efficient use of measurement resources, addresses a broad population not duplicative, or contributes to alignment -- if

you believe this measure is both duplicative of other measures and does address some areas of alignment but does not encompass broad populations, please select medium. And for low, please select 3, no evidence that the measure demonstrates or addresses any of the above criteria measures similar to this one already in use.

Eighty percent of the 20 voting members selected high; fifteen percent selected medium; and five percent selected low.

We will move on to the next step in the decision logic. To what extent is this measure or concept ready for immediate use?

If you would like to select high, a fully specified measure and may have undergone scientific testing and is currently in use or planned to be used in states, select 1. If you believe this measure demonstrates medium, not duplicative of other measures and does address some areas of alignment but does not encompass broad populations, please select 2; or select 3,

low, no evidence that the measure demonstrates or addresses any of the above criteria.

Seventy-five percent of the 20 voting members selected high. So, it will move forward as a measure.

To what extent do you think this measures is important to state Medicaid agencies and other stakeholders? Select 1, high, important to state Medicaid agencies and beneficiaries and families; medium, important to two stakeholders, including state Medicaid agencies; or low, important to one stakeholder.

CO-CHAIR MOORE: Bill's making cheat sheets up here for us. I think he was a kindergarten teacher at some point.

MS. KUWAHARA: Eighty percent of the 20 voting members selected high; fifteen percent selected medium; and five percent selected low. So, this measure will be recommended for inclusion in the BCN measure set.

We can move on to our next measure, Clinical Risk Score. I will tee it up by

providing some of the measures specifications.

The description is: Patient's clinical risks have been assessed and scored. Rationale: An individual's risk score will speak to degrees of compliance with preventive measure guidelines, for example, cancer screenings, addiction screening, and also chronic care management gaps.

The numerator is those having risk score in their medical records. The denominator is population by ZIP code, gender, et cetera.

MEMBER GELZER: Hi, this is Andrea. Can I make a comment?

CO-CHAIR MOORE: Please, Andrea.

MEMBER GELZER: There are lots of different ways to measure a clinical risk score. I'm very confused by this one. Which one are we recommending? Are we saying any method that is utilized should include all of those stipulated requirements?

MEMBER SIDDIQI: This is Alvia and I just raised my hand as well on the webinar but I

agree. I was pretty confused by this one as well. There are so many different methodologies to determine a patient's clinical risk score, depending on the disease condition, or the screening measure, or testing that we are talking about here.

So, I was very concerned about this measure as well, that there really is no great blanket clinical risk score methodology that encompasses every single different kind of preventive screening test.

CO-CHAIR MOORE: And for the benefit of those on the phone, folks around the room are also nodding their head.

Deborah?

MEMBER KILSTEIN: My question is what is the source of this measure and where is it being used?

CO-CHAIR MOORE: Good question.

DR. TERRY: As you look here, it's not being used anywhere. Let's see the source of it. I think we actually got this from a TEP measure

-- TEP member is what said.

I don't know where -- it doesn't say it's being used in any programs at this time.

MEMBER KILSTEIN: Just a question then about validity testing, and all the testing. So there is no indication that is has gone through any of that.

CO-CHAIR MOORE: Yes.

MEMBER KILSTEIN: Okay.

CO-CHAIR MOORE: So I failed to mention at the beginning for this particular measure, that, as your cruise director, I have been informed that the honeymoon is over and that we will be limited to about three minutes for discussion for each of the measures going forward.

So we now have two minutes and I'm a time keeper.

Judy.

MEMBER ZERZAN: So I agree this is super vague and yet I think each of use risk adjustment in some way. And in the spirit of

this is the beginning of this and there needs more refinement, I am in support of this measure because both plans and health teams should be risk-stratifying their population in some way and I think that you know I didn't nominate this but that's what this captures for me is that you know who is high risk and you know who is not and you focus on those folks.

CO-CHAIR MOORE: I guess, not as the chair but as someone who practices at FQHC here in D.C., and we get this long list of measures to potentially use, I don't think we would know what to do with this because of vagueness of it.

So, I'm not sure that it would be useful for us at the ground level.

CO-CHAIR GOLDEN: I suggest we vote now.

CO-CHAIR MOORE: Across the board.

Any other comments or thoughts? Anyone on the phone?

MEMBER MOHANTY: Yes, hi, this is Sarita. I kind of agree with the last comment in

the sense of I think you're right I think; it's extremely vague. But if the goal is to maybe start to have systems and health plans or delivery systems start to have a risk score, start to think about how they're defining risk in their population segmentation. It could kind of spur some kind of guidance about having a risk score and what you should be thinking about.

I don't know but I do think it is extremely vague. So I am kind of torn. I am just kind of trying to decide here. But I think if there was some ability, if folks feel strongly the other way, there would have to be a lot of guidance on this particular measure. I don't think we could just lay it out like this without some kind of guidance about how to possibly utilize it.

MEMBER HENNESSEY: Yes, this is Maureen. The one thing that I would say is that I would be concerned that because it is so vague, it might be a measure that would be vulnerable to biases that might then perhaps create unnecessary

barriers to carry down the line for patients.

CO-CHAIR MOORE: Yes, that's a really good point.

MEMBER MOHANTY: Yes, that's a good point.

CO-CHAIR MOORE: Any other comments? Okay, I think we are ready to move on.

Good job, you guys; three minutes exactly. I'm proud of you.

MS. KUWAHARA: Okay, this is Measure Clinical Risk Score. It has the numeric assignment number of 2 on our discussion guide.

For the first question, to what extent does this measure concept address critical quality objectives of the CMS quality measurement domains and/or identified program area key concepts? Please select 1 if you feel this measure is high; for medium 2, and low, 3.

Fifteen percent of the 20 voting members selected high; 35 percent selected medium; and 50 percent selected low.

So this measure will not continue

forth in the decision logic and it will not be recommended for inclusion in the BCN measure set.

CO-CHAIR MOORE: But you know and I agree. Even when we vote against them, we also add the contextual information from the discussion that goes to CMS, indicating that we do feel looking at risk is important but this measure does not meet what we feel would be sufficient to be used as a recommended measure.

MS. KUWAHARA: We will include those sentiments in the report.

CO-CHAIR MOORE: Okay.

MS. KUWAHARA: So for our next measure number 26 on our discussion guide, Referral to Community Based Health Resources, the description is referral of high risk score patients to address social determinates of health. Rationale: referral to community-based health resources will be a proxy indicator for health behaviors at large.

The numerator is individuals with referrals and the denominator is population by

ZIP code, gender, et cetera.

CO-CHAIR MOORE: Can you repeat where this is found, what number it is?

MS. KUWAHARA: Yes, this is measure number 26 and that's not to be --

CO-CHAIR MOORE: So we're not going in order of what's online?

MS. KUWAHARA: Yes, I will make this distinction. So, every measure, whether or not it is NQF-endorsed has a numeric assignment system. For instance, this is 26 and you will notice that they are out of order. This isn't used as an ordering system. It is really just an assignment system mostly for transcript purposes so we can make sure we are identifying the same measure but also multiple measures are discussed in different program areas. So we just want to make sure we are highlighting the right measure.

CO-CHAIR GOLDEN: As the clock starts, I would like to point out that the denominator on the item 26 is the entire population and not people with high risk scores. So something is

wrong in how this is specified.

CO-CHAIR MOORE: And again, this is a measure that comes with very little information for us to go based on.

Deborah, go ahead.

MEMBER KILSTEIN: I just had the same issue with this measure, that it wasn't specified, it hasn't been tested.

CO-CHAIR MOORE: Yes.

MEMBER KILSTEIN: You know there's no data on it.

CO-CHAIR MOORE: Yes.

Andrea, were there discussions in your group about this that should be added? Because it looks like in the room we do not have a lot of comments.

MEMBER GELZER: No, I think it's too general but that's my personal opinion.

CO-CHAIR MOORE: Okay. So, if there are no other comments or questions, we'll move on to voting.

MS. KUWAHARA: That sounds good. And

before we dive into voting, I just wanted to make a note. On your discussion guide, even though it may not be in numeric order, it is an order if you follow the agenda. So, we should be able to keep on time with that.

All right so this is Measure 26: Referral to Community Based Health Resources. For the first vote, to what extent does this measure or concept address the CMS quality measurement domains and/or program area key concepts?

If you would like to select high, please press 1; medium, 2; and low, 3.

MEMBER RYAN: Some of us can't access these so we're kind of stuck.

CO-CHAIR MOORE: Okay, thanks for letting us know that.

MS. KUWAHARA: In the meantime, it looks like voting technology is working. So, for this measure, 50 percent of the 20 voting members selected low, it does not clearly address CMS quality measurement domains or program area key

concepts. So, Measure 26 will not be recommended for inclusion in the BCN measure set.

CO-CHAIR MOORE: Okay and considering that they do not have access to the information, I think that we should take a quick break. Okay, thank you.

(Whereupon, the above-entitled matter went off the record at 12:13 p.m. and resumed at 12:36 p.m.)

CO-CHAIR MOORE: All right, you guys. So in a previous life, I was a cheerleader at Michigan during football season. So if I have to break out my cheerleader voice, I will.

MS. KUWAHARA: So we will be evaluating the last and final referred measure from a separate program area. We'll be looking at Measure number 14. This is NQF number 1888, Workforce Development Measure Derived from Workforce Development Domain of the C-CAT.

The description is 0-100 measure of workforce development related to patient-centered communication derived from items on the staff and

patient surveys of the communication climate assessment toolkit.

The numerator is workforce development component of patient-centered communication. An organization should ensure that the structure and capability of its workforce meets the communication needs of the population it serves, including by employing and training a workforce that reflects and appreciates the diversity of these populations.

Measure is scored on two items from the C-CAT patient survey, and 21 items from the C-CAT staff survey. Minimum of 100 patient responses and 50 staff responses. The denominator, staff respondents should include all staff categories, including both and clinical and non-clinical staff, as well as those in roles such as building, environmental services, food services, et cetera.

There is more to that denominator, and I can go into detail if you all would like to.

CO-CHAIR MOORE: Yes, I'm just reading

some other pieces. So I am struck, if you look at the gray tag here, that the threshold score is 1.71 and the overall measure score is 1.5, so, where some of the other ones, they were zero point.

MS. KUWAHARA: So I would like to note that the threshold score is specific to the BCN program area. And this measure, I believe, came from LTSS, and I believe the LTSS program area had a lower threshold score, so just keep that in mind. But it is good for comparative purposes.

CO-CHAIR MOORE: Great, thank you. Can you use your microphone?

MEMBER HAMBLIN: Sorry, are we on number four?

CO-CHAIR MOORE: Fourteen.

MEMBER HAMBLIN: Fourteen, awesome, thanks.

CO-CHAIR MOORE: Yes, we're on number 14. Andrea, did you want to jump in? I just want to make sure you're on the call, too.

(No response.)

CO-CHAIR MOORE: Do we know if we have everyone back on the call?

MS. MURPHY: Everyone is on the web platform. But I suppose we can do a quick roll call to see who's actually dialed back in after lunch. Andrea Gelzer, are you still on the line with us?

(No response.)

MS. MURPHY: Jeff Schiff, have you been able to rejoin?

MEMBER SCHIFF: Yes.

MS. MURPHY: Great. Alvia Siddiqi?

MEMBER SIDDIQI: Yes, I'm back.

MS. MURPHY: And Sarita?

MEMBER MOHANTY: Yes, I'm here.

MS. MURPHY: So I think we're just missing Andrea.

CO-CHAIR MOORE: Could we send a email to her, just to?

MS. MURPHY: Yes.

CO-CHAIR MOORE: Should we wait for her to come on, or?

CO-CHAIR GOLDEN: I think we should move on.

MS. KUWAHARA: As she didn't assess this measure, perhaps we can move on and she can jump in.

CO-CHAIR MOORE: Okay, great. Any questions, thoughts? Does anyone have any experience using this measure?

MEMBER SIDDIQI: I can tell you we've had experience in trying to capture a similar sort of measure around follow-up from either, you know, alcohol diagnoses or alcohol abuse diagnoses, as well as substance abuse diagnoses, and there are a lot of challenges.

And part of the challenges, as we all know, is that behavioral health is typically a carve-out, so that the vendors that manage it are oftentimes different from the traditional medical folks who are trying to work on these types of measures.

And so I can tell you that there's a lot of challenges with the capture of the data as

well, in terms of how it's being diagnosed and reported. So, for example, a patient may come into the emergency room and not have that priority diagnosis listed even though that is part of what they came in for, is maybe diagnosing anxiety or something else.

And so I don't know if that's part of the challenges that others have experienced. But I do think that this measure really challenges a couple things.

One is that it's saying really that emergency room visit needs the follow-up, and that's sort of the emphasis, rather than necessarily that intensive outpatient encounter, or I should say the hospitalization or intensive inpatient encounter, and that follow-up from that setting. Which I think many times is more important, not just the emergency room follow-up.

And then also the two parts of the 30-day, versus the seven-day. I do think that to be very challenging, especially with the seven-day, but even 30 days is a good way to at least start,

maybe, to have the conversation. But, you know, I do think this is a very interesting measure.

But again, I just think because of the complexities around behavioral health and vendor management around that, sometimes unfortunately this isn't always very well managed. But it's an interesting measure nonetheless.

CO-CHAIR MOORE: So, okay, I'll open up. Deborah.

MEMBER KILSTEIN: I just want to know how widely used this survey is compared to other surveys that are looking at --

CO-CHAIR MOORE: I'm looking at staff notes, person and family-centered care projects. Can you guys clarify?

MEMBER GELZER: It gets reported in New York.

DR. TERRY: Well, it went to the Person and Family-Centered Project. But the use of the measure appears to be really, it doesn't have any information about how actually it's used today, if you go through the details here.

C-CHAIR MOORE: So we don't know if it's been used and it was found to not be useful or effective?

MS. MUNTHALI: Right, and just to add a little more context to Peg's statement, it was last looked at at NQF in 2012, so it is due for a maintenance review. And so then we would probably find out, you know, how it has been used in the field.

We are trying to pull up the report from then to see. But I think that was the initial endorsement date, yes.

CO-CHAIR MOORE: So it is a -- NQF found it to be a valid and reliable measure. So we do have that, as opposed to some of the other measures.

MS. GORHAM: Yes, and I was able to finally pull up the information from the last PFCC report, the last PFCC Project 2015-2016. Based on the discussion at the meeting and update from the developer indicated plans for a substantial update to its assessment data and

analysis, the PFCC committee approved a deferment for the consideration of maintenance endorsement.

So NQF will work with the developers to remain updated on progress, and expects to review the measure in 2017. So as Elisa said, the initial endorsement was 2012. And so right now, we don't have any more information.

CO-CHAIR MOORE: Well, I don't see anything around the room. Anyone online or not online, but on the phone? And do we know if Andrea's joined us?

PARTICIPANT: She has.

CO-CHAIR MOORE: Okay, great. Sheryl.

MEMBER SIDDIQI: Yes, and excuse me, but I don't have any additional comments on this one.

CO-CHAIR MOORE: Okay, thank you. Sheryl.

MEMBER RYAN: Is this part of the patient experience satisfaction domain? It wasn't clear what domain it was from.

MS. GORHAM: So we designated this,

and for the CMS domain it's the safety domain.

DR. TERRY: If you look at the numerator and denominator, they're not looking at information from patients, so.

MEMBER RYAN: It can be related to patient satisfaction, how well your workforce is aware of diversity.

(Off-mic comment.)

COURT REPORTER: I'm sorry, could you please use your mic.

MEMBER PHELAN: Just from what I'm reading, it looks like they do take two questions from the C-CAT patient survey.

MEMBER RYAN: I see it. Yes, okay.

MEMBER PHELAN: And 21 items from the staff survey to identify this. I just don't have any experience with this. Does anyone on the call use this C-CAT or heard of it? Anyone in the room? No? Because it sounds like a pretty well validated measure.

MEMBER WALLACE: My gut reaction just from what little information we have is that it

might be a really useful tool. It covers a lot of really interesting domains, workforce and, you know, having patient voice in a measure. That's amazing.

But the idea of recommending it to a state-level department of Medicaid for use, just the implementation barriers would be huge. This measure seems to me to say, like, provider improvement for use at like a program level, and not so much as a part of our recommendations.

CO-CHAIR MOORE: Any other comments. Are we ready to vote? Okay.

MS. KUWAHARA: So we are voting on Measure number 14, NQF 1888, Workforce Development Measure Derived from Workforce Development Domain of the C-CAT. For the first vote, to what extent does this measure or concept address the CMS quality measurement domains, and/or program area key concepts?

For high, please select one; medium, please select two; and low, please select three. Polling is now open.

(Voting.)

MS. KUWAHARA: And Alvia, if you're on the line, if you wouldn't mind typing in your vote into the commenting box.

MEMBER SIDDIQI: Sure, I just realized I was on the wrong measure when I called in late, so I apologize for that.

MS. KUWAHARA: Could everyone please submit their votes one additional time? Great.

Twenty percent of the 20 voting members selected high, 55% selected medium, and 25% selected low. So this will move on to the next step in the decision logic.

For vote number two, to what extent will this measure/concept address an opportunity for improvement and/or significant variation in care? Please select one if you choose high. Medium, please select two, or low, please select three.

(Voting.)

CO-CHAIR MOORE: He has a fancy clicker.

MS. KUWAHARA: So 15% of the 20 voting members selected high, 45 selected medium, and 40% selected low. And this, we'll move on to the next step in the decision logic.

Vote number three, to what extent does this measure or concept demonstrate efficient use of resources, and/or contribute to alignment? For high, select one; medium, select two; or low, please select three.

(Voting.)

MS. KUWAHARA: For those on the phone, we're just conferring over here. Okay, NQF staff had some quick deliberations over here. So we are actually going to modify the last vote.

So the last vote was -- I'm sorry. The last vote was related to an opportunity for improvement or significant variation in care. Although 60% was achieved between high and medium, we did not achieve greater than 60%, so the measure will go down and not be included for the BCN measure set.

Okay, so that concludes our portion

for measures referred from other program areas. We can move into measures which were identified for reconsideration by members of the Coordinating Committee.

So the Committee identified two measures for reconsideration. Reasons for reconsideration include: the measure is currently in use in state programs; stakeholders, particularly state agencies, consider this measure important; or the measure addresses a high-impact area for the BCN population.

The Committee Member who retained the measure is the lead discussant, and will discuss with the rest of the committee why the measure should be included in the final program area measure set.

Following a brief discussion, the committee will vote on the discussion using the decision logic. And before I hand it over to the lead discussants, I wanted to provide some of the TEP's rationale for not including the measures. And we'll begin with the first measure slated for

discussion.

CO-CHAIR MOORE: Is there a number for this one? Okay.

MS. KUWAHARA: Yes, so this is NQF number 2483, and let me get the numeric number for you. This is, on your discussion guide, number 17, NQF number 2483, Gains in Patient Activation Scores at 12 Months. This measure was identified for reconsideration by David Kelley and John Shaw.

So the TEP recognized this measure as a critical construct for beneficiaries with complex care needs and high costs, and they unanimously agreed that this measure is a promising concept. One member of the TEP noted that this measure was considered for the California Medicaid 1115 Waiver Program.

During the state's discussions and research, it chose not to include the PAM measure for a number of reasons. One, the applicability of the questionnaire to the Medicaid population was considered marginal. The concept of

competing demands, for example, the inability to manage congestive heart failure due to concerns about eviction, are not contained in the questions that the PAM assesses.

There was also a perceived floor effect. Everyone score a low in the PAM, and it was difficult to measure improvement because the incremental changes are such that they did not affect the measure. Simply, the measure is skewed to a higher level of activation.

And finally, a literature review of the PAM and safety net high risk/high cost populations found that found that there are few studies to support its use in the population. So with that, I'll turn it over to our lead discussants. John, we can start with you. Can you use your microphone, please.

MEMBER SHAW: I think my viewpoint is affected by where I'm coming from and looking at the whole system. And I've seen for decades the issues with beneficiaries with complex needs tend to be much broader than clinical areas.

And when I look at the overall measure set, we've got a hundred-plus measures, mostly on clinical and coordination and safety, but very few, if any, in really engaging the patient.

And yet, from a responsibility perspective, for those who look, the patients may be responsible, or their indirect caregivers, for half of the variation in outcomes. So that's the context I'm coming from.

And so this appeared to be the only measure, definitely within BCN and somewhat across the board, really trying to address that aspect of this whole area that we're trying to address.

Several technical points. It's indicating in the scoring that there's no use of this anywhere, and I'm not sure that that's correct, because we've been using a form of it in New York state for a couple years. There was historically, you mentioned California looking at, and there wasn't a huge amount of movement, and that's when they were looking at four levels,

rather than a score of 100.

And so much of that came through in discussions of NQF endorsement where they shifted the measure to not go from one level to another of the four, but a point score with three to six increase in points of activation being the threshold for use.

And recognizing that New York state and CMS, in their 1115 waiver, shifted what was used and is currently being used for payment pay-for-performance in New York state, to the NQF-endorsed measure that we're looking at here.

The other thing is that LTSS also looked at this measure and did recommend it for use. And I'm scratching my head, trying to see how do we align yes and no for the same measure, and is it really different in those populations.

Whereas the LTSS population tends to be mostly Medicaid, this being addressed to mostly Medicaid. The use that I'm aware of in New York is for the Medicaid and uninsured population, which is that population.

And there's a variety of studies over the last several years looking at the correlation with improvements in patient activation, with reductions in readmission and unnecessary admissions and ER visits. So to me this says this is a good one, and a high one on my own personal priority list.

MEMBER KELLEY: I would echo everything that John said. I will say that within the Pennsylvania Medicaid -- first of all, it's an outcome. We have very few outcome measures across this entire portfolio. It's patient-focused, which, I think, one of our public commenters earlier today was encouraging us to think about that and the importance of that.

And within our Medicaid program, we have always learned to listen to our stakeholders, and especially our consumers. And if you're not measuring the consumer's voice or their potential, how well they're being engaged in care or how well they're being activated to be

engaged in care, I think we're missing the boat.

I will say that, and there is some literature that does suggest as you move activation scores up that there is reduction in utilization. I also, in my comments that I submitted, reached out to one of our behavioral health managed care plans who has used us in a PCORI grant that'll probably be released some time this summer that had very nice outcomes.

And it was used in a model of individuals with persistent serious mental illness, as well as, many of those folks also had co-occurring substance use disorder, and oh, by the way, they had all kinds of physical health comorbidities. Very high-risk population, I think almost 2,000 studied in various care management models.

And one of the key components of the care management model was the staff were taught how to administer these activation scores. And that was part of the program. And these individuals were able to become much more active

in their care. They got more physical health actually done, and a lot of the other patient satisfaction outcomes were very good.

They, on the physical health side, they actually said they didn't feel as good. Probably because they actually understood some of their physical health conditions. So in that model, studying probably 1800 patients, and this did not cost -- PCORI grants, they don't get a lot of money to operationalize.

They were able to do it. They were able to show an effect. And the outcomes were positive. What PCORI doesn't allow you to do is to do a cost-effectiveness. Well, we as a Medicaid program were able to look at cost effectiveness as well, and I will just tell you that we did see reduction in utilization, even with those very mild, modest gains in patient activation.

So it's an outcome measure, it can be done clinically, the clinical level. I think it's helpful, it is very patient-focused, so.

CO-CHAIR MOORE: All right, thank you. I'm not sure which of you is first, Maureen or Judy, but I'll just go with Maureen.

MEMBER HENNESSEY: Thanks. Maureen Hennessey. So my question is, is do we have a sense at this point of what kind of cost and administrative burden this represents for Medicaid plans? And then is that factored in when we look at the cost-effectiveness, or essentially the health economic outcomes for the use of this tool when implemented? Does anybody know?

CO-CHAIR MOORE: So I mean, I don't want to jump in with my own thoughts, but I will. So I actually take issue with some of the critique that came out related to that. Patient activation is actually the focus of a lot of my research that I do. It's focused in the Medicaid population, and women, at the University of Michigan.

And we did find that there was high levels of activation. Patient activation is sort

of this utility to take action. There are social determinants of health that affect an individual, but their ability to take action and be activated, they're not always correlated. So I think that we have to careful about that comment. So that's an issue that I had.

What we found within our research, and we use patient activation all the time, is that when there's a low outcome, it's typically, or poor outcome even though the patient was highly activated, it's because the clinician was not activated.

And so what we're trying to push is to create a clinician activation score, because both have to come to the table highly activated for patient activation to actually be associated with positive outcomes and to know what we're looking at.

The cost effectiveness piece, it's not a PCORI restriction, that's a member of Congress, just to clarify. Yes, absolutely.

MEMBER KELLEY: (Off-mic)

CO-CHAIR MOORE: Yes, exactly.

MEMBER KELLEY: (Off-mic)

CO-CHAIR MOORE: Yes, exactly.

MEMBER KELLEY: (Off-mic)

CO-CHAIR MOORE: Mic, please. Yes. So --

MEMBER KELLEY: I will say that that health plan saw a lot of cost-effectiveness in that their already disseminating. They have these patient-centered medical homes for people with serious mental illness. They started with ten and a PCORI grant. They didn't wait to complete the PCORI process; they started to actually disseminate this more widely to other clinical sites.

So if that bespeaks the financial motivations of a managed care plan, you can infer what you want. But as a Medicaid program, we're very excited about this, because --

CO-CHAIR MOORE: Well, I think what I'm trying to understand is what is the responsibility of the health plan. So from my

setting at the University of Michigan, we administer the survey, we respond to it as clinicians, we do the analysis internally.

So I'm curious what role does the health plan play in this, other than if in a state, you find a way to reimburse the clinician for doing this work? I guess I'm not understanding the link to health plans.

MEMBER ZERZAN: So I'll be brief about -- I totally support this measure, and it's in use in Colorado in one of our RCCOs that is a health plan, Rocky Mountain. And they stared just measuring scores, and now they're moving towards improving. But we pay them incentives based on doing it, so it is part of them.

And I think there are options, either the clinic does it or the health plan does it on behalf of the clinic and feeds the information back. So it depends on how you're set up. And that's how Colorado does it.

CO-CHAIR MOORE: Cool. Allison.

MEMBER HAMBLIN: So I largely support

this measure. I just want to, and I hate to be negative in the conversation, because I think patient activation is a really important concept. I think the patient activation measure is a really well studied and validated tool.

However, in our experience working with either state-level programs or plan-led or provider-led programs, I've heard some variable feedback over the years in terms of, I guess I would put it in the context of, I think providers who are administering the PAM need to be really well trained in terms of how they're administering it.

And oftentimes we hear feedback of people aren't sure how much to trust the responses that they're getting back. And I think part of that gets to literacy issues, and is the instrument worded in a way that's sort of universally understood and applicable to, you know, in some cases a highly transient, highly vulnerable, low literacy, low health literacy Medicaid population.

And so I do think it's a very important construct. I think it's arguably the best we have in this space. But I do think it's important to recognize that the implementation experience from where I sit has not been universally positive.

CO-CHAIR MOORE: I mean, I think that's really good feedback. Because if this is a measure that goes forward to CMS as a recommendation, this could be something that they could look at, especially looking at the variation within the Medicaid population and those barriers that may come up, and how people have overcome them or haven't been able to. Because we're an incubator for innovation, and there's opportunities there.

I know that we have someone on the call that wants to speak.

MEMBER SIDDIQI: Yes, this is Alvia. I just didn't want it to go without notice that the PAM -- use of that PAM tool actually has a significant amount of expense as well.

And so to assume that sort of everyone or all Medicaid agencies would be able to afford the use of the tool and then use that tool across the board, there is definitely fiscal impact. So it does impact, I think, feasibility.

I do like the idea behind obviously trying to look at how do we measure activation and do we continue to have patients be very much engaged with their clinician or with their care plans. However, I do think that the fact that it is Insignia Health that is the measure steward, in conjunction with the University of Oregon, I do think I need to just call that out.

CO-CHAIR GOLDEN: So is PAM in the public domain, or is it fee-related? Okay.

MEMBER HAMBLIN: My understanding is anyone can access the tool, but the scoring is proprietary. And so you need to pay for the scoring.

CO-CHAIR GOLDEN: How does that square with NQF policy? I'm just curious.

MS. MUNTHALI: It's a great question.

So for the purposes of endorsement, we ask developers or stewards to disclose that information that might be proprietary. But it is one of the issues that we discuss, the feasibility. It is a criteria, it's not a must-pass.

But this would go into the discussions around our table on feasibility of use of the measure that's based on this tool.

CO-CHAIR MOORE: Yes, I think it would be challenging for us at our FQHC to use it. But at the University of Michigan, we have the resources to be able to make that happen. I'm not seeing any other -- oh, you have one final comment? We're running out of time, so I assume it can be brief.

MEMBER KELLEY: Last parting comment. Again, I think there, even though it may be a variation on a theme, I think there is another tool that is in the tool that is in the public domain that is free.

Within our program, we will probably

pay for this through our patient-centered medical home program. So, and our value-based purchasing. So we as a state are certainly willing to put up dollars to make this happen.

We think it's important going forward, so probably in a year or so, this will probably be the key metric that we want to be able to measure across, maybe not all populations, but especially this population. And especially, again, many of these folks overlap, they have serious mental illness and they have substance use disorder.

CO-CHAIR MOORE: I just want to check one more time to see if there's anyone on the phone. Oh, one quick question. Okay, I'm sorry.

MEMBER PHELAN: So the survey's administered at the patient level.

CO-CHAIR MOORE: Correct.

MEMBER PHELAN: And somebody's got to administer the survey. Who would do that? Would it be the clinician? Would it be --

**CO-CHAIR MOORE: So, yes, we typically give it to them on a clipboard, or now we have iPads that we give to them. And it's a really well validated tool, it's really phenomenal.**

**We have our issues with it, so it's really well researched in chronic conditions. I mean, that's where it first started. It's done a lot work in cancer. We run into a lot of issues within women's health.**

**It's such a dynamic area. It's an area in health care where there's a lot of overuse that's not necessarily evidence-based. It's an area where, for some reason, the clinician-patient dynamic, there tends to be more of hierarchical power dynamic between women and their clinician. Kind of a theme for this year. I didn't say that.**

**Anyway, so that's where we're finding that in the area of activation specific to women's health, that we really need to be looking also at clinician activation specific to this population. But it wouldn't cause me to have any**

hesitation about moving forward so that CMS could continue to develop and explore this as a potential.

MS. GORHAM: I just wanted to clarify, as John stated in the opening remarks, the usage information in the discussion guide was incorrect.

So you've already heard some places were issues. I just wanted to add to that. So I have here in front of me Monroe Health in New York State, the District program, and New York state is requiring the PAM in their Medicaid program.

Washington State Medical Health Homes, as well as South Carolina, DHHS Healthy Outcomes Program. So those are just a few, just for transparency.

CO-CHAIR MOORE: Great. Are we ready for a vote? Okay.

MS. KUWAHARA: This is Measure number 17, NQF number 2483, Gains in Patient Activation Scores at 12 Months. For the first vote, to what

extent does this measure or measure concept address critical quality objectives and/or identify program area key concepts?

For high, please select one. Medium, please select two, or low, please select three.

(Voting.)

Eighty-five percent of the 20 voting members selected high, and 15% selected medium.

Moving on to vote number two, to what extent will this measure address an opportunity for improvement and/or significant variation in care? For high, select one. Medium, select two, or low, please select three.

(Voting.)

Sixty percent of the 20 voting members selected high, 35% selected medium, and five percent selected low.

For the third vote, to what extent does this measure or measure concept demonstrate efficient use of resources and/or contribute to alignment? For high, please select one, medium, select two, or three -- I'm sorry, low, please

select three.

(Voting.)

Thirty-five percent of the 20 voting members selected high, 40% selected medium, and 25% selected low.

Moving on to the next vote, to what extent is this measure or measure concept ready for immediate use? And I would like to point out that if you select high, you vote for it as a measure, and if you select medium, you are voting for it as measure concept.

If you would like to select high, please press one; medium, please press two; and low, please press three.

(Voting.)

Sixty percent selected high, 30% selected medium, and ten percent selected low.

MS. GORHAM: So if I can just clarify, the only difference between one and two is one is a measure and two is a concept. We know that this is a measure; this is NQF-endorsed. So two is really not an option, because you can't put

this forward as a recommendation as a concept because this is definitely a measure.

So as we vote on this for other measures or concepts, just know that on this question, the only difference between one or two is that one is a measure and two is concept. So we should vote on this again, so that we know that this is a measure.

CO-CHAIR MOORE: Shaconna.

MS. GORHAM: Okay, so our chair has spoke, and so because it passes, we'll just pass it as a measure. Sheryl.

MEMBER RYAN: Could I just point out you used the greater than 60 as the cutoff, when in the TEP groups, there were always five of us. So a sixty percent, three out of five, that carried the day.

So I wonder, you know, our scale is a little bit different than it was before, because it was 60 and above. So I'm just, yeah, I know it was hard to make it like, you know, you were stuck with equal numbers, but still.

DR. TERRY: It was really hard when we only had five people. That was really the issue. So now that we have more than five, at NQF it's usually greater than 60. Just so you know, we kind of lowered it a bit because of the number.

MEMBER WALLACE: Can I ask just a clarifying question about measure, because in most of these you can tell pretty easily if it's a measure or a measure concept, because you pretty clearly laid out the definitions.

So the purpose of this group voting for that, I'm trying to -- there may be a few that are ambiguous, but for that particular decision, in my mind, when I was looking it at it, if there's a measure that needs changes or whatever, that might be sort of downgraded or you know, sort of, to a measure concept. But is that the right thinking, or what's the utility in that vote?

MS. GORHAM: So we can't, you can't really change a measure. So what's in front of you is what is in front of you. So you're voting

on it as is. You're voting, we know the NQF measures are NQF measures.

When you look at those measures and the specifications are not clear, or some measures you all -- or concepts you all have looked at, and you say, well, there's not enough detail. So you know that those are concepts. So when you're voting, again, on those concepts, you're using two. Does that answer your question?

MEMBER SIDDIQI: This is Alvia and I kind of agree with that last comment. Because there may be many endorsed measures, but I thought the part of the TEP's role was to actually say which measures did we want to sort of prioritize as a measure that CMS should be working on including, or trying to promote within states, versus others that may be more at a concept stage, even though it may have an endorsement.

MS. GORHAM: I'm sorry, Alvia, repeat your question.

MEMBER SIDDIQI: Sure, so I was basically saying that, you know, in my mind the way I think about it is there are a multitude, many, many endorsed measures that are out there.

But I thought that the work of this TEP as part of the decision logic was to sort of prioritize which of existing endorsed measures should be used more and promoted as measure concepts, versus measures that we would really promote with the states, and for CMS to actually work on with the states.

So I guess I kind of see that we were doing one, two, or three, we're really trying to help in that prioritization, not necessarily just saying, Well, it's an endorsed measure already. So we would just move that through.

MS. GORHAM: So I'll take a stab at your question, and then I'll ask probably Karen to weigh in. But we have not been asked to prioritize the measures within the measure sets. What we are doing is recommending measure sets. And so when you recommend those measure sets,

then we are recommending the measures as measures, or concepts as concepts.

But within the measure sets, we have not been asked to prioritize the measures in the measure set. So we're recommending as a whole measure set, but.

MS. LLANOS: Yes, I agree. This is Karen. I think it would just get too complicated for that to prioritize this in measure set.

MS. MUNTHALI: And this is Elisa. I think what we probably should mention is a commentary that you mentioned that accompanied the discussion will go along with the inclusion of those measures in there.

So even though, I mean, we can't, the measures are what they are. That was an NQF-endorsed measure. We know that it is reliable, it's valid, and it's gone through all of the criteria. But you do have concerns. So it's not changing the inclusion of that measure in the menu, or it's not changing the inclusion of that measure.

What it is doing is saying that you recognize it's a fully specified measure, it has been tested. But you do have some concerns, and I think that language can be added. I don't know if that will address --

MEMBER SIDDIQI: Yes, that helps. That helps, thank you.

CO-CHAIR GOLDEN: If 80 percent vote red or green, then it passes and we go to the next question.

MS. GORHAM: So we're fine with that. It passes, and we know that it is a measure. So when we add it into the set, it will be added as a measure that was recommended.

MS. KUWAHARA: Okay, so this moves forward as a measure.

To what extent do you think this measure is important to state Medicaid agencies and other key stakeholders, for instance, consumers, families, Medicaid managed care organizations, and providers? For high, please select one; medium, select two; and low, please

select three.

(Voting.)

Sixty-five percent of the 20 voting members selected high, 25% selected medium, and ten percent selected low. So this measure will be recommended for inclusion in the BCN measure set.

So we'll move on to our second measure identified for reconsideration. This is Measure number 19 on your discussion guide, it's NQF number 2631, Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function.

This measure was identified for reconsideration by Cheryl Powell. But before I turn it over to Cheryl, I wanted to provide the TEP's rationale for not including this measure in their recommendations.

One TEP member noted that functional assessments are invariably performed at LTACHs. As such, the measure may not add value to the

measure set. Although this measure could capture dually eligible beneficiaries, the TEP determined that the measure is not appropriately suited for the Medicaid BCN population. Cheryl

MEMBER POWELL: Okay, sorry, that last piece is confusing to me. So I'm just going to skip that and move on. I think it's incredibly valuable for a Medicaid population, particularly given how much Medicaid pays for HCBS.

Yes, the functional assessment may be done already, but it's that discharge plan based on the assessment I think is very important to assure that the individuals that are being discharged have the care plan that's based on that assessment and that follows them.

You know, we found doing some work with QIOs in one area that, even discharged from a hospital to home health, there was only ten percent that had a discharge plan that followed them.

And so I think this is incredibly important. It's, I think, focuses very much on

the Medicaid population. It's something that the long-term care hospitals are reporting within the current programs for impact.

And so the additional burden, I like, I personally, having been the duals deputy director for several years, like to focus on what, you know, what can be used across and I think about what's feasible and least burdensome.

So I think for a Medicaid agency with the large population that the functional assessment would be important for, particularly for the programs where, you know, within Medicaid, there's personal care assistance, there's actually payment for the services that support an individual with limitations in any of these areas, that that would be critical for Medicaid. And within this larger population group, and focus for IAP, it seemed incredibly important, and also beyond just the clinical idea of quality, but more focused on a broader and more holistic concept of health and quality, which is something that Medicaid agencies

certainly are focused on.

DR. TERRY: And Cheryl, you're at RTI, correct?

MEMBER POWELL: No, I am not. I'm at Truven.

DR. TERRY: Who's at RTI? Oh, Truven. Because I noticed that RTI was the steward of this, so I just wanted to -- Barbara.

MEMBER McCANN: Yes, if I could clarify. I don't understand the measure as requiring a handoff to home and community-based services of a care plan that includes functional assessment. And was that the reason I just heard as to why we should consider it?

CO-CHAIR MOORE: Cheryl, do you want to respond to that?

MEMBER POWELL: Sure, sorry, I lost my place. I was trying to review it, but I've lost it now. But I will look at it in a second. I think the care plan at discharge, given that Medicaid and HCBS require that care plan too, if you have the discharge and the care plan, that,

and I don't know, because I would have to look more deeply into this, and perhaps the researchers looked into this, at NQF, as to whether that handoff is required.

I think it's probably more likely if it's done at least, that the handoff would be required. And then it would inform the piece needed under HCBS. But I don't know.

MEMBER McCANN: I would just make two comments. It's not required as an HCBS provider. The other thing we significantly acknowledge as a provider is that functional status in a facility with life safety code is very different than functional status in your home, and the ADLs and IADLs.

So if the primary reason for reconsideration of this is because it will pass off to the community, I would question whether that happens, and the validity of that assessment outside the home.

CO-CHAIR MOORE: Good point. Judy.

MEMBER ZERZAN: I want to like this

measure, but it's not quite it for me, and I think part of the reason is that this is only in long-term care hospitals, and that's such a narrow, teensy, tiny population.

And it also seems weird to be in the BCN TEP and not the LTSS one. So it seems like this is a measure that's not quite there yet.

CO-CHAIR MOORE: Thank you. Susan. No. You sure? Speak now.

MEMBER WALLACE: No, I'm trying to remember if this is -- I've looked at a couple of these impact measures, and I know at least some of them make the downstream provider responsible for the upstream information. And that was sort of what I was trying to get from reading this numerator statement and trying to remember if this is one of those or not.

CO-CHAIR MOORE: We have a comment on the phone. You've got to take it off mute. And they decided not to. All right, David, and then we'll go over here. Did you have a comment?

MEMBER KELLEY: Again, just to

reiterate what Judy said. This is probably, from a Medicaid standpoint -- first of all, Pennsylvania Medicaid doesn't recognize LTACHs as a provider type.

So we don't pay for this. Sometimes our managed care plans have creative ways of paying for it, but we typically don't even pay for this service for straight-up Medicaid.

Now, for duals and long-term care, you know, that might be another issue. It may be it really belongs under long-term support services. But it is a very, very, very narrow -- this is a niche industry. There aren't like tons of these hospitals around.

For this population, I can guarantee you that my straight-up Medicaid population that is extremely complex, these facilities tend to be -- shall we say, they do wallet biopsies before anybody gets in. So even if it was a provider type that we recognized, very few people in Pennsylvania Medicaid have access to this service.

They either get it in other sites or services, or they actually go home and get the support services at home, so. But also, I think that within a long-term care support system, I would think that -- and this is a nice measure for the facility, but quite honestly, a really good program is going to -- there are going to be care coordinators that should be hovering over folks like this as they leave this facility.

They are the ones who really -- in a good managed care program, they're the ones that should be doing this and making sure. Because I can tell you, these facilities are like, see you, bye byes. And you're gone. And, you know, they'll check all the boxes and this will look great. But it's really -- it's those coordinators who take care of them once they leave and once they're back in the community.

CO-CHAIR MOORE: Thank you. Michael. Microphone, please.

MEMBER PHELAN: I'm sorry, what was the cut-off for this? Because I think this was 1.8.

And again, it was the same question, why was it in the BCN and not the LTSS? Was there a reason for that?

And the cutoff was 1.8 for this group. What was the actual -- yeah, so the overall measure score was 1.8. Oh, the threshold score was --

CO-CHAIR MOORE: 1.71.

MEMBER PHELAN: 1.71. But it still got rejected anyway.

CO-CHAIR MOORE: Yeah.

MS. KUWAHARA: Correct. The TEP evaluated it because it did meet the threshold score, it exceeded it. And then they threw it out, correct.

CO-CHAIR MOORE: All right. Susan.

MEMBER WALLACE: I just want to make the additional comment. It looks, from the measure specs here, that it is in use in the SNF QRP, which makes me think that this one of the ones that align. So just to bring that up, because I know that some folks criticize the, it

only applies to long-term care hospitals.

I don't -- is this measure, I think they're -- when they're done, they're parallel measures, that they look a lot the same, but -- as how the impact measures are working. But --

DR. TERRY: Exactly. This is clearly an impact measure if you look at what they're evaluating, and there are each of the post-acute sectors. But they're a little different sometimes, depending on -- yeah.

CO-CHAIR MOORE: Someone on the phone? Just a second, is there someone on the phone?

CO-CHAIR GOLDEN: Was it a public comment?

MS. BUCHANAN: No, it's Andrea.

CO-CHAIR MOORE: Oh, okay. Do we want to wait, or continue? Yeah, we need her to --

MS. BUCHANAN: Hi, Operator, it looks like Andrea Gelzer's line is muted. Is it possible to unmute her?

OPERATOR: She is actually dialing back in.

MS. BUCHANAN: Okay, thank you.

CO-CHAIR MOORE: Cheryl.

MEMBER POWELL: Yes, I just wanted to highlight this is part of that family of measures. This was the only measure that was on our list. But I meant to bring it up for that family of impact measures. And they are looking across settings to align all of those, including the home and community-based waiver setting, SNF, LTACH.

So yes, the reason this one is selected is because it was the one on our list. But it's really meant to be broader than that. My apologies for not saying that earlier.

CO-CHAIR MOORE: Susan, did you want to follow up? Okay. Andrea, are you on the line?

MEMBER GELZER: Hello, can you hear me now?

CO-CHAIR MOORE: Yeah. Welcome back, Andrea.

MEMBER GELZER: Oh, what do you know.

I thought, well, they've finally cut me off.

(Laughter.)

CO-CHAIR MOORE: No, we know where to find you.

MEMBER GELZER: But anyway, I just wanted to reiterate that the TEP -- you know, this got to our TEP. For whatever reason, however reason, we felt it was too low bar. And I mean, you do a functional assessment -- I believe that nursing does a functional assessment on any acute inpatient hospitalization, as well as at discharge, with regard to function. We just did not see that this was going to be impactful.

CO-CHAIR MOORE: Thank you. Any other comments or questions? I'm doing a horrible job of holding us to the three minutes. I'm afraid I'm going to lose my job. So are we ready to move for the vote? Okay.

MS. KUWAHARA: We are voting on measure number 19, NQF number 2631, Percent of Long-Term Care Hospital Patients with an

Admission and Discharge Functional Assessment and a Care Plan That Addresses Function.

For the first vote, to what extent does this measure or measure concept address the CMS quality measurement domains and/or a program area key concepts? Please select one for high, two for medium, or three for low.

(Voting.)

Twenty percent of the 20 voting members selected high, 25 percent selected medium, and 55 selected low. So this measure will not be recommended for inclusion in the BCN measure set.

CO-CHAIR MOORE: Susan.

MEMBER WALLACE: Is it possible that we could bump this to tomorrow's discussion on LTSS? Because I think it might have some utility there. I don't think it is appropriate in this setting, or in this -- is that something that's feasible?

CO-CHAIR MOORE: Let me consult with the experts. If this measure we just voted on

could be moved to the discussion for tomorrow under LTSS.

CO-CHAIR GOLDEN: Didn't LTSS already vote on this?

DR. TERRY: No, BCN.

CO-CHAIR MOORE: No, BCN did.

CO-CHAIR GOLDEN: So, but the LTSS moved it here, right?

CO-CHAIR MOORE: No, it was saved by I believe --

DR. TERRY: It was Cheryl.

CO-CHAIR MOORE: Cheryl, yes. Somebody saved it, yes.

MS. GORHAM: So I just looked at the list. Of those recommended, it was not one recommended. But give me a minute, and I'll look and see if it's one that we considered, because I can't remember off the top of my head.

MEMBER McCANN: I believe that we looked at home and community-based, and not LTSS.

MEMBER WALLACE: Did you have the -- this is Susan.

CO-CHAIR GOLDEN: So the notion here would be that this would be useful for home and community-based by having the plan at the discharge from the institution. Because I think we were told this was not for institutional care.

MEMBER McCANN: No, this is LTECH.

CO-CHAIR GOLDEN: Right.

MEMBER McCANN: So that would be institutional.

CO-CHAIR GOLDEN: Right, but the LTSS group was for non-institutional care. That was --

MEMBER McCANN: Right, home and community-based, right. Yeah. Which there is an impact measure of functional status, but it's different than this.

MEMBER WALLACE: This is Susan. Was that impact -- the home health one, was considered in your group or it wasn't?

MEMBER McCANN: No, because I don't think it's finished actually.

MEMBER WALLACE: Okay, all right,

that's good clarification. Thank you.

MEMBER McCANN: Our group gauges. Yeah.

MEMBER WALLACE: Thank you.

MS. KUWAHARA: So as I mentioned previously, there were no related NQF measures identified for the BCN program area. So we will not be conducting voting on this section. But we will move on.

CO-CHAIR MOORE: To lunch. Think there are some leftovers over there if you want lunch number two. That's how good of a chair I'm doing, we're really keeping us on time.

MS. KUWAHARA: But right now, we are pulling up the revised BCN measure set in its entirety, and our staff diligently reported the up-to-date measures that were just included in the measure set. So this is the most up-to-date version.

So if everyone would like to take a few moments to take a look at these measures in your discussion guides, review them, and then

we'll vote on any measures for potential removal.

CO-CHAIR MOORE: So how will we, I guess I'm trying --

CO-CHAIR GOLDEN: So let me go back to process. I was under the impression we were voting on all of these individually. We're not, we're just going to vote them in whole?

MS. KUWAHARA: So, we're looking at the measure set as a whole. If you find a measure that you deem unworthy of the measure set, then you would ask to have a discussion. But that must be seconded by another member of the Coordinating Committee to vote.

CO-CHAIR MOORE: Okay, so this is what the TEP -- the BCN TEP -- recommends as the measure set.

MS. KUWAHARA: Correct.

CO-CHAIR MOORE: Okay.

MS. KUWAHARA: And this also includes the measures that we just recommended to the set.

CO-CHAIR MOORE: Got it, all right.

MEMBER GELZER: Could you display it

on the webinar, what we're looking at here?

MS. BUCHANAN: This is Kate. I thought I had, but let me try that one more time.

CO-CHAIR MOORE: Could somebody who is on that committee or perhaps the lead walk through and talk about why -- just give a high level -- high, high level -- summary and discuss why these were selected? Or some background on the discussion that the TEP had I think would be helpful.

DR. TERRY: Sure, so --

MEMBER GELZER: Can you hear me? This is Andrea.

CO-CHAIR MOORE: Yeah, yeah, we can hear you.

MEMBER GELZER: Okay, and if NQF staff would feel free to chime in after me. You have to understand that -- and this is similar, I think, to every group. Each TEP was presented -- you know, we started -- NQF started with a universe of measures that might be applicable, I think, to any of these four areas.

So when you got to the universe that was deemed potentially applicable to beneficiaries with chronic needs, we started with, what, like some 43 measures that actually got to the TEP and went through. And these were the measures of that subset of the universe that we determined were -- should move forward and be recommended to the Coordinating Committee for inclusion in the set.

So we didn't -- you know, are these the best measures that could possibly indicate outcomes, process measures of quality for beneficiaries with chronic measure? Perhaps they're not the best, but they're the best of what we were able to collate -- what NQF was able to collate and we were able to cull, if that makes sense.

DR. TERRY: I just wanted to mention there is a measure on here, it's an NQF-endorsed measure. But we know the measure has just gone through one of our committees, and it looks like it has not gone to CSAC yet, which is the final

decision. But at this point, the measure does not look like it will retain its endorsement.

So I just wanted to raise that. And that is Measure number 0647. It is a timely transition record from inpatient to home self-care.

CO-CHAIR MOORE: You mean 0648?

DR. TERRY: Did I not say that? 0648, yeah, I'm sorry.

CO-CHAIR MOORE: Okay.

DR. TERRY: And I can just tell you the reason it's probably not going to be endorsed is it did not have up-to-date performance data, it was very old, it was not re-presented during this current review of the measure. And there were some issues regarding reliability.

So I just wanted to let you know these measures may come back to NQF in the future, the committee really liked the concept, the thought. But they were not really -- it does not look like it'll retain it. So again, we didn't take it out, because CSAC has not had the final vote, and

that happens later this month.

MEMBER GELZER: And this is Andrea again. I would note on this specific measure that one of the members of our committee was from California and had experience with the measure because California's Medicaid program has been using it. And noted that the measure was currently driving change in California.

The TEP members did acknowledge that this measure could be subject to gaming, and we probably -- or we did pass it because of the advocacy of the member and the use in the California Medicaid program. We did not have the benefit of the most recent determination at NQF.

MS. GORHAM: So for sake of organization purposes and to respond to Cheryl, we do have -- we would like to go in order, so the measures on the screen in front of you and then for you all on the phone, for the measures that you see before you in your webinar. We have the rationale for why the TEP included the measures that are before you.

So for, again, sake of organization, we will go one by one and state those rationale. If -- for those of you in the room would like to also look at the specifications in your discussion guide, if you click on that measures tab, and there is a list of the -- not the -- yeah, this. If you click -- yeah, if you click on the measures tab, it will give you the first, Improving Care for Beneficiary Complex Care Needs and High Costs.

You have the measures in front of you in a list, so you can click on the links as we discuss each measure. So Miranda will go through the rationale. Andrea, please chime in if you want to add any additional information from the discussion.

MS. KUWAHARA: All right, we'll begin with Follow-up after All-Cause Emergency Department Visit. And the TEP determined that this measure addresses an opportunity for improvement specifically pertaining to unnecessary emergency department utilization,

transitions of care, and quality of care. The TEP viewed this metric as an important concept.

The next measure, Follow-up after Emergency Department Visit for Alcohol and Other Drug Dependence. The TEP identified substance abuse as a critical indicator among the Medicaid BCN population.

Although SUD is often identified in the emergency room, it is inconsistently acted upon. The TEP flagged this measure as similar to Follow-up after All-Cause Emergency Department Visit.

CO-CHAIR MOORE: I think it would be helpful -- because you're going over it with a rationale -- if folks have something to contribute about the issue or the measure, that we do it then, as opposed to doing all of them and then going backwards. If that works for you.

MS. KUWAHARA: That sounds great.

CO-CHAIR MOORE: Okay, good.

CO-CHAIR GOLDEN: Okay, so item number one, I have an issue with that, if people want to

go into it. Having used this measure, please note the numerator is an outpatient visit, an intensive outpatient encounter or partial hospitalization.

And for all-cause ED visits, which could be a sore throat or a sprained ankle, it is quite a burden and probably unnecessary to require a visit.

So we have modified our measure back in our state for medical homes as a visit or a phone call or contact with the patient. Which makes a lot more sense for an all-cause ED visit. So as written, I cannot support this material.

MEMBER GELZER: This is Andrea chiming in. And I would note that when the TEP reviewed this measure, we recommended it as a measure concept. So I know we were -- we've gone through that clarification and determined that the measure concepts are actually going to -- moving through now as measures.

But we did not feel it was ready for prime time as a measure per se, but was an

important concept.

MEMBER PHELAN: It looks like the threshold score was 1.71 for this, but the overall measure just made it to 0.9. What was the reasoning for keeping it? Just because of the idea of a measure concept?

MEMBER GELZER: Yes.

MEMBER PHELAN: Okay.

MS. KUWAHARA: So moving on to the next measure, this one was the Follow-up after Emergency Department Visit for Alcohol and Other Drug Dependence. The TEP identified substance abuse as a critical indicator among the Medicaid BCN population. Although SUD is often identified in the emergency room, it is inconsistently acted upon.

The TEP flagged this measure as similar to Follow-up after All-Cause Emergency Department Visit.

MEMBER SIDDIQI: And this is Alvia. I know I commented earlier. This is to reiterate that my concern with this one is that it's

following up on the emergency room visit but not the inpatient hospitalization for those same conditions. So I'm not sure, it sounds like we have follow-up after hospitalization for mental illness later below.

So I can still support it, but I agree with the earlier comment that for the other follow-up after all-cause ED, I do think that should remain as a concept around where there may be prioritized follow-up indicated.

MEMBER SCHIFF: This is Jeff, can I just make a comment about why is this one in this category versus the SUD?

CO-CHAIR MOORE: Yeah, that's a good question, why it's not in the SUD group.

MEMBER ZERZAN: Jeff, this is Judy. My guess would be most of our complex folks have substance use, whereas the Jeff Thompson's schizophrenic, diabetic alcoholic, that that is the definition of this group.

MEMBER SCHIFF: Yeah, I just think that in some ways this is -- the ED is an

opportunity to identify SUD folks at an earlier or a different presentation. And I think of -- I probably think of this category as folks who we know already to have complex needs versus folks who may show up acutely with an opportunity to identify and treat them out of the ER.

So I support this measure, but I wonder if we could support taking it and moving it over to that to the SUD list. If there's a mechanism to do that.

MEMBER GELZER: I will tell you that the TEP chair has no -- that would be perfectly all right if there is a mechanism to do that. We would be supportive of that.

CO-CHAIR MOORE: Does it need to go back to SUD TEP, or?

MS. GORHAM: Now, so you all again have the overall authority to do that, so that's fine. I think that just for a sake of a process, and again, to make this as easy as possible, we're making notes as you go along.

But remember, these are the measure

that the TEPs recommended. You have the option to pull the measure from the set and say, you know, for example, Bill mentioned for that first one, Follow-up after All-Cause Emergency Department Visit, he did not support that measure.

So you all have the option to say -- to motion -- to make a second motion that you also do not support that, and we will take a separate vote on that measure. So I think it's best to do that while we're at that particular measure, versus going through all of them and then coming back.

So I just want -- so, so far that's what I've heard for the measures that we discussed. And then this Medication Reconciliation Post-Discharge, I haven't heard that we should pull it, but I did hear that it should also be recommended for the SUDs.

So, but before we handle that, can we go back to the Follow-up after All-Cause Emergency Department Visit, and just see if we

have a second to say that you don't support or you would like to have more discussion and vote on this measure.

But it should not automatically be passed as a recommendation, because that is what we're doing in this step.

MEMBER SIDDIQI: This is Alvia, and I would second that.

MS. GORHAM: Okay, so we're going to take that, we're going to put it aside for right now. Because we're going to come back and discuss that measure and vote on that measure, because we have heard and there's a motion that it may not be appropriate, although it was recommended.

CO-CHAIR GOLDEN: So I would suggest, why don't we go through these and approve measures. And if we want to move them around later for the final report, we'll do that later.

MS. GORHAM: Sounds good.

CO-CHAIR GOLDEN: So we can play Rubik's Cube later in the day.

CO-CHAIR MOORE: And what's the utility of having them in certain buckets as opposed to -- I mean, could one measure be in two buckets? Okay, as opposed to moving it, okay. Because it seems like that makes more sense for this one, as opposed to moving it. Okay, Allison, and then we'll go over.

MEMBER HAMBLIN: So that was just a really helpful clarification, that they can be in multiple. And just since we're taking comments right now, I would just like really want to underscore that SUD measures have a -- there's a lot of value to having them in the BCN, even if it means having them in duplicate.

CO-CHAIR MOORE: Yeah, great comment.

MEMBER MUSUMECI: This is MaryBeth. I just had a clarifying question about number three versus number four, the all-cause ER versus the ER for SUD. Is there some duplication there if we ended up retaining both, or can someone speak to how one isn't caught up in the other?

CO-CHAIR GOLDEN: Well, I mean, if you

are in the ER because you overdosed or because you had a psychotic break, you know, a follow-up visit might be a good idea --

MEMBER MUSUMECI: Right.

CO-CHAIR GOLDEN: In an all-cause visit --

MEMBER MUSUMECI: That's what I'm saying. I understand the all-cause is broader. But if we did keep the all-cause, which I understand we may not, wouldn't the next one be duplicative? No?

CO-CHAIR GOLDEN: No, it's for a specific event, as opposed to an all-cause event. So there might be specific events -- specific health events -- that would be beneficial to have a visit, as opposed to an all-cause event, which may be many cases of the visit may not require a visit.

MEMBER MUSUMECI: Okay, so all-cause is something that is separate, it's not -- I thought that it would be -- got it, okay, thank you.

MEMBER PHELAN: So is this measure currently being used in any other health plans? Because this looks like a very common measure that's used in -- the first one, the Follow-up after All-Cause Emergency Department Visits. If it's a common measure used --

CO-CHAIR MOORE: It's not a measure. It's currently not an endorsed measure. So it's a concept, yes.

MEMBER PHELAN: This looks familiar, I've seen it on some of the, like, plans sending, I think maybe our employee health plan has a --

CO-CHAIR GOLDEN: I think that that measure does exist in some form or another. But as I said, as written, it really is not a viable -- I mean, we've actually changed it, because we had a visit and we told them to get rid of it. Where did I get it from? You know, it might have been part of CPC+, or CPC Classic. Yeah, I think it was in CPC Classic.

MEMBER PHELAN: Because even if you don't capture everybody that comes in for a sore

throat that comes back, because that's going to, those are going to wash out. Do you know what I mean? So you're going to have a population of people that you definitely want to get a follow-up, and unless you identify them specifically and say, okay, anyone with CHF, anyone with hypertension.

Unless you do that, the fact that you're capturing all ED patients that come in with complex behavior or complex needs, so there's already a defined population of that.

CO-CHAIR GOLDEN: But we're having discussion before the vote. I think we want to go through the list.

But I'm just saying, but we changed it to be not necessarily a visit, but at least contact and a note that you've contacted the patient.

MEMBER HENNESSEY: The note of clarification. We can ask questions on any of those measures in the set right now? Okay, thanks. So could someone --

CO-CHAIR MOORE: No, we're going to go in order.

MEMBER HENNESSEY: We're going in order.

CO-CHAIR MOORE: We're going to go in order. They just got off onto a deeper discussion. They should have waited, and I failed as a chair to knock them off.

MEMBER HENNESSEY: I'll table my question until we get to that one.

CO-CHAIR MOORE: All right, Miranda, you get the floor.

MS. KUWAHARA: Okay, the third measure on the list, Medication Reconciliation Post-Discharge Percentage of Discharges from January 1 to December 1 of the Measurement Year from Members 18 Years of Age and Older for Whom Medications Were Reconciled the Date of Discharge through 30 Days After Discharge. That's the longest title we have to go through today.

The TEP determined that this measure addressed the BCN population and is important to

key stakeholders. The TEP finds this measure as similar to NQF number 0097, Medication Reconciliation Post-Discharge.

One member noted that including this measure in the measure set would give providers consistency in measure recording while also aligning with Medicare.

CO-CHAIR MOORE: Any comments? Any comments on the phone? Okay, next one.

MS. KUWAHARA: Measure number 6 on your discussion guide, NQF number 0097, Medication Reconciliation Post-Discharge.

TEP members noted similarities between this measure and NQF Number 2456, Medication Reconciliation Number of Unintentional Medication Discrepancies Per Patient. TEP members recognized that NQF number 0097 placed emphasis on a global standard and the measure's ability to identify errors.

CO-CHAIR MOORE: Any comments? Any comments on the phone?

MEMBER GELZER: Hey, this is Andrea

speaking. So there are four medication reconciliation measures, I believe, in -- no, more than four, actually. We felt that medication reconciliation is an important concept for this population, and that's why so many of these were retained.

So again, we're giving a -- the guidance we were given is we're giving them a menu of measures to the states, or recommending that CMS be able to give a menu of recommended measures to the state. So I'm not sure, you know, to debate, are we debating each one per se, or are we debating, or are we looking at them as to do they make sense to include in that menu?

CO-CHAIR MOORE: Yeah, we're looking at --

MEMBER GELZER: Question in my mind.

CO-CHAIR MOORE: Yeah, we're looking at each one individually. And Bill had asked if we're looking at best in class. And just to reiterate Karen's comment, we're not prioritizing. We're just simply recommending.

So if we have eight medication reconciliation ones that we recommend, then that's eight that we recommend. And then CMS can figure out what they're going to do with it. Yeah.

MEMBER KELLEY: But one of the key concepts really is harmonization, to make sure that you're not being redundant. And it looks like one of these is not NQF-endorsed, so it's more of a concept, versus we have an NQF-endorsed med reconciliation post-discharge.

I mean, are there enough differences here in the populations or the methodology to recommend both?

CO-CHAIR MOORE: Well, I think probably the purpose is to give the universe of recommendations. And then as a second phase, CMS will take on that work as the next phase of the work. That's my understanding. Is that correct, Karen?

MS. LLANOS: Yeah, I mean, so we don't have an official second phase of the work. I

think we wanted to see what the first phase produced. But yes, I mean, I think that's one of the considerations, and that's why the context and the caveats are so helpful for us to make sure we're capturing.

MEMBER KELLEY: I mean, if I'm given this list, the first thing I'm going to say is I'm not going both. So I need to pick one. I mean, that's what I'm going to do as a Medicaid program. I'm going to do as few, I'm not going to be redundant at all.

CO-CHAIR MOORE: Yeah, of course.

MEMBER KELLEY: Because we can't afford it.

CO-CHAIR MOORE: But it's my understanding that this isn't going to then be released just based on our recommendation to CMS. If they have a second phase, we continue to work on this.

MS. LLANOS: So I think the redundancy piece, if there are some that just seem like they are many of the same, I think you should flag

those, right.

But I think if there's, I think what we want to make sure is it is a menu approach. So think about it that way. If one state might need one particular measure, another one might need another type of measure within the broader bucket.

MS. GORHAM: I want to be a little contradictory, because we are going to look at kind of best in class in some of these program areas where we have multiple measures of the same type and they're NQF-endorse. Because we can compare those. This, we can't really compare because we're talking about a measure versus a concept.

So we didn't set up a table, a related table to do that, because it is not apples to apples, if you will. But we will definitely do that for NQF measures. We do it across all of our programs so that we are not recommending to CMS a bunch of measures that we clearly can look at and say, This is the best measure.

So we didn't do it here, again, because this is a concept versus a measure. But you will see in the other program areas that we will do that.

CO-CHAIR MOORE: Thank you. Oh, one more.

MEMBER PHELAN: Is our job to do that for you, to get rid of the concept one and pick the measure, or get rid of the measure and pick the concept? Is that our job?

CO-CHAIR MOORE: No, it's not my understanding that, is that correct?

DR. TERRY: Not at this point.

CO-CHAIR MOORE: Okay.

DR. TERRY: We will be doing something on related measures. But again, those are only NQF-endorsed ones, so.

MS. KUWAHARA: The next measure is Measure number 7, NQF number 0105, Anti-Depressant Medication Management. TEP members expressed concern about the single diagnosis distinction in the measure specifications, as

well as the phrasing, Newly treated with an anti-depressant medication.

TEP members were concerned about accurately capturing those newly treated for the BCN population. Ultimately, TEP members noted that the measure is reported by HEDIS, health plans, and multiple states, which supports states' ability to report this measure.

CO-CHAIR MOORE: Comments? Allison? No?

MEMBER HAMBLIN: Sorry, I'm backtracking here. So just going back to the process. If somebody wanted to make a motion to --

CO-CHAIR MOORE: Remove.

MEMBER HAMBLIN: Remove. Can we go back to the --

CO-CHAIR MOORE: To number 6?

MEMBER HAMBLIN: To number 5?

CO-CHAIR MOORE: Okay.

MEMBER HAMBLIN: So this is one, just to make sure, the one that's a measure concept.

MS. GORHAM: Yes, you definitely can. And we would need a motion for a second.

MEMBER HAMBLIN: Okay, so I will make a motion to remove.

PARTICIPANT: Can you give a brief statement why you want it removed?

MEMBER HAMBLIN: I think, given the, trying to balance the objectives of having measures on the menu that reflect important areas of focus and important opportunities for quality measurement for the states.

But also using the opportunity to put some stake in the ground when there is a validated measure that's getting that largely the same measurement construct, preferring to limit the menu where it's reasonable to do so.

CO-CHAIR MOORE: It's my understanding that this is a validated measure. It just hasn't gone through NQF endorsement. Is that correct, am I reading that correct, number 5? Because it looks like measure source is from AHRQ, for the number 5, and the steward is NCQA.

It's a HEDIS measure. So it's, number 5 is an existing measure. It appears that it's not NQF-endorsed.

MEMBER HAMBLIN: Thank you for clarifying that, because that wasn't clear to me in the conversation. This is the one, just to be sure we're all talking about the same thing. This has been referenced in this conversation as a measure concept.

CO-CHAIR MOORE: As a measure concept.

MEMBER HAMBLIN: And now we're clarifying that it --

CO-CHAIR GOLDEN: With your comment, do you want to continue with your motion or rescind your motion?

MEMBER HAMBLIN: I will not continue with my motion if it's a validated measure. Further, I do think it would be helpful, and I don't want to belabor the conversation, I don't feel like I have a good understanding of what the utility of one of these is versus the other. I think it would be helpful to hear from the TEP if

there is a meaningful distinction between these two.

MEMBER GELZER: I wish that that had been the charge. But that is not the charge. The charge was to go through this set of measures and determine which ones we thought were valuable to go through, as either a measure or a measure concept for consideration going forward.

I mean, with the states and the whole menu concept. I don't know how to answer you, I apologize.

CO-CHAIR MOORE: Judy.

MEMBER ZERZAN: Can we sort of, since we don't have any of that information here today and I think that's sort of too deep in the weeds for us, can we make some sort of recommendation to CMS to say, it's sort of weird to have both of these in there, and maybe you could -- that we support medication reconciliation in general.

And go forth and figure out which one of these is better for whatever reason, we'll trust you.

CO-CHAIR MOORE: That is on record, that you trust CMS.

MEMBER ZERZAN: I know that's dangerous.

MEMBER HENNESSEY: I would reinforce what Judy just said from the perspective of usability. Because the first reconciliation measure doesn't appear to have any information regarding what entities are using it, whereas the second one does have that information.

CO-CHAIR MOORE: Yeah, I appreciate that. John, you have something to say? Can you use your microphone?

MEMBER SHAW: To reiterate and maybe save us some time in the future, I think the sense I'm getting is this group does have opinions. They would perhaps like to see those opinions reflected. And a mechanism to do so that you've talked about is to actually state context with pro's and con's for each of these measures, and maybe focusing on the words that go into there, instead of is this a concept or a

measure, and which is better at this point.

So let's give CMS the pro's and con's, and the eventual users of metrics the pro's and con's to make it easier for them to select off the menu what I'm interested in eating today.

CO-CHAIR MOORE: Yeah, because I think that the TEP spent a lot of time on these measures. And we are not purview to that in-depth discussion, that we are now trying to dive into. And I do appreciate that, John, and if everyone's comfortable with that, maybe we can proceed that way. Okay, all right.

MS. KUWAHARA: So the next measure is Measure number 8, NQF number 0576, Follow-up after Hospitalization for Mental Illness.

TEP members viewed this measure as potentially valuable for states with inadequate behavioral health networks because it could potentially highlight deficiencies or critical issues. TEP members noted that this measure does not count patients who move from an inpatient setting to a residential setting.

TEP members concluded that excluding this measure from the BCN measure set would create a critical gap.

CO-CHAIR MOORE: Any concerns for this one, comments? Anyone from the phone. Bill.

CO-CHAIR GOLDEN: And for the record, it's already part of the adult core set, I think, for Medicare/Medicaid, and I think even the child set as well.

MEMBER MOHANTY: Actually, this is Sarita Mohanty. I actually, I was going to ask that question for the last of the anti-depression medication management measure is also, I believe, part of the endorsed measure or the core set of behavioral health measures for Medicaid and CHIP from CMS.

So I guess my question would be, as we're looking at these measures, you know, is there information that tells us if some of these have already been recommended as core set measures from CMS?

DR. TERRY: Yeah, we have on this,

yes, we do have that. We just should go down and read a little bit further if we have it. But this measure is also used in multiple states: Oregon, Washington State, Ohio, Kansas, Missouri, and Colorado.

So, just a little more information about its use. But it is part of the adult and child core sets as well, Medicaid. Does that help?

CO-CHAIR MOORE: Comment on the phone. Maybe your phone's on mute?

MS. BUCHANAN: Sarita, do you still have a comment? We can't hear you if you're trying to talk to us.

MEMBER MOHANTY: No, I'm sorry. That was my comment, actually, the one I just. Yeah, this is Sarita.

MS. BUCHANAN: Thank you.

MEMBER MOHANTY: Thank you so much.

MS. KUWAHARA: So the next measure is Measure number 9, NQF number 0648, Timely Transmission of Transition Record. Andrea just

provided the TEP's rationale for this a little bit earlier. This is the measure that's also going through the Care Coordination Standing Committee review currently.

The next measure --

CO-CHAIR MOORE: This is the one that you just talked about, that may not be endorsed. Now, we can recommend, just to clarify, recommend a measure that's not NQF-endorsed, or that we know is, okay.

DR. TERRY: Yeah, and we didn't do that initially. Initially, we had a measure that was not continued in endorsement, we did not include it. We couldn't really determine always why that was.

This measure, because I'm on that committee I knew the reasons, they needed more updated information. So if you choose to do that, just know that it won't be endorsed now, it may be endorsed in the future. But those are the reasons.

MEMBER ZERZAN: So this is one I'd

like to make a motion to remove, actually, because it is not on the adult core set anymore. It's going to be removed, is my understanding, with the next go-round, because it's extremely burdensome and I think one state's reporting it, or maybe no states are reporting it.

And I just think this is sort of too hard. And if it's going to lose its NQF endorsement and it's also coming off of the core set, it doesn't really make sense in my mind to have this on a set.

CO-CHAIR GOLDEN: Judy, do you know, it was my understanding this was a Joint Commission measure. I don't have timely transmission of discharge information. And it's part of hospital accreditation. So in some ways, is it redundant? Are they still keeping it or not?

MEMBER McCANN: It's PCPI.

CO-CHAIR GOLDEN: Oh, I thought the Joint took it up. No? Okay.

CO-CHAIR MOORE: Do we have a sec, are

you -- Deborah, you second the motion? Okay.

MS. KUWAHARA: All right, the next measure is NQF number 0709, Proportion of Patients with a Chronic Condition That Have a Potentially Avoidable Complication during the Calendar Year. The TEP determined that this measure specifically addresses the Medicaid BCN population, and identified the measure as actionable.

CO-CHAIR MOORE: Any comments from the group? Anyone from the phone? Okay.

MS. KUWAHARA: And I apologize, that measure was Measure number 10 on your discussion guide.

CO-CHAIR MOORE: Thank you.

MS. KUWAHARA: So measures number 11 and 12 on your discussion guide, those are NQF number 1598, Total Resource Use Population-Based Per Member Per Month Index, and NQF number 1604, Total Cost of Care Population-Based Per Member Per Month Index, respectively.

During the TEP's review of both of

these measures, they concluded that one measure alone would not provide the complete picture of quality, but they viewed these as extremely important. So the TEP recommended both of these measures that they be recorded in conjunction with one another as a stipulation of their recommendation.

CO-CHAIR MOORE: And so used together.

MS. KUWAHARA: Exactly.

CO-CHAIR MOORE: Any comments or concerns from the crew? Anyone on the phone? Should we ask that question individually, or can we group it together, since it's being recommended as a group?

MS. KUWAHARA: I think you can.

CO-CHAIR MOORE: That's okay? Okay. All right, let's move to 13.

MS. KUWAHARA: This is Measure number 13 on your discussion guide, NQF number 1768, Plan All-Cause Readmissions.

Unlike similar measures evaluated during the TEP in-person meeting, NQF number 1768

appropriately addresses the squeezing the balloon phenomenon, where patients are no longer hospitalized at hospital A, but are instead hospitalized at hospital B.

TEP members also identified this measure as appropriate for the Medicaid population.

DR. TERRY: And it's part of the adult core set.

CO-CHAIR MOORE: Any comments or concerns from the group? Anyone on the phone? Okay.

MS. KUWAHARA: Measure number 15 on your discussion guide, NQF number 2371, Annual Monitoring for --

CO-CHAIR MOORE: Wait, I think you skipped number 14.

MS. KUWAHARA: I'm sorry.

CO-CHAIR MOORE: Yup.

MS. KUWAHARA: Let's see.

CO-CHAIR MOORE: Have we done 14?

MS. KUWAHARA: We took that one out.

CO-CHAIR MOORE: Okay.

MS. KUWAHARA: Fifteen, yeah, sorry.

CO-CHAIR MOORE: It's okay.

MEMBER KELLEY: Questions, all-cause readmission. Is that, I know it's in the adult core measure set, but has NCQA finally developed a Medicaid specific? Okay, great, finally. Okay.

MS. LLANOS: It's 2018.

(Off mic comments.)

(Laughter.)

MEMBER KELLEY: Happy to hear that.

MS. KUWAHARA: Okay, so number 15. Number 15 is NQF number 2371, Annual Monitoring for Patients on Persistent Medications.

The TEP determined that this measure captures what providers should be doing in cases of beneficiaries with complex care needs and high costs. The TEP noted that NQF number 2371 is a process measure, making it less favorable than an outcome measure.

CO-CHAIR MOORE: Any comments or

concerns from the group? Anything from the phone? Okay.

MS. KUWAHARA: All right. Measure number 16, NQF number 2456, Medication Reconciliation, Number of Unintentional Medication Discrepancies Per Patient.

One TEP member noted that the measure established the gold standard of medication reconciliation due to the measure's ability to identify who is responsible in delineating which action should be taken.

Additionally, TEP members noted that the measure could incentivize emergency departments to pull continuity of care documents. The TEP acknowledged potential challenges in extracting data.

CO-CHAIR MOORE: Any comments or concerns from the group? Anyone on the phone? Great. You guys are doing good, you know. This three minute thing, we're down to like 30 seconds.

CO-CHAIR GOLDEN: Your soothing voice

has put them to sleep.

CO-CHAIR MOORE: On to the next.

MS. KUWAHARA: So this is number 18 in your discussion guides, this is NQF number 2605, Follow-up after Emergency Department Visit for a Mental Illness or Alcohol and Other Drug Dependence. TEP members acknowledged that the measure is derived from claims data, making it feasible to implement.

TEP members flagged NQF number 2605 as similar to follow-up after emergency department visit for alcohol and other drug dependence, and NQF number 0576, Follow-up after Hospitalization for Mental Illness. However, TEP members identified number 2605, this measure we're discussing here, as the stronger measure because it encompasses both mental health and substance use.

CO-CHAIR MOORE: And this measure is part of the adult core set.

DR. TERRY: It says map Medicaid adult core set.

CO-CHAIR MOORE: Any comments or concerns from the group? Allison?

MEMBER HAMBLIN: Sorry, just a question, and I'm worried about going back and losing my spot. The other follow-up, the TEP mentioned this, it was just summarizing the comments, but I was confused by it. There is another follow-up after emergency department.

I think the comment that was just read said that that one was not about both mental health and substance use. Is that what the comment was? I thought they both were. No?

MS. KUWAHARA: One measure is for alcohol and other drug dependence. The other one is just for mental illness.

CO-CHAIR MOORE: Thank you. Sheryl.

MEMBER RYAN: I mean, I don't know, do we want them to be redundant in different TEPs? Because both of these that you just mentioned are included in the substance use TEP. I mean, will we look for redundancies after?

CO-CHAIR MOORE: But we also agreed

that it's okay to have them in multiple groups.

MEMBER RYAN: Okay, okay.

CO-CHAIR MOORE: Yup. Anyone on the phone? Okay.

MS. KUWAHARA: The next measure is Measure number 25 in your discussion guides. This is not an NQF-endorsed measure. It's Psychiatric Inpatient Readmissions, Medicaid PCR-P.

The TEP agreed that this measure addresses an opportunity for improvement. Readmissions for this measure's target cohort are particularly high. These readmissions could be mitigated with enhanced care coordination.

CO-CHAIR MOORE: You're on number 25?

MS. KUWAHARA: This is 25. And the name of the measure is Psychiatric Inpatient Readmissions.

CO-CHAIR MOORE: Okay, got it.

MS. KUWAHARA: Medicaid PCR-P.

CO-CHAIR MOORE: Any comments or concerns from the group? Anything from -- oh,

Allison, you look like.

MEMBER HAMBLIN: I think a few of us are just lost. I think we skipped a bunch.

CO-CHAIR MOORE: I think we did.

MS. GORHAM: We went out of order just a bit. The psychiatric inpatient readmission is actually the last measure listed on your slides. So you might want to before you go back, go back up in order.

CO-CHAIR MOORE: Because it appears we skipped 20, 21, 22, 24, and then we went to 25. So we're on number 25, but we will go back to those others. Okay.

MS. KUWAHARA: We'll jump back to Measure number 19, NQF number 2631, Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and Care Plan That Addresses Function.

DR. TERRY: We did that one.

MS. KUWAHARA: I'm sorry.

DR. TERRY: So we're on 20.

MS. KUWAHARA: This is Potentially

Avoidable Emergency Department Utilization. And this was in a bundle with 20, 21, Potentially Preventable Emergency Room Visits; 23, Potentially Preventable Readmissions; and 22, Potentially Preventable Emergency Room Visits for Persons with Behavioral Health Diagnosis.

Four measures were evaluated as a group. TEP members noted that the 3M measures, which are 21, 22, and 23, were widely used across states, but due to proprietary restrictions, TEP members were unable to evaluate the measures' detailed specifications.

The TEP concluded that the measures are insufficient as currently designed. However, they represent promising concepts measuring potentially avoidable visits and hospitalizations.

MEMBER GELZER: Yeah, and I just want to clarify. We did not -- I think that's not quite written accurately. We said that they were insufficient as currently designed because of the potential, some of the blackbox proprietary

nature of the 3M measures and the fact that they were not NQF-endorsed, we did not pass them on as measures, just as concepts.

But in view of today's discussion, we would have passed them on as measures. So I don't want you to think we thought they were inadequate. And we noted that they were in common use in many state Medicaid programs, as well as in common use in many pay-for-value programs in Medicaid.

CO-CHAIR MOORE: Aren't they used, didn't CDC do some work with these measures? They adapted them, or?

MEMBER GELZER: That I can't comment on.

CO-CHAIR MOORE: Yeah, so NQF staff have it noted that it has been adapted for use by the CDC to describe characteristics of high safety net burden.

CO-CHAIR GOLDEN: Yeah, but that's item 20, I want to pull that one. I'm going to make a motion to pull Item 20 for deletion, which

is Potentially Avoidable ER Admissions.

When I was a medical student in Texas, I learned many Texas legends, of which there are many. One of which was, Governor Dolph Briscoe once appointed a dead man to the Texas Railroad Commission. And this is the equivalent of appointing a dead person to a national measure set.

We have used this measure, and NYU was the steward. And they created the NYU algorithm, and it was okay. It wasn't very discriminating, it had everything clustered around a small area. The problem is, it's written in ICD-9, and they are not making it available in ICD-10.

They don't have the time, energy, and money. So essentially it is not ICD-10 compatible. So I would recommend it be moved.

CO-CHAIR MOORE: Second the motion. Yeah, we could vote now on that one.

MEMBER GELZER: And in keeping the three 3M measures but not the potentially avoidable ED utilization measure.

CO-CHAIR MOORE: Yeah.

MEMBER GELZER: Is that correct? Okay.

CO-CHAIR MOORE: Correct.

MS. KUWAHARA: So I think the last measure is the Prevention Quality Indicators, number 90. This measure is currently used in California's 1115 Waiver Program as a pay-for-performance measure across all public hospital systems, both for complex care management intervention, as well as intervention more broadly.

The TEP determined that PQI #90 is an actionable measure that addresses avoidable admissions. Guys, this is number 24 in your discussion guides.

CO-CHAIR MOORE: Andrea, was there any conversation during the TEP meeting that this is a composite measure?

MEMBER GELZER: And I'm sorry, I'm having a heck of a time following the measures, with the notes that I have in front of me.

CO-CHAIR MOORE: Yeah, okay, no problem.

MEMBER GELZER: So which measure are you referring to?

CO-CHAIR MOORE: We're on number 24, Prevention Quality Indicators #90.

MEMBER GELZER: So it's just PQI #90.

CO-CHAIR MOORE: Yeah.

MEMBER GELZER: There wasn't, no, I think that the gentleman on the TEP from California has so much experience in it and was very passionate about his advocacy for it. So we included it.

CO-CHAIR MOORE: Okay. Any additional comments or questions? Karen, did you have the?

MS. LLANOS: I think it's a composite. I don't know 90 as well, but I think --

CO-CHAIR MOORE: It's listed as a composite.

MS. LLANOS: If it's a composite, then it's not the individual ones that are stand-alones that are part of the adult core set. At

least from what I'm reading.

CO-CHAIR MOORE: Okay. You want to use your microphone.

MEMBER PHELAN: California and New York on the specs are using it in their Medicaid waiver programs as a measure of quality. So, I mean, if we believe our coastal cities, coastal states drive where we're going, I have a feeling this is a pretty decent measure.

CO-CHAIR MOORE: Okay, any other comments or concerns? Anything from the phone? Miranda, I have one more listed, 26, Referral to Community-Based Health Resources.

MS. KUWAHARA: Let's see. This is the measure that was referred to from another program we already, that we discussed earlier this morning.

CO-CHAIR MOORE: Okay, great. Thank you.

MS. KUWAHARA: So by our accounts, we will be voting to strike two measures. The first is Measure 9, NQF number 0648, Timely

Transmission of Transition Record, Discharges from an Inpatient Facility to Home Self-Care and Any Other Site of Care.

The other measure is Measure 20, Potentially Avoidable Emergency Department Utilization.

CO-CHAIR GOLDEN: We also had number 1 for discussion. Number 3?

MS. KUWAHARA: Number 3, Follow-up after All-Cause Emergency Department Visit.

CO-CHAIR MOORE: And just to incentivize everyone, we'll take a break after we're done with voting.

MS. GORHAM: Just for clarification, Judy, you actually made this motion and someone seconded. I just want to make sure we have the measure correct. Did you ask for 0576 or 0648 to removed? 0576 is number 8 in your discussion guide, and 0648 is number 9 in your discussion guide.

MEMBER ZERZAN: Number 9.

MS. GORHAM: Okay.

CO-CHAIR MOORE: Okay. So we'll open up for discussion for number 1, Adult Access to Preventive Ambulatory Care, 20-40, 45-64, 65+.

MS. GORHAM: So it's, no. It's number 3.

CO-CHAIR MOORE: Number 3.

MS. GORHAM: In your discussion guide.

CO-CHAIR GOLDEN: Number 1 on the list, number 3 on --

MS. GORHAM: Exactly, it's number -- it's listed as the first measure on your slide. But in your discussion guide, it's number 3. And it's the Follow-up After All-Cause Emergency Department Visit.

CO-CHAIR GOLDEN: And again, my main reason is having implemented it as written, it actually had unintended consequences of pressuring practices to reach out to make people come in. So it was actually generating unnecessary visits and increasing the burden of care. That's why it needs to be modified.

CO-CHAIR MOORE: Any other questions

or comments or concerns? Anyone from the phone? Do we move to a vote now?

MS. KUWAHARA: Yes, so we'll be moving through the decision logic, but we will not be using our clickers. We're going to be going to a hand vote.

CO-CHAIR MOORE: Okay, and those on the phone type in their responses? Okay.

MS. KUWAHARA: Yeah.

CO-CHAIR MOORE: Hand up or hand down, thumbs up or thumbs down, do they have that option? And we're just going to pull up the questions so that you can see them as well when we go through them.

MS. KUWAHARA: So we'll be voting on Measure 3, Follow-up after All-Cause Emergency Department Visit first. To what extent does this measure or measure concept address the CMS quality measurement domains and/or program area key concepts? Those who vote high, please raise your hand.

CO-CHAIR MOORE: I mean, I guess I'm

-- it sounds like this is a good concept, but needs context, just like some of the other measures that we discussed for modifications. Or --

MEMBER GELZER: That's exactly what the TEP concluded.

CO-CHAIR MOORE: Yeah, so are we really voting for this to be eliminated, or are we --

CO-CHAIR GOLDEN: Yeah, I mean we could -- do we have to go through all these five question, or can go up the measure, up or down?

MEMBER GELZER: Yeah, that's what I thought we were doing.

DR. TERRY: To go through all five questions at this point in time. I mean, if it's easier to you -- I can't hear you.

MS. GORHAM: I think that to stick to the standardized process is probably best. But remember, so you're voting, this is the measure concept. And when you get to the first question, if it doesn't pass, then it can fail and can stop

right here.

So you want to go take the concept through the logic and address the question at hand.

CO-CHAIR GOLDEN: Yeah, I didn't get, as the person who made the motion, I think it passes the first concept. It might even possibly pass the second concept. But it fails the third concept, and possibly the fourth concept. So I mean, that's, you know, so.

MS. GORHAM: So for record purposes --

CO-CHAIR GOLDEN: I recommend a no vote on three and four.

MS. GORHAM: Right. So for record purposes, we know how Bill will vote. But we want to know how everyone else in the Coordinating Committee will vote.

CO-CHAIR MOORE: But this is specific to complex care needs, right. Medicaid beneficiaries with complex care needs. So we're not necessarily going to get the sore throat and have to follow --

CO-CHAIR GOLDEN: If it's all-cause --

CO-CHAIR MOORE: But they do everything, and then the denominator. Okay.

I mean, I'm struggling with this. Having, I mean, you know, having a child with complex care needs, you know, even if you come in with a sore throat, it's nice to have that follow-up. I mean, having to physically come in is very challenging, but --

MEMBER PHELAN: But I think what Bill mentioned was the fact that this isn't specified in detail enough to get to where you want to be at. If it was specified the other way, where it said a follow-up, a phone call, a this or a that, where it could be -- then, that would be a decent.

So the measure as specified will fail in one of the third or fourth category because it just doesn't do that. We just have to let CMS know that that's where it failed, is if they had added the word telephone follow-up or some other sort of follow-up, it would have done it.

Because this was forcing his group, his Medicaid providers to call these patients in when, oh, you had a sore throat. Well, you feeling better? Oh, great, okay, well, come on in. Or, you're feeling worse, come let me see you and see what's going on.

MS. GORHAM: I just want to highlight the importance of the mic. So we can hear you in the room. I just want to make sure the folks on the phone can hear you. So cut your mic on and also speak into the mic if you would, please.

MS. KUWAHARA: Sure, so again, this is Measure number 3, Follow-up after All-Cause Emergency Department Visit.

To what extent does this measure or measure concept address critical quality objectives of the CMS quality measurement domains, and/or identified program area key concepts? Those who vote high, please raise your hand or submit your votes online.

(Show of hands.)

Those who vote medium, please raise

your hand.

DR. TERRY: Could you put your speaker on?

MS. KUWAHARA: And those who vote low, please raise your hand.

Sixteen total between high and medium, so we'll move on to the next set.

To what extent will this measure or measure concept address an opportunity for improvement and/or significant variation in care evidenced by quality challenges for each program area? Did you want to weigh in?

CO-CHAIR MOORE: Yeah, I just wanted to ask a clarifying question. Do we have to identify the percentage, because that's what we're using, as opposed to a number?

DR. TERRY: We should do both.

MS. KUWAHARA: So we had 80% for set one. We're now voting on vote number 2. To what extent will this measure or measure concept address an opportunity for improvement and/or significant variation in care evidenced by

quality challenges? Those who vote high, please raise your hand.

(Show of hands.)

MS. KUWAHARA: Medium.

And low, please raise your hand.

Eighty-nine percent for high and medium combined. We'll move on to the next set.

To what extent does this measure or measure concept demonstrate efficient use of resources, and/or contribute to alignment? Those how vote high, please raise your hand.

(Show of hands.)

MS. KUWAHARA: Medium. And low.

Twenty-two percent between high and medium, so this measure will fail and not be recommended for inclusion in the BCN measure set.

Okay, this is Measure number 9 on your discussion guide, it's NQF number 0648, Timely Transmission of Transition Record Discharges from an Inpatient Facility to a Home or Self-Care, or Any Other Site of Care.

CO-CHAIR GOLDEN: And Judy, since you

announced this, do you want to discuss which elements it's not going to work well for?

MEMBER ZERZAN: I anticipate it will fail at the same place the last one did. I mean, I think really the challenge is, is this is really administratively burdensome, so there's not efficient use. And it doesn't contribute to alignment because it's coming out of places where it's at now.

MEMBER KELLEY: I'll speak for Pennsylvania Medicaid. Within our state we have health information organizations that are linked to statewide exchange. And several of them are pushing continuity of care documents from the hospitals, and in some instances, from EDs to PCPs and to our managed care plans.

So, at least in Pennsylvania, again, we're not using it right now. But we're probably in the next year or two we'll start to use this. And we know that, especially in our Philadelphia area, this is in heavy use, where the continuity of care documents are being pushed electronically

from the hospital to the health plan and to the PCP of record.

And they're doing it with emergency department visits as well. So it's one of those metrics that if you don't have an infrastructure in place, it's probably burdensome, it's a paper chase. But increasingly, I think we're still interested in meaningful use, I think, within the Medicaid program.

So you know, even though operationally it may difficult, some states may not be anywhere close to doing that. I know at least for us in some parts of Pennsylvania, both, we have one health information organization, Geisinger, that they're pinging this stuff to their rural PCPs.

So where that's operational, this is certainly a measure. If it's automated, to know somebody who has been multiple times to an emergency room, if a PCP knows that or they know that they've been in and out of various hospitals all over, you know, within a geographic region, it's very valuable, so. It raises a challenge,

though.

CO-CHAIR GOLDEN: I would -- Arkansas has a similar experience. We made this part of a P for P program for hospitals about seven years ago. We had a lot of whining and gnashing of teeth, but they redesigned their discharge documents. And now it's electronic from the health information exchange.

So it actually, you know, we've removed it from our pay for performance program, but we did double and triple the transmission of useful data. So there is some value to some of the elements of being adopted and incorporated.

MEMBER PHELAN: Why did you remove it from your pay for performance program?

CO-CHAIR GOLDEN: Because it was my understanding it was being done by the Joint Commission. And we'd already done it, so many of the hospitals were already doing this. Yeah.

CO-CHAIR MOORE: Judy, can you share more about who, from your perspective, who takes on the burden so I can get a better understanding

of that.

MEMBER ZERZAN: So I think the hard part is, I mean this is, I think it is done a lot at the local level, and a lot of hospitals do this or have done quality improvement things to do that. Where this measure is, especially at the core set, is the Medicaid agency or the health plan reporting on how much that was done.

And unless you have a really good electronic medical record way of doing it, I mean, this is potentially an electronic clinical quality measure. But those things, again, I want to like them, but they're just not there yet. So there's a lot of burden in terms of the paper chase, and I think that's sort of the how do you know that this has been done or not.

And then I agree with Bill that this is happening already at a lot of hospitals. And so sort of which is the place to make it happen. I'm definitely not arguing this is not an important thing, because I do think this is important. But I'm not sure what benefit it has

of the health plan or the Medicaid agency reporting where this is. This is sort of a better perhaps hospital measure.

MEMBER GELZER: This is Andrea Gelzer on the phone, and I'm representing, I mean I work for a health plan, and I think it's hugely important. And to Dave's point, I mean, I'm on the board of the Health Share Exchange in Philadelphia, and we are working very hard to get not just encounter notifications, but also CCDs in place across the region.

I think it's very important to approve. I also think that I don't see why if we approved this measure, why we wouldn't put those caveats in along with the approval.

MEMBER ZERZAN: The part that I struggle with is that it's being taken off of NQF endorsement, according to Peg, and it's being taken out of the Medicaid adult core set. And so I sort of think this is an important thing, but maybe this is not the measure.

Or maybe people need to use it more or

something else. But I struggle with if it's being taken off of those different measure sets, then why would we include it.

CO-CHAIR GOLDEN: Good question. I could see the core set removal as a burden issue. Why is it losing NQF endorsement?

DR. TERRY: Yeah, I'll just mention it again. This was presented this spring, and the developer did not present new performance data. Every time measures come back, which is about every three years, they need to update the performance data.

There was no information, it was PCPI, and they were working with another developer before. So it may be a complication of that.

I will tell you the committee liked these measures, there are several of them. But there's a little problem with the reliability testing too, I think it was only one site, didn't, you know, didn't, was a large number.

CO-CHAIR GOLDEN: Technical issue.

DR. TERRY: Yeah, a little technical.

You know, it just was soft, I will call it in that way. But because they, you know, it was very clear that there was nothing that they could look at to say, ah, what is the, you know, how is it performing today. So that's why probably it hasn't. But it will go to CSAC, it may lose endorsement.

CO-CHAIR MOORE: Any other -- John,

MEMBER SHAW: Just a point of clarification.

CO-CHAIR MOORE: Microphone please.

MEMBER SHAW: Just a point of clarification. I think there's a variety of metrics that are not NQF-endorsed, and this one that was and may not be now. How are they worse than the ones that were never endorsed?

From a practical perspective, I've been looking at endorsement over the years, and a number of measures the developer has not come back for endorsement because they didn't want to go through the burden and cost of doing that, particularly if people are using it anyway. So I

don't think losing endorsement in the context of this particular project is that meaningful to me.

CO-CHAIR MOORE: Appreciate that. Deborah.

MEMBER KILSTEIN: I think part of things are too is it makes sense as a hospital number, I mean as a hospital measure. But when you start slicing and dicing this by line of business and then within health plans, you know, how many of that hospital's membership is associated with each of the different managed care plans, the number becomes less relevant.

So it made sense at a hospital level, but it doesn't necessarily make sense as it flows through, especially when you get to an individual health plan that may only be serving one line of business.

CO-CHAIR MOORE: So you're saying the utility from a health plan perspective is that this measure isn't useful.

CO-CHAIR GOLDEN: So a point of clarification. So since we developed these

measures, I mean, we have managed care plans, but I think we're developing, aren't we, a toolkit to be used throughout the system. So does it have to be plan-specific, or can it be a hospital measure?

CO-CHAIR MOORE: Yeah.

CO-CHAIR GOLDEN: I mean --

MEMBER GELZER: This is Andrea again. Isn't it important to patient outcomes to get that timely transmission of a transition record?

CO-CHAIR MOORE: Yeah.

MEMBER GELZER: I mean, doesn't it impact follow-up rates, and don't follow-up rates impact returns to the hospital? So I mean, at least intuitively it makes lots of sense not just for a hospital.

I mean, I think it's a hospital's duty to ensure timely transmission. But it's very important for me as a health plan to get this information in a timely manner so I can act upon it.

CO-CHAIR MOORE: Yeah, I can say at

the FQHC, we have a hospital in the area, in the DC area, who never, ever sends us this information. So eliminating this measure I am afraid there'd be no accountability to push them to do this kind of stuff, because we can't get anything now. But go ahead, Maureen.

MEMBER HENNESSEY: Yeah, from my perspective I think as a health plan, having worked in health plans at executive positions for several decades, I think it's very important. However, there's two things that concern me. The first is that we do have a plan all-cause readmissions measure, which from my perspective is even more important than that transmission of data.

But the other thing I'm concerned about is that if there is no updated performance data for the past three years, I have some real questions about what we are measuring, what our benchmarks are at this point and what we are comparing it to.

Because hopefully over the past three

years we've seen improvements in transmission of information because of electronic records. So at this point, I don't know that we've got really good data to compare whatever is being collect to.

CO-CHAIR MOORE: And I'm going to allow Andy to respond after an NQF staff member wants to jump in.

MS. GORHAM: Yeah, I just wanted to jump in to share some more information on what Judy said and just thinking about Karen's introductory presentation that these measures will be for the use of the Medicaid state agencies. We spoke or Judy mentioned that this measure was removed from the core set, and I just wanted to provide CMCS's reasons.

So they have after consulting with states, this measure that we're speaking on now was removed due to low number of states reporting this measure, a decrease in the number of states reporting over time, and the challenges that states have described in collecting the

information in the measures. I just wanted to share actual.

CO-CHAIR MOORE: Andrea, do you want to respond?

MEMBER GELZER: And exactly what am I responding to, I'm sorry?

CO-CHAIR MOORE: Maureen's comment. Maureen, you want to sum up your comment?

MEMBER HENNESSEY: Oh, sure. So I would say two components. One is, is that we do have a measure of plan all-cause readmissions, and theoretically if we believed that one of the reasons why people readmit is because poor transmission of data from one point of care to another is the case. And we already have one way of measuring it.

I think the other concern that I have is because this is lacking current performance data, it's been three years, my concern is is that we don't necessarily have really good benchmarks to compare performance to at this point in time. Because theoretically, one would

think that the bar has risen because of the increase in electronic health records, which can facilitate this transmission. So it's a concern.

CO-CHAIR MOORE: Andrea, did you want to respond to that?

MEMBER GELZER: Yeah, and I would just say that we have lots of measures to hold the plans accountable. The plans are also looking for tools as they develop more value-based constructs to hold the hospitals, to hold the primary care providers responsible and share in the accountability.

So I think for that reason, it's a decent measure. Perhaps it's aspirational in nature, but I just don't want to lose it going forward, and to throw it out and say it wasn't without merit.

CO-CHAIR MOORE: John.

MEMBER KELLEY: From a Medicaid program and from a managed care standpoint, and again, we don't measure this as a Medicaid program at this point. I will, full disclosure,

when we did the adult core measures, I think I was the one that was pushing to put this on as a stretch measure in whenever, 2000-whenever.

That being said, though, I don't think the steward has really been a steward of the measure. There's a lot of this activity going on, it just hasn't been measured by the steward.

So how can a health plan use this? I would be looking at this. This is a gold mine. A health plan that doesn't use this -- my plans and AmeriHealth Caritas is one of them, they love this stuff. Because in the constitutive care documents, they have their meds.

You want to do med reconciliation, this facilitates that. If you want to look at some of the quality metrics, some of the documents have blood pressures, and hemoglobin A1Cs, weights, BMIs. I mean, it's like a gold mine of activity.

We're actually thinking, as a state, to start to move towards collecting some of the ECQMs, but also some of the constitutive care

documents. Because it is actually a gold mine of information.

So as a health plan, if you're not thinking in terms of, and you know, we haven't contractually required our managed care plans to do this yet, but we're thinking about that. And some states have actually done that with their managed care plans, where they have required them to be parts of the HIO.

So I mean, this is, in my mind, this is enlightened the managed care. This is managed care 2017 and beyond. And just because the steward hasn't done their due diligence -- I think there's a great opportunity still intact, it's not perfect.

CO-CHAIR MOORE: So I think we've had a chance to debate this and express concerns. I think we --

MEMBER ZERZAN: I apologize, everyone, for opening this can of worms.

CO-CHAIR MOORE: And I have realized that breaks is not enough of an incentive. So

tomorrow when I lead another section, I'm going to have to think of something more creative. So Miranda, can you lead us through a vote.

MS. KUWAHARA: Sure, so to refresh everyone, this is Measure number 9, NQF number 0648, Timely Transmission of Transition Record at Discharges from an Inpatient Facility to Home Self-Care or Any Other Site of Care.

For vote number 1, to what extent does this measure address the CMS quality measurement domains and/or program area key concepts? Please raise your hand for high.

(Show of hands.)

MS. KUWAHARA: We have 15 members for high. Those who vote medium, please raise your hand. And low.

So we have 100% for high/medium.

Great, so moving on to the next vote. To what extent will this measure address an opportunity for improvement and/or significant variation in the care? Those who vote high, please raise your hand.

(Show of hands.)

MS. KUWAHARA: We have 14 for high. Medium. And we have six for medium, so 100% for high and medium combined.

Moving on to the next vote. To what extent does this measure demonstrate efficient use of resources and/or contribute to alignment? High, please raise your hand.

(Show of hands.)

MS. KUWAHARA: We have seven for high, I'm sorry, eight for high.

Those who vote medium, please raise your hand. Seven for medium. And those who vote low, please raise your hand. We have seventy-five percent combined for high and medium.

Moving on to the next step. To what extent is this measure ready for immediate use? And please remember that because it's NQF-endorsed currently, we'll vote for it as a measure. Those who vote high, please raise your hand.

(Show of hands.)

MS. KUWAHARA: Twelve for high. Those who vote medium, please raise your hand. I'm sorry, I apologize. Low, please raise your hand.

DR. TERRY: I think people may have been confused that we're only voting high and low, right. It's either a measure or not at this point, yeah.

MEMBER ZERZAN: But I thought you couldn't vote low really either. This is a weird one because it's already a measure, and so it's already set, this doesn't really apply.

MS. GORHAM: Actually, if you look at your definition for low, low is a measure or a concept that is not in use or planned for use in the Medicaid populations. So I know that this is a measure. Did we specify that it is in use, or is that?

CO-CHAIR GOLDEN: Yes.

MS. GORHAM: Okay.

MEMBER HENNESSEY: So it would appear that really the only choice that's appropriate is high, correct? Okay.

MS. KUWAHARA: NQF staff is conferring. Just a couple minutes.

CO-CHAIR GOLDEN: We will take a commercial break while the referees go to the video tape.

MEMBER SIDDIQI: This is Alvia, but just to add to the second criteria under low, it would be nice if it said a measure or measure concept with no indication of specifications cannot be easily replicated. That way we would be able to vote low on measure that is endorsed but not easily replicated or has, you know, no indication of specification.

MS. GORHAM: So you all are smarter than a fifth grader, you are on the ball. So actually, so right, so it will default to high. But we understand that there are some people who would not like this to be recommended. So it defaults to high, we can take it to the next step, and that is where, you know, it will either be recommended or it will either fall out.

Defaulting to high, there's no really

reason to vote, yeah. Could we just go to the next one.

MS. KUWAHARA: All right, so for the next vote, to what extent do you think this measure is important to state Medicaid agencies and other stakeholders? High, please raise your hand.

(Show of hands.)

MS. GORHAM: And actually, they can be high, medium, or low. If it is low, it will fall out, it will not recommended. If you go high or medium, it will be recommended. So we'll take time to give you a minute to read, and then we'll open the vote.

MS. KUWAHARA: Again, this is to what extent do you think this measure is important to state Medicaid agencies and other key stakeholders. Those who vote high, please raise your hand.

(Show of hands.)

MS. KUWAHARA: Those who vote medium, please raise your hand. And those who vote low,

please raise your hand.

MS. GORHAM: Do not have all of the voting members voting, so if you could actually, we'll go to vote again. If you can raise your hand high and keep them up until we actually count hands. So Miranda.

MS. KUWAHARA: Those who vote high, please raise your hand.

(Show of hands.)

MS. KUWAHARA: Medium, please raise your hand. And low.

CO-CHAIR MOORE: It's because they haven't had a break.

MS. KUWAHARA: So we have 85% combined for high and medium, so this measure will be recommended for inclusion in the BCN measure set.

We'll move on to our next and final measure. This is Measure number 20, Potentially Avoidable Emergency Department Utilization.

CO-CHAIR GOLDEN: So it'll pass, it should pass one. Might pass. But it will absolutely fail item 4. So I don't know if you

want to jump to that. So it'll fail 4 because it's not usable anymore, that's all.

CO-CHAIR MOORE: So do we need to go through each of the decision tree if we know that it's not even usable?

MS. GORHAM: So we'll take the pause. I mean, I'm all for standardization, but I also recognize that it is now 3:10 and we are a hour and ten minutes behind schedule. So we will, whatever the chairs.

CO-CHAIR MOORE: Let's do one big vote. Is everyone comfortable with that, unless there's any opposition? Okay, one vote. Anyone on the phone, opposition? Sorry.

MEMBER SCHIFF: No.

MEMBER GELZER: No.

CO-CHAIR MOORE: Okay, let's move forward. One vote.

MS. KUWAHARA: One up or down vote. If you would like to see this measure removed from the BCN measure set, please raise your hand.

CO-CHAIR MOORE: Removal.

MS. KUWAHARA: Yes.

CO-CHAIR MOORE: We have over 60%, so we're done.

MS. KUWAHARA: Ninety-five percent voted to remove this measure from the BCN.

CO-CHAIR MOORE: Good job, everyone.

MS. GORHAM: Okay, so this is an up-or-down vote. The measures that remain on the set that we did not disagree, no one made a motion to remove, we are going to do a up-or-down vote for the en bloc voting.

Okay, so you are now voting for all of the measures that you see on your screen and the next slide is on, go to the next slide, those measures as well. So one vote, one up-or-down vote. Everyone I guess should agree, because we've already discussed and no one had any opposition. So Miranda.

CO-CHAIR MOORE: Allison, do you have a process question or? You can't throw any more measures in the bus.

MEMBER HAMBLIN: I'm not trying to do

that. I would like to make one comment, since there will be comments reflected in the report, and I can do that at any time.

CO-CHAIR MOORE: Okay, let's do that afterwards then so we can do the vote. Thank you.

MS. KUWAHARA: So for record purposes, we just want to note that 20 people voted to remove the measure from the BCN measure set. And that was Measure number 20, Potentially Avoidable Emergency Department Utilization. All right.

So this is the up-or-down vote for the BCN measure set as a whole. We're going to be going back to our clickers, and Kate will no longer be on calculation duty. If you would like to recommend the BCN measure set to CMS's Medicaid Innovation Accelerator Program, please press 1 on your clickers. If not, please press 2.

(Voting.)

MS. MURPHY: We're just waiting on one vote over the phone. Yes. One of our

participants can't access the online portion but is emailing the vote. So we're a multi-platform machine right here.

CO-CHAIR MOORE: How many stars would give for that delivery?

MS. MURPHY: So Sarita, if you're -- here we go.

MEMBER SIDDIQI: Did you get it? I sent it. I'm so sorry, I'm having major technical issues. So I appreciate you letting me email. I just can't get on the web at all.

MS. BUCHANAN: No worries, thank you.

MS. KUWAHARA: All right, 100% of the 20 voting members voted to recommend the BCN measure set.

MS. BUCHANAN: And just one more comment before we take a break. We would like to open up the lines for public comment. And so anyone on the line is able to comment either through the phone or using the chatbox. Staff will read it, and we will hold the comment period open for 20 seconds.

OPERATOR: At this time, if you would like to make a comment, please press star then the number 1.

MS. MURPHY: Jeff Schiff on the phone says he has a comment. Committee member, but I think he's still eligible.

MEMBER SCHIFF: Yeah, I didn't know if that was public comment or not. I just would like the notes to reflect that there's really a shortage of measures for children with special healthcare needs in this set. That means some measures go down to young age, but there's really nothing specifically addressing parents or schools. So I think we have a good set to go forward, but I just think that should be noted.

CO-CHAIR MOORE: Thank you for that. Lots of heads are nodding.

CO-CHAIR GOLDEN: So it's time for a break. We can take a good break. Good job, everybody, good job, Madame Chair.

CO-CHAIR MOORE: Thank you, sir.

CO-CHAIR GOLDEN: And we can come back

from the break and do it all over again, so.

MS. GORHAM: And so I stated earlier, we are grossly behind. So if we can take a hard stop in ten minutes. So if we can start back in ten minutes. Oh, five. That's even better.

CO-CHAIR MOORE: I'm still chair.

MS. GORHAM: All right.

(Whereupon, the above-entitled matter went off the record at 3:15 p.m. and resumed at 3:25 p.m.)

CO-CHAIR GOLDEN: Okay, and we do not include too much coffee in substance abuse. It's not part of the tranche. So I know many of you are probably over-caffeinated, but that's okay. It's not part of our domain and not part of our agenda. And we will do the same process we did for the middle of the day.

So we will have new and referred measures for our review. And this one looks awfully familiar. It's about adult access to preventive care. So here's a question. We've already reviewed and approved this for the other

measure set, correct?

MS. MURPHY: So actually though before we get started, I'm going to go through just a couple of updates and hopefully some clarifications from everyone before we jump into this second set.

CO-CHAIR GOLDEN: Sure.

MS. MURPHY: Great.

CO-CHAIR GOLDEN: I got people back.

MS. MURPHY: So thank you all for bearing with us through this very process-heavy part of the day. Just a couple of updates that we made during our brief break.

So given this concern over the NQF-endorsed measures in their designation as either a measure or a measure concept, moving forward, for NQF-endorsed measures, they will automatically receive a high ranking and we will skip that portion of the decision logic. So we will be skipping a question for the NQF-endorsed measures as they go through the decision logic.

The second change we made was that

pursuant to our brief change we just made in the last measure set, we will be doing an up-and-down vote on measures that we pull off of the measure set.

So in that last step where we walk through the recommended measures and review the measure sets in full, rather than having to go through the decision logic to fail a measure, we will do an up-or-down vote.

This will definitely save us time as we move through the day, but we are still asking that if you would like to pull a measure, we'll still be using the process of motioning to remove the measure. The motion must be seconded, and further, we ask that you provide as detailed as possible a rationale for why you think this measure should be removed.

And we ask that you try to base that rationale in some criteria on the decision logic. So while we're not walking through it explicitly, if you can tie reasoning to one of the criteria that we had previously gone through, that would

be especially helpful for us.

But we do hope that these little ironing out the wrinkles in our process will smooth this along for our second, third, and fourth sets. Okay.

So, yeah, just to start us off, we are now turning our attention to the Reducing Substance Use Disorders TEP, or program area, I should say. So once again, on this previous slide we listed out your role. I just went through this.

If you have any questions about what we're doing, at this point, please continue to bring them up, but I think we're all pretty good now, having been through it.

Before we dive into the measure specifics, I will turn it over to Sheryl. Sheryl Ryan was the TEP chair of the Reducing Substance Use Disorder TEP. And Sheryl will give us an overview of the conversation that was had at that meeting. Sheryl.

MEMBER RYAN: Okay, thank you. I will

be brief, I promise. I want to thank the other members of our TEP. We had Richard Brown from the University of Wisconsin, Dennis McCarty from the Oregon Health System, Tiffany Wedlake from the Department of Health in Maryland, and Christine Andrews from University of South Carolina. And were very, very helpful with the discussion.

So we started out with probably more than 100 that the committee reviewed, and then we ended up having 43 measures and measures concepts that we ended up reviewing during the in-person meeting. And we ultimately recommended 19 measures and six concept measures.

So there were a number of these, and these consisted of we felt that we needed more measures that really covered the whole scope of substance use disorders, starting with screening, prevention, and ending with assessment and intervention. And we felt that we were really missing measures that really addressed the early aspects of prevention or screening.

We also felt that we needed to broaden some of the tobacco measures to include not just tobacco but drugs and other nicotine products. And we found a number of critical gap areas, substance abuse measures that focused on pregnant women, the lack of available outcome measures. I'll also put a plug in, there were not very many measures for anybody under the age of 18, when much of our substance use starts.

And we also felt that a lot of the process measures sort of set a low bar. So I think those are pretty much, you know, the themes that we identified.

MS. MURPHY: Thank you so much, Sheryl. So you might recognize this next measure, or actually, let me back up and just say that we received no late submission measures in this program area, so we can move on from there.

The next set of measures we'll review are those that were moved between the technical expert panels. So this next measure comes to us from the LTSS TEP. If it looks familiar, it's

because we just discussed it as part of the BCN TEP.

So what we will do is we will open this back up for discussion. You will most likely want to focus your conversation on how it relates to the substance use disorder program area. And rather than taking this through the entire decision logic again, we'll take this through the first two components of the decision logic, as though as the two that relate most closely to the actual suitability for the program area.

The other three we presume will hold over from your previous vote. If anybody has any objections to skipping those last three votes, please let us know, and we're happy to --

CO-CHAIR GOLDEN: I would suggest that we not even do that, because I thought we were going to, at the end of the day, look at all the measures and where they fit. And we talked about that earlier. Because the measure's already approved. Unless you just want to make that

decision.

MS. MURPHY: It's up to you. I mean, you are the Chair. I will say that our end of the day time is getting smaller and smaller. But --

MEMBER PHELAN: I second that motion. If it's been already approved, we just --

MS. MURPHY: Sure.

CO-CHAIR GOLDEN: Okay.

MS. MURPHY: On to the next one. Yeah.

CO-CHAIR GOLDEN: I'm pushing work till later. So then we would go to measures for --

MS. MURPHY: Microphone.

CO-CHAIR GOLDEN: Okay, so now we got to measures for reconsideration. Is that correct? So tell us where this one's coming from. Did somebody pull it?

MS. MURPHY: Sure. So members of the Coordinating Committee identified three separate measures for reconsideration. Just as a

reminder, these measures were reviewed by the TEPs, went through the decision logic, and they found them to be unsuitable, and they were not recommended.

The first measure we will reconsider is Mental Health, Substance Abuse, Mean of Patients' Overall Change on the BASIS-24 Survey. This is Measure 46 in your discussion guides, and it is not NQF-endorsed.

The TEP noted that the BASIS-24 Survey upon which this measure is built is a proprietary behavioral and symptom identification tool, and has feasibility concerns about recommending a proprietary tool. The TEP also noted that the tool is available online and can be acquired in other ways.

The TEP also raised concerns around providers being able to differentiate between using the BASIS-24, the PHQ-9, the CAGE, or some other tool or combination of tools.

And just for some context, this went down on the first decision logic question, which

was suitability, or applies to a critical quality objective. So we'll open this up for discussion. And this was retained by Deborah Kelley. So Deborah, you'll serve as our lead discussant for this.

CO-CHAIR GOLDEN: Debbie Kelley?

MS. MURPHY: David Kelley, oh gosh. There's a Deborah Kilstein, right? I'm sorry. Oh gosh.

CO-CHAIR GOLDEN: So before Deb gets started here, you said the measure source is AHRQ Clearinghouse, but the clearinghouse is usually a repository from other sources, so I would not -- were they the steward or was somebody else the steward of this?

MS. MURPHY: Which one is it?

CO-CHAIR GOLDEN: This is number 46.

CO-CHAIR MOORE: Because I may have that information.

DR. TERRY: It's a person, Susan Eisen. An individual person.

MS. GORHAM: So we have the AHRQ

Clearinghouse as the measure's source. So we found the measure information there.

CO-CHAIR GOLDEN: David.

MEMBER KELLEY: Even though this is not a perfect measure, and we actually used something a little bit different, 15 questionnaire, not proprietary in our Opioid Use Disorders Centers of Excellence.

There is no way to measure someone moving towards recovery, and we are spending hundreds of millions of dollars in opiate use disorder treatment. And we have no objective validated way, we've stolen, all 15 of those questions come off of one of SAMHSA's I think hundred-and-some question questionnaire.

So the bottom line is this is, this would be in my mind an outcome measure. I thought that the tool was validated. I guess I didn't realize it was proprietary, but that shouldn't preclude us from saying that this, you know, a concept we would like to move forward with.

But it is an outcome. It starts to measure as people move towards recovery, it looks at certain domains. And it's patient-centric, patient-focused. So from my standpoint, I thought it was important --

CO-CHAIR GOLDEN: You have not used it but you used something like it?

MEMBER KELLEY: We used something similar to it. And because otherwise you can't rely on claims data to look at this type of information. So it's asking about things like are you reunited with your family, are you seeking employment, do you have stable housing, are you reunited with family. Are you, you know, reconnecting with social institutions like church or other important.

So again, it's an outcome measure, helps you measure folks as they're moving towards recovery. It's patient-centered, patient-focused.

CO-CHAIR GOLDEN: You're advocating it could be useful to some programs for the

consideration for a concept.

MEMBER KELLEY: Yes.

CO-CHAIR GOLDEN: Type of comments.

MEMBER KELLEY: It's a measure concept, not as a measure.

MEMBER RYAN: Also, we agreed with what you say. The group felt it was one of the rare outcome measures. I guess we just felt like the feasibility of a proprietary measure being used by Medicaid. That was really the only, really the main concern. We didn't think it was appropriate to --

MEMBER KELLEY: At all time and each stages. I mean, there are other screening tools that are proprietary that as a Medicaid program we pay for in development screening and autism screening. Fortunately or unfortunately, we do it all. We love to find validated tools in the public domain that we don't have to pay for.

CO-CHAIR GOLDEN: I just want to make sure I'm not out of school here, I'll check with Peg and the staff. If we were doing a required

measure, prior proprietary measure would be precluded if we were looking for tools and a proprietary measure is an option. Would that be a fair way to say it?

DR. TERRY: I would say that we could use them. I mean, I think we've actually now looked at some from 3M, as well as the PAM, which was, you know, endorsed. So yeah.

MS. MUNTHALI: But I do want to remind you that we don't endorse tools. We endorse the performance measures that are based on the tools.

DR. TERRY: Yeah, sorry.

CO-CHAIR GOLDEN: Do we have other comments on this measure.

CO-CHAIR MOORE: So do we know that this is proprietary? Because it was funded through and RO1 through NIH. So it has, there's a large element that has to be publicly available. And also to clarify, I went to a resource I have when I was at AHRQ. It's not an AHRQ measure.

AHRQ has a clearinghouse -- did we

already discuss that? Okay, sorry. Anyway. But it's been funded by NIH, so I'd like to clarify whether or not it really is proprietary. It has a registered trademark, but that could just be in terms of name, not necessarily analysis.

But going back to your point that, you know, we looked at patient activation and you know, didn't have that issue.

CO-CHAIR GOLDEN: Michael, do you have something?

MEMBER PHELAN: I see so little of adequate measures on this topic, like you were saying. And if this is one that's actually been studied at, I don't know where it's been used, or if it even has any usability.

But if Medicaid programs are willing to purchase this, and it actually does what it says it does, you know, this is such an area of high patient distress and things like that, that I think this can show a way of some improvement and give people some hard evidence that they're going along the improvement process.

I see it almost like a no-brainer, from this aspect of this disease entity that kind of ravaging our communities right now. If there's a better one out there or something that's even close to this, you know, take it and grab at it.

But from the people that I see on a daily basis in our EDs and stuff like that, this is, you know, probably a measure that -- and I don't know the science behind it. I don't know who's used it, has it been validated. Do you know it?

CO-CHAIR MOORE: Yes, I want to for the record update the, what's in the guidance document for number 46 under usability. According to ARQH, which I don't know that this is actually publically available, but this is being used across all the VAs health service research and development program system specific to mental health and substance use.

So it's fully integrated into the VA system, and it continues to go through testing at

specifically 27 treatment sites across the United States that are affiliated with the VA health system.

CO-CHAIR GOLDEN: Okay, Deborah.

CO-CHAIR MOORE: Yeah, there are publications. In Medical Care, there's a JAMA. That's all I can see right now, but I can dig deeper.

MEMBER KILSTEIN: I just want to confirm, though, we're talking about approving this as a concept only, so that we're saying the idea of doing some kind of screening to identify people as they approach recovery is worthwhile, but we're not necessarily endorsing this tool or any other tool to do that.

CO-CHAIR GOLDEN: I think technically we would be saying that we are endorsing the idea of using the BASIS tool to track progress in recovery. But it's not a mandated activity, it's something that one can consider in your local programs.

MEMBER KILSTEIN: Well, none of these

are mandated, right. So I mean, yeah, okay.

MS. GORHAM: Just for terminology purposes, we are not endorsing anything. We are recommending to CMS.

CO-CHAIR GOLDEN: Jennifer and I will learn this by the end of tomorrow. Other comments or questions on this one? On the phone, anybody want to say anything on the phone?

MEMBER SCHIFF: This is Jeff. I just want to pile on a little bit. A tool that gets at some of the social determinants is I think a worthwhile thing for us as we try to integrate those into our value-based purchasing products. Thanks.

CO-CHAIR GOLDEN: And another comment, Allison.

MEMBER HAMBLIN: So I don't know about others, I feel like I'm doing like a speed education here, trying to read through this BASIS-24 and trying to understand it. And I agree that it seems incredibly promising, and I want to underscore the desire to see some type of

measures that address social determinants, both in this program area, as well as in the BCN program area.

I didn't have a chance to make this comment before, and I think there's sort of a very regrettably lack of measures in the BCN area that address sort of the concept of social determinants at all. And so I would really appreciate if the final report would acknowledge that, recognizing that perhaps it's due to just a lack of validated measures at this point.

But there should be an aspiration to move towards including some measures of social determinants of health in the BCN group. And so wrapping it up back to the SUD measure here, it maybe, I mean the group may feel like they can vote on this measure perhaps folks need to spend more time understanding what this tool is.

And in the absence of recommending the addition of this measure, it could also be a comment that there's a recommendation to CMS to explore tools like this further, and the science

behind these tools further to ultimately include them in this list.

CO-CHAIR MOORE: I just want to clarify that it has been validated. It has undergone reliability and validity testing, it's been published. It just appears that the developer has never taken it through NQF process.

But it has publications in Medical Care and JAMA about reliability and validity testing. And then the VA has also published extensively on the impact of this measure in their population.

MEMBER HENNESSEY: Yeah, I would just add I'm on the McLean Hospital, and they've got a site called eBASIS, B-A-S-I-S, and they list their tools, one of which is the BASIS-24.

CO-CHAIR GOLDEN: Are we ready to vote? Final last comments? Vote time.

MS. MURPHY: All righty, this is mental health substance use mean of patients' overall change on the BASIS-24 survey. This is Measure number 46 on your discussion guide.

We're going to be returning to our clicker vote.

If you would like to select high for to what extent does this measure address critical quality objectives of the CMS quality measurement domains and/or identify program area key concepts, please press one. For medium, please press two, and for low please press three.

(Voting.)

Okay, we're waiting for one more vote on the phone. Eighty percent of the 20 voting members voted high, 15% voted medium, and five percent voted low.

Moving on to the next step, to what extent will this measure address an opportunity for improvement and/or significant variation in care? If you would like to vote high, please press one; medium press two; or low, please press three.

(Voting.)

We're just waiting on one more over the phone.

MS. MURPHY: Sarita, if it's easier

for you, you're welcome to call out your vote over the phone. It is entirely up to you, however.

CO-CHAIR GOLDEN: She's among friends.

MEMBER MOHANTY: I'm sending the emails. Maybe it's just there's a delay, I think. I'm trying to send them as soon as you say vote, so maybe it's just not coming through that quickly. But I'll be voting high for this one.

MS. KUWAHARA: Sixty percent of the 20 voting members selected high, 30% selected medium, and ten percent selected low.

MS. BUCHANAN: One moment. We're working with our voting slides, which are being a little finicky.

MS. KUWAHARA: Okay for vote number three, to what extent does this measure or concept demonstrate efficient use of resources and/or contribute to alignment? Please select high -- I'm sorry, please select one for high, two for medium, or three for low.

(Voting.)

MEMBER KILSTEIN: Require, unless you have an EMR that captures the survey results, this would require chart review? Just wanted to make sure I understand it.

MEMBER HAMBLIN: Similar to the PAM.

CO-CHAIR GOLDEN: It's a bit of a survey date, I would think also, isn't it? Yeah, so. I guess we're missing a vote or two?

MS. KUWAHARA: We're missing one, I think. We're about to get it in just a moment.

CO-CHAIR GOLDEN: Alex Trebek is getting nervous.

MS. MURPHY: Sarita, can you --

MEMBER MOHANTY: Are you still waiting --

MS. MURPHY: Yes, I haven't --

MEMBER MOHANTY: Okay, so I guess the, so the email thing is not working, okay. So, yeah, you can put me on high on that one as well.

MS. MURPHY: Great, thank you.

MS. KUWAHARA: Sixty percent of the 20

voting members selected high, 25% selected medium, and 15% selected low.

Moving on to the next vote, to what extent is this measure or measure concept ready for immediate use? If you would like to select high, please press one, medium press two -- or, I'm sorry.

MS. MURPHY: So because this is not an NQF-endorsed measure, this question still applies. I'm sorry?

DR. TERRY: I said it's a concept, it's not a measure at this point. Then we should take it through.

MS. GORHAM: So you would not vote two then, because two is for a concept.

DR. TERRY: But it is a measure, yeah, okay.

CO-CHAIR GOLDEN: Okay, so we're voting on the item. A one is a measure, a two is concept. Is that? And a three is I don't like it.

(Voting.)

MEMBER MOHANTY: I'm sorry, is this, I'm sorry, did you say, this is a measure, or is this a concept? I think I got a little confused about the distinction here.

CO-CHAIR GOLDEN: It is an item for reconsideration. If it's already an existing measure, it's a measure, all right.

DR. TERRY: That's right.

MS. GORHAM: And we just determined, based on what Jennifer reported, that this is a measure.

MEMBER MOHANTY: Thank you. So my vote is high.

CO-CHAIR GOLDEN: All right, we have to vote. That's fine. Appreciate it.

MS. KUWAHARA: Voting is open.

CO-CHAIR GOLDEN: We got her voice vote, right?

MS. KUWAHARA: So we -- oh, there we go. Sixty percent of members, I'm sorry, sixty percent of the 20 voting members selected high. Twenty-five percent selected medium, and 15%

selected low. It's 60% high.

DR. TERRY: Was unclear, because you were saying it's a measure. It's either high or a zero.

CO-CHAIR MOORE: So I guess the question is why do we vote on this one if it's a measure. Because the question is essentially is this a measure, yes or no. Is this a concept, yes or no. So I think that's the confusion, because --

MS. GORHAM: Yeah, so this would be the same as what we said earlier about the NQF measure. So it's just kind of defaults. And so we know that we can just pass this because you're going to go to the next question in the decision logic.

CO-CHAIR GOLDEN: It has passed, so. So go to the last item.

MS. KUWAHARA: To what extent do you think this measure is important to state Medicaid agencies and other key stakeholders? If you would like to select high, please press one,

medium, two; or low, three.

CO-CHAIR GOLDEN: And does our phone colleague want to throw their vote in?

MS. MURPHY: We're also waiting on -- Andrea, I don't know if you've sent your vote yet, but we haven't received it.

MEMBER MOHANTY: My vote is high.

MS. MURPHY: Is that Andrea or Sarita, just to?

MEMBER MOHANTY: Oh, sorry, Sarita.

MS. MURPHY: Hi Sarita, okay, thank you.

MEMBER GELZER: And I just sent mine as well.

MS. MURPHY: Thank you, Andrea.

MS. KUWAHARA: Sixty-five percent of the 20 voting members voted high, 25% voted medium, and ten percent voted low. And this measure will be recommended for inclusion in the SUD measure set.

MS. GORHAM: So before we do that, I just want to clarify. It's late in the day, so

bear with us for one minute. So let's go back for a minute. We discussed the fact that the NQF measure kind of defaulted through because we knew that it was used in the states according to what our immediate use question states.

For this particular measure, we do need to look at whether it is used in the states. So is it ready for immediate use. So we do need to actually go back to that question and vote, because we need to answer the question, I'm going to steal Bill's decision logic just so I can get the wording correct.

So to what extent is this measure or concept ready for immediate use. So we know that it is a measure, but the measure, a fully developed measure, we know that is currently in use or planned to be used in states. Or low, it could be a measure that is not used or planned for use in Medicaid populations.

So what I didn't hear in the conversation, and maybe I missed it, correct me if I'm wrong, is this measure used now or planned

to be used in the Medicaid population. That's what we need to vote on, the immediate use piece.

CO-CHAIR GOLDEN: Well, no, I interpreted it differently, so maybe help me out here. I thought is it sufficiently specified and available that it can be used now. And that's different than is it already in use.

DR. TERRY: No, is it ready.

CO-CHAIR GOLDEN: Yeah, can you take it off the shelf. Can somebody go tomorrow and use it? So we're having heads nodding and shaking.

DR. TERRY: So it is a little confusing. I think the difference between this measure and an NQF-endorsed measure is we can attest to that, because it's come through our process. Even though this is a fully specified measure, we haven't, we don't know. We just know the information that was there, so.

CO-CHAIR GOLDEN: However, it is being used at the VA.

CO-CHAIR MOORE: Yeah, it is in the

AHRQ Clearinghouse, which would imply that it's gone through their process to identify that it can be used.

MS. MUNTHALI: But it's not NQF. We can attest to the NQF process.

CO-CHAIR MOORE: Yeah.

MS. MUNTHALI: But there's an implication that it has, but we can't. And you can say yes or no, but I mean, that's why we have to go through the process to decide.

CO-CHAIR MOORE: Yeah, I mean from my perspective, while I value NQF, I also recognize that others could also identify that a measure can be used. So for me personally, I feel like I can trust our process.

MEMBER PHELAN: I'm not sure ARHQ does that. I think that's just something you could self-nominate a measure to. I don't think --

CO-CHAIR MOORE: You can self-nominate, but there's a process. They just don't automatically get put into the clearinghouse.

CO-CHAIR GOLDEN: You've got to submit

a dossier.

MEMBER PHELAN: Right.

CO-CHAIR MOORE: And it goes --

MEMBER PHELAN: But I'm not sure anyone does any --

CO-CHAIR MOORE: Yes, they do.

MEMBER PHELAN: Oh, they?

CO-CHAIR MOORE: Yeah, it has to go through a review. The whole intention is to make sure that there's a repository of measures that meet certain criteria that can be utilized, that may or may not be ready for NQF endorsement. But it's to get things moving.

MEMBER PHELAN: Can someone ask the, from NQF reach out to Dr. Eisen and say, have you ever thought about submitting this as an NQF measure. She may not know that that's an avenue to get something like this promoted.

DR. TERRY: Yeah, it's a very good point, because people think it's an important measure. So thank you.

MEMBER SHAW: I'm not sure if I'm

begging the question here on this. I'm trying to follow the logic. So are we saying that if it's not already in use, we can't move it forward as ready for use ever, as either a measure or a measure concept? Reading the words, it looks that way. Nothing new is ever going to be ready for use?

DR. TERRY: Well, if it's NQF and it's just gotten through, it could be ready for use. It's not always used. That's one way. But this one is apparently used in the VA and other places. So we know it's in use. So I don't know if that answers it, John.

CO-CHAIR GOLDEN: Yeah, I think the second bullet below is a measure that's not in use or planned to be used in Medicaid. One could argue that a VA population is Medicaid-like. So there would be, I mean, maybe that needs to be, that bullet might need to be tweaked. Because the second bullet is nobody can use it, or it's not, there's no specs, so.

Okay, so we're being asked to vote.

We have -- okay, have we voted on number 5? I just want to make sure. Have we voted on the fifth item too or not? Where have we voted?

MS. KUWAHARA: Oh, yes, we're done with this measure.

CO-CHAIR GOLDEN: No, we're not. I'm having a request for a revote on item 4.

DR. TERRY: Item 4, please.

CO-CHAIR GOLDEN: I will, without discuss, we will vote on item 4.

DR. TERRY: And we just want to clarify, this is either a measure or it's not. I mean we're not going to vote on it as a measure concept at this point, because we have information, more information. So. Two is not an option.

CO-CHAIR GOLDEN: So ready, have we opened?

MS. KUWAHARA: Polling is now open. If you would like to select high, please press one, or low, please press three.

(Voting.)

CO-CHAIR GOLDEN: I don't follow that at all, no.

MEMBER SCHIFF: Bill, can I say something? I'm just wondering if we're getting a little confused between the tool and the measure itself. Because its seems like we have a validated tool but we don't have a measure that's been endorsed yet on what the change in the score means.

CO-CHAIR GOLDEN: Yeah, I have to say that I'm a little concerned that medium is still a valid vote. Because one is a, scientific testing for a measure is one thing. Medium says it's actually, you know, it hasn't formally been tested, but people are using it for whatever purposes in their environments, which.

Right, and that's what I think that one does. I think that's the whole direction of, you know. I think that to some extent, the fourth bullet, the fourth question is more of a technical question than it is a vote.

CO-CHAIR MOORE: I agree. I think

that's a really good point.

CO-CHAIR GOLDEN: So that's where we're getting hung. I mean it either has been tested to scientific validity, a la NQF standards. It is in use, and people are using it and getting, for whatever purposes. Or it's not really, or it's truly just out there kind of floating around.

And I think that there are, as we said earlier, there are some perfectly useful measurement devices that haven't met NQF testing. And probably never will. So it's almost a technical assessment as opposed to an opinion poll.

CO-CHAIR MOORE: And I think there's a need to define terms that are in this question too.

CO-CHAIR GOLDEN: So tell you what. Why don't we -- well, we can have this, this is a happy hour discussion. We could have a parking lot, the happy hour. I think that the measure has passed, with the exception of what level of

item it is on the fourth bullet.

We can discuss that later. Let's put that aside for now. And we can back to that. That's a technical nuance.

So let's go to the, I think we're done with this measure or this item. So let's go to the pediatric psychosis before we go there ourselves.

MS. MURPHY: Great. Thank you, so moving on to the next measure that was selected for reconsideration by a member of the Coordinating Committee. We'll review NQF Measure number 2806, for reference that is number 58 on your discussion guide. The measure title is Pediatric Psychosis, Screening for Drugs of Abuse in the Emergency Department.

The description of the measure is percentage of children or adolescents aged five to 19 years old seen in the emergency department with psychotic symptoms who are screened for alcohol or drugs of abuse.

The numerator is eligible patients

with documentation of drug and alcohol screening use, using urine drug or serum alcohol tests. The denominator is patients aged five to 19 years old seen in the emergency department with psychotic symptoms.

So the TEP agreed that, the TEP's objection to this measure was around the premise of the psychosis screening. They felt that unless a person already has an existing diagnosis of psychosis, usually children will receive a health screening first. And if the screening is negative, will then be referred to the psychiatrics for the psychiatric screening.

The TEP did, however, note that they thought it addressed a critical population that's often under-represented in SUDs measurement.

But they also felt that the practice was a minimum standard of care. This wasn't anything above and beyond, they didn't feel it addressed a critical measurement gap. But that this is already being done and should be standard practice already.

So we can open it up for discussion. The lead discussant on this was Karen Amstutz. Karen unexpectedly couldn't be with us today. So if anybody else would like to jump in and discuss this, please feel free.

MEMBER PHELAN: I can speak a little to this because I'm an emergency medicine physician. There is no one that comes in with psychosis that doesn't get a substance abuse screening. That just, I can't call a psychiatrist, I can't get a psych bed outside without having.

Because they'll call and say, Oh, you didn't get us a urine tox screen yet. You're like, they're ten, they haven't peed yet. I don't think they've got it. And they still, they are very resistant to take these patients because they have protocols that they follow.

Now I know the people behind the scene, so I'm usually able to call and you know, call Marymount or wherever I'm at, and say, I can't get a urine. Can you accept her? If she

pees for us in the next nine hours, I'll send it over. But can we go over process going?

So I'm not sure there's, and I mean, and I don't know, and I have colleagues all over the country. We all complain about the standardized psychiatric screening eval. There's no child that would have psychosis and being needing mental health screening that wouldn't get the substance abuse screening and the alcohol screening up front. So.

CO-CHAIR GOLDEN: The question is you're not debating the appropriateness. You may be saying that the practice variation is small and the question is, is it universal. And I mean, does every ER do it. And you're pretty confident they do?

MEMBER PHELAN: Very confident. You can't get a psych bed without doing the prescreening, so.

CO-CHAIR GOLDEN: So you would be concerned that this would be difficult for the second item.

MS. MURPHY: Just for some context, the TEP voiced the same exact concerns. And they also failed this on the first item in the decision logic, which was addresses a critical quality objective.

CO-CHAIR GOLDEN: Thank you. Do we have --

MEMBER SCHIFF: Bill.

CO-CHAIR GOLDEN: Yes. Is that Jeff?

MEMBER SCHIFF: Yeah, from the pediatric yard, I just want to, I second that. And I'm also curious when this was approved whether, where the --

CO-CHAIR GOLDEN: It wasn't approved. It was approved, this was for reconsideration.

MEMBER SCHIFF: No, it was an approved as an NQF -- and then when it was approved as an NQF measure, where the gap was. Because it seems like, I agree that that screen would always be done.

And then it gets into a secondary thing, which is the drugs or abuse screen misses

things like LSD and mushrooms and rohypnol and those sort of things. So you have to wonder what's an adequate screen depending on symptoms. So I don't think this is a good, I think it could fail on the first bullet because it's not a big gap.

CO-CHAIR GOLDEN: Okay, any other comments in the room or on the phone? In the room or on the phone? I think we're ready to vote.

MS. KUWAHARA: This is Measure number 58, NQF number 2806, Screening for SUD in Child and Adolescents with Psychosis. For the first vote, to what extent does this measure or measure concept address the CMS quality measurement domains and/or program area key concepts?

Polling is now open. If you would like to select high, please press one. Medium two, or low, three.

(Voting.)

Eleven percent of the 19 voting members selected high, 16% voted medium, and 74%

voted low. So this measure will not be recommended for inclusion in the SUD measure set.

CO-CHAIR GOLDEN: Okay. And we will move on to the next item. So this goes to use of opioids at high doses. And Cheryl, you want to make some comments?

MEMBER POWELL: Yes, I think this group basically felt that --

CO-CHAIR GOLDEN: All right, it's number 61 in the massive big list.

MEMBER POWELL: One of the members who is active in treating opioid patients felt that the CDC guidelines is really 90 milligrams is considered a high dose, and not the 120. So that the measure, it includes a level of opioid use that is really out of, not in the standard of care at this point.

So that was the main issue there. And we felt like couldn't change the measure to reflect 90 milligrams versus 120. We were limited to what we had.

MEMBER GELZER: This is Andrea. These

are for individuals with cancer pain.

DR. TERRY: No, this excludes, specifically excludes patients with cancer or who are on hospice.

MS. MURPHY: So just for a little bit of background, we can jump into discussion. There are two very similar measures to this that were recommended and are in the set now, and we have the opportunity to discuss those later.

This measure is specified for use of opioids at high doses from multiple providers in persons without cancer. In the recommended set, we have use of opioids at high doses and use of opioids from multiple providers. So this is both of those together.

Also, I will note that Cheryl Powell, we have two Cheryls here, was the one who opted to retain this measure. So we'll Cheryl give her reasoning, and then open it up for conversation.

MEMBER FINESTONE: I just have one clarification. Yeah, it's without.

MS. MURPHY: Oh, I'm very sorry about

that.

MEMBER FINESTONE: It's incorrect, yeah.

MS. MURPHY: It is without cancer, not with cancer, yes.

CO-CHAIR GOLDEN: All right, Cheryl.

MEMBER POWELL: Yeah, so the reason that I asked for this one to be reconsidered was I noticed that there were the others, and I wanted to know the reasoning about the why those two and not this one, particularly this one. And it was 2950 had the same score.

And from the notes that we had that I could find, I couldn't tell why one and not the other and why two and not the other. So it was really more just to open up the discussion about the three and to understand the reasoning for why those two were better than this one. That was really, I mean, I only saw the one.

I think you said two, but I was having trouble understanding the difference and wanted to hear about what that discussion was from that

TEP. That was it.

CO-CHAIR GOLDEN: So let me ask a question to someone. So five years ago, I'd say this is great. From my perspective now, this is becoming less relevant because most plans, most Medicaid programs are putting prescribing limits into operation so you can't get, under the Medicaid program, more medication paid for.

But you can certainly do it by cash. So then you get into what's in the PMP items. And there are laws being passed now to require accessing the PMP directories before you prescribe the opioids.

So while the concept here is good, the question is, is it reflective of what the current way of managing this problem currently is. And so maybe other folks can comment about whether or not this will be a useful tool or just another redundant tool on top of something that would be managed administratively. Judy or?

MEMBER WALLACE: This is Susan Wallace, and I would just echo that. But yeah,

this is a quickly becoming a moot point, just because of the kind of regulations. At least in the State of Ohio, we've got a number, we have at least 15 or 20 now different legislative regulatory initiatives to tighten up the prescribing of opioids. So I'm not sure this could even happen in a lot of cases in some communities.

MEMBER PHELAN: I still think there is value in keeping this measure on, even though it may seem redundant or a mute point across maybe your platform and our platform, because I'm in Ohio.

But I still think this idea that this is a decent measure of over-prescribing, and if people want to look to it and point to it, they can say, The over-prescriber right here, it's more than 30 in your plan, or that you're higher. We need to get that number down, we need to go and address providers.

So I think some plans may want to keep that in there. And they may choose from a

measure set or a toolkit and say, You know what, this is going to really help us in New Mexico, because we're not as advanced as Pennsylvania or Ohio right now. Let's use this. So I still think there's value in it.

MEMBER KELLEY: I would agree. We actually have run this measure, and we also looked at varying MMEs. So we started with 120, we went down to 90, we went down to 50. We ran it across our entire Medicaid population. That will tell you there were a lot of folks that were over 120.

We are in the process of helping, or might could say forcing, but helping our managed care plans that are managed that -- I'm thinking that there were at least ten or eleven thousand people in 1.2 million adults. About ten thousand that were on and above 120 MMEs.

So it's a valuable tool, because unfortunately, the prescribing has happened. And we now have ten thousand individuals that are already on this high dose. So, and our managed

care plans are using this as a tool to say, You know what, we need to be judicious. We are, for new starts that we know of, we're going to start at a lower.

But we know we have this population, and we're going to have to titrate and manage them. So there is value. Even though it's above the current CDC guidelines, we have found a lot of value.

We want to do this judiciously, and we've told our plans this is not about denial, denying claims. This is about identifying those individuals with these high MMEs and working with them to wean and get them into better pain management.

CO-CHAIR GOLDEN: Again, a technical question. So Tara, do we have other measures? Because I suddenly looked at the numerator, and it's high MME and more prescribers and four pharmacies. Is that something --

MS. MURPHY: So yes.

MEMBER ZERZAN: And it appears that

the two measures that are in are high doses and multiple providers.

CO-CHAIR GOLDEN: Right.

MEMBER ZERZAN: And so I feel like that, my comment was going to be that sort of nicely separates the two issues. One's a prescriber problem, one's a person problem, that you need to offer addiction treatment or do other things. And that the actions are very different in them.

I'd also say that Colorado Medicaid's at 300 MME limit. We're moving down to 250, but 90 is way low, and we have a lot of pushback on it. So baby steps.

CO-CHAIR GOLDEN: But looking at the numerator as specified, the number of people that would hit all three of those in the numerator would be very tiny.

MS. MURPHY: So I just wanted to chime in with a little more detail on the TEP's conversation. I think, similar to what a lot of you are saying, they noted that in their

experience, something like this is usually measured in terms of a flat number, and rarely a rate.

And they found that that might not work so well, that that could undermine this measure's suitability for use in the Medicaid population.

They also mentioned that it didn't seem to them as though the numerator and denominator really went together very well. They thought there were some issues with the specifications. So I just wanted to raise those points.

CO-CHAIR GOLDEN: Michael.

MS. MURPHY: Microphone, please.

MEMBER PHELAN: The staff preliminary review gave, the measure was tested in different health plans, so the Medicaid population, the mean was 23 per thousand. So is that what you're referring to, that that number wouldn't be appropriate?

CO-CHAIR GOLDEN: 2.3.

MS. MURPHY: Right, I can't really speak exactly from their thoughts. But from my memory of the conversation, it was that they felt that this was usually provided as a flat number, there were X number of prescribers within some body. It wasn't as a rate, it wasn't per 1,000 or per 100.

CO-CHAIR GOLDEN: All right, are there people in queue? Oh, you are, okay.

MEMBER HENNESSEY: Yeah, just as a point of clarification. Isn't this a NQF-endorsed measure? Yeah, that's what I thought.

MS. MURPHY: Yes.

MEMBER HENNESSEY: And it is a rate per thousand, that's my understanding.

CO-CHAIR GOLDEN: And Cheryl.

MEMBER POWELL: I just wanted to ask David, but I'll wait. Sorry, David, when you said you use this measure, which one of the three did you use, or did you use something slightly different?

MEMBER KELLEY: We've done all.

MEMBER POWELL: All. All three? Is one better than the other? Is there a reason why this one should be left off and the other two kept, just from your experience? I thought that would be helpful.

MS. GORHAM: David, please cut your mic on.

MEMBER KELLEY: Reflects really, this measure reflects kind of the problematic individuals that are both on a high dose and they're doctor and pharmacy shopping. And to the point earlier, yeah, you can find the high dose and then you can find the people that are doctor-shopping. This combines it.

I mean, these are people that I would tell my managed care plans, You guys need to really figure out what's happening with them. These are not people that you just carte blanche deny the next prescription, you need to get them in the lock-in or you need to get them into pain management. And then you need to work with and get them to behavioral health.

So it is a, I think the 10,000 I quoted was actually, I think that was the high dose measure. When you combine it the number goes down. But these are patients that, from a managed care plan, this is a sweet spot. I'm going to, right to these individuals, because I need to really figure out what the heck is going on.

And I need to talk the PCP, I need to talk to their four prescribers. Hopefully, they're using the, we call it the PDMP in our state. So, there's value to all of them. And we don't make our managed care plans do this. Some of them are already doing it.

But as a program, we have started to this. We're going to do it on an annual basis. We actually had University of Pittsburgh run it for us in our claims data.

CO-CHAIR GOLDEN: Andrea, you have something to say.

MEMBER GELZER: Yeah, I would just add, and I agree with all of those comments. And

I think it is valuable to retain this measure. And I think there may even be some cross-border issues with registries, such that while you might think, if you have a regulation in the state and a requirement to check the registry in your state, you may not be catching all these different providers.

I think it's valuable. I think the measure's valuable

CO-CHAIR GOLDEN: Other comments before we go to vote? Phone, room? Room, phone? Okay, let's vote. Oh, got something, Deborah?

MEMBER KILSTEIN: It's not going to catch everybody the way it's drafted now is because managed care plans are going to use their claims data, and they don't have access to the PDMP.

So they could only know what they paid for it, they can't tell what the patient paid cash for. So this is, if you're catching somebody with this, they're probably actually much worse.

CO-CHAIR GOLDEN: Okay, vote.

MS. KUWAHARA: This is Measure number 61, NQF 2951, Use of Opioids at High Dosages from Multiple Providers in Persons without Cancer.

To what extent does this measure or measure concept address critical quality objectives of the CMS quality measurement domains and/or identified program area key concepts? For high, please vote one; medium, two; or low, three.

(Voting.)

MS. KUWAHARA: Seventy-nine percent of the 19 voting members voted high, five percent voted medium, and 16% voted low. We'll move on to the next step.

To what extent will this measure address an opportunity for improvement and/or significant variation in care? Please select one for high, two for medium, or three for low.

(Voting.)

MS. KUWAHARA: Fifty-eight percent of the 19 voting members selected high, 21% voted

medium, and 21% voted low.

To step number 3, to what extent does this measure -- I tried to get my place. To what extent does this measure demonstrate efficient use of measurement resources and/or contribute to alignment of measures across programs, health plans, and/or states? For high, please select one; medium, select two; low, select three.

(Voting.)

MS. KUWAHARA: Forty-seven percent selected high, 26% selected medium, and 26% selected low. Because this measure is NQF-endorsed, we're going to skip this question because it would be high.

To what extent do you think this measure is important to state Medicaid agencies and other key stakeholders? Press one for high, two for medium, or three for low.

(Voting.)

MS. KUWAHARA: Sixty-three percent of the 19 voting members selected high, 32% selected medium, and five percent selected low. This

measure will be recommended for inclusion in the SUD measure set.

CO-CHAIR GOLDEN: So now, if I get this correct, we're supposed to have public comment. And wait a second here, let me just look at my agenda. Yeah, so we have to -- do you want to do public comment now, or do you want to do the entire tranche for BCN?

MS. MURPHY: Well, so actually our next step, this is a new step, we didn't --

CO-CHAIR GOLDEN: For SUD, I'm sorry.

MS. MURPHY: Yeah, this is a step we didn't have to do for the BCN group. But we'll be looking at some related measures. So these are measures, NQF measures, that are due for review for endorsement. The standing committees felt that these measures were related to one another.

So we've created some tables that my colleagues are passing around now for your viewing pleasure. We had to wait because this was a real nail-biter, that 2951, we had some

contingency planning if you all struck that down. So please refer to those as we go through this next portion of the conversation.

MEMBER RYAN: I'd like to add to that there were, you know, we had to do each, as went down our list, we didn't know that we would, you know, approve one and then five later we'd find one that was better than the one we'd approved. And you couldn't go back and unapprove.

So we found that there were some that actually are probably duplicative and one is better than the other. So that happened a number of times, and I think that is one of the reason's Tara's put this together. And some were very similar. You'll see that.

MS. MURPHY: Yeah, you'll see. So just from the standpoint of voting, your role in this part of the process is to review these similar measure specifications or these similar measures and decide if you'd like to remove any of the measures on these tables on the basis of redundancy or a superior measure.

CO-CHAIR GOLDEN: So help me out here, I'm confused.

MS. MURPHY: Sure.

CO-CHAIR GOLDEN: So the SUD TEP met.

MS. MURPHY: Yes.

CO-CHAIR GOLDEN: And they approved some measures?

MS. MURPHY: They did. So the --

CO-CHAIR GOLDEN: Are these those measures?

MS. MURPHY: So these are a subset of those measures. So in these tables that you're looking at now, all of the measures listed here are measures that were recommended by the TEPs.

CO-CHAIR GOLDEN: Yeah.

MS. MURPHY: These measures were identified by approving NQF standing committees to be related to one another. So we've laid them out here as a chance for you to review again and potentially choose a best-in-class or two best-in-class measures.

There is no obligation to remove any

of these measures. This is simply an opportunity for you to look at them and potentially remove some redundant measures.

As Cheryl said, our ask of the TEP was that they reviewed measures individually, based on the merits of the individual measures. And now we're giving the Coordinating Committee the opportunity to review some of these measures that NQF committees have identified as related. Yeah, go ahead.

CO-CHAIR MOORE: Could Sheryl, I assume the ones that are on the page are the ones that are for comparison?

MS. MURPHY: Yes.

CO-CHAIR MOORE: So would it be possible to have Sheryl to point out the ones where as a TEP, they had conversations about, well, we can't back but this is really where we're at? So that we can expedite this?

MS. MURPHY: Yes, I mean, yeah.

DR. TERRY: It's a little bit different, my list is going to be a little bit

different than these tables. I'm kind of like trying to --

MS. MURPHY: Right.

DR. TERRY: But I could indicate, because I tried to pull some together. So for example, let's see if I can, okay. If you look at number 2152, now is that somewhere on these pages?

MS. MURPHY: Well, if it would be helpful at all, and please tell me what works best for you, I've prepared a synopsis of these measures that I think will be helpful, that kind of highlights some of the TEP's thinking and does just kind of a once-over of their similarities.

Would that be helpful? And then Sheryl, if you want to add any commentary.

DR. TERRY: 2152, I know. I'm trying to show you how I tried to clarify some of the overlap.

MS. MURPHY: So I think this is a great point of clarification. Our review for related measures was limited to those measures

that are NQF-endorsed.

So it's very possible that, as a member of the TEP, Sheryl recognized some other measure that was from another source that is not has not come through NQF that was related. And you will have, members of the CC will have an opportunity to remove those measures as part of the review of the final measure set. So I'm not sure exactly --

DR. TERRY: No, I'm comparing two NQF measures.

MS. MURPHY: Okay.

DR. TERRY: So that's not entirely true.

MS. MURPHY: Gotcha. Okay, so we'll definitely have time to take those considerations into account. But for the purposes of this portion of the review, we're limiting the scope of this portion to NQF measures.

And any member of the TEP is free to raise concerns of redundancy or related measures with the review of the final measure sets. And

that will come at the end, when you have the opportunity to strike measures.

CO-CHAIR GOLDEN: So again, everything in this document was approved by the TEP.

DR. TERRY: Right, correct.

CO-CHAIR GOLDEN: Okay.

DR. TERRY: They're on the list. But I don't know if you've gotten your question answered.

MEMBER RYAN: Well, I was trying to give an example how they would be two that we found one we found better. For example, if people can look at just, this is an example, if you look at 2152, NQF number 2152 versus NQF number 2957, okay.

One is screening for unhealthy alcohol use, and the other is screening for unhealthy alcohol use, but it includes and intervention. So we felt like, we took the first one, that was great. But then we were like, Hey, this one's got an intervention. So of course we would prefer the one that has the intervention along

with a very similar type of screening.

So that would be one example where we felt, in that case, maybe the first one was. Or there'd be follow-up for people with serious mental illness and alcohol and drug.

And then other one would be just follow-up with alcohol and drug. And we thought, Well, of course you want to do the one that has both if it's a follow-up from the ED. So those are examples.

Now I haven't seen, haven't, you know, absorbed your table. But those were example where two right there you might not need the one that was similar but not quite as comprehensive. But similar in all other respects.

CO-CHAIR GOLDEN: So let me just -- that may not be true. Because if you have, say, the one with the screen and the treatment and it's a low rate, you don't know if they didn't screen or they didn't treat, or they couldn't treat.

So, you know, I mean start putting in

treatment in with the screening. They've done that with tobacco screening, I think, in -- it gets very confusing as to what you've actually measured.

MEMBER HENNESSEY: But don't some of these measures actually have sub-measure components, like for example, with the tobacco one, you can get three sub-measures so you can find out whether, you know, they're doing the screening but then they're not doing the intervention.

So the question would be in my mind whether that's the case for the two measures you're talking about.

DR. TERRY: Can I suggest that we start with what we have here. And if there's some that we miss that you think we should look at, why don't we do that first thing in the morning.

MS. MURPHY: Yeah, so maybe Terry, you should walk people through it. I think walk through the chart would be helpful.

MEMBER ZERZAN: Yeah, so in like the

matter of time because we still have the whole next thing to go through, is this a place that we can tell CMS similar to what we did with the first set of look for parsimony and we recognize there's overlap, we like outcomes more than not. Do something smart with it.

DR. TERRY: Right, that's what we're trying to do there. But are you asking, is this where we're going to stop today?

MEMBER ZERZAN: I'm saying do we need to -- no, no. I'm saying do we need to review all this and make any decision? Or can we just say yup, we recognize there's overlap in this. Yup, these are all input alcohol screening, tobacco screening is important. CMS, you know measures as well as we do.

And these are only suggestions anyway. So look at these, don't have too much overlap. We like outcomes in favor of other things, but do your good work. And we'll keep working on these, especially since this is the first year of this.

MS. MUNTHALI: I love that idea. I

think you guys should do that in the interest of time. And also, just one point of clarification. These are not competing measures. So a best-in-class decision would not be very appropriate here. These are actually related measures. So I think that is very appropriate, that decision.

CO-CHAIR GOLDEN: Judy, I think we're actually, potentially if we do what you say, we'll be sort of ahead of schedule, which is good. David.

MEMBER KELLEY: I would advocate that we take Judy's approach. And again, in looking at these measures and eyeballing them, I don't really see them as competing. And states and other, you know, MCOs in other programs may say, you know, I can, at this point, I can operationalize this because it's easier.

But here is the menu, and CMS is offering this menu. More sophisticated organizations may go deeper and may. So I like --

CO-CHAIR GOLDEN: Just talk about one

measure then go to the next measure in a year or two or something, yeah.

MEMBER KELLEY: So I think we could expedite.

MEMBER ZERZAN: And I definitely agree states are at different places. So that might be appropriate. And I'd also like to take credit for the time I've saved to balance off what I did earlier.

CO-CHAIR MOORE: I think that means you might be chair next year.

CO-CHAIR GOLDEN: But I think you still owe us five minutes.

MS. GORHAM: Since it's an agree and we all love Judy's recommendation, we'll move forward with that. I want to propose something, because we were going to stop here after this related conversation, realizing that we still have to look at the overall measure set recommended by the TEP.

So we can do one of two things, and it's totally optional and up to you in your

preference. So we can --

CO-CHAIR GOLDEN: I would say we should do the whole set and identify measures for potential discussion.

MS. GORHAM: Okay, so do we want to do that now --

CO-CHAIR GOLDEN: Yes, you want to do that now.

MS. GORHAM: Or do we want to come early in the morning?

CO-CHAIR GOLDEN: We'll see if anything gets pulled, and if we have lots to pull, we can carry them over. But let's see what we want to pull.

MS. GORHAM: Okay.

CO-CHAIR GOLDEN: So this will not be a democratic decision. I just said let's keep going, we're ahead of schedule, let's keep going.

MS. GORHAM: Just one minute to rearrange the slides just a bit.

CO-CHAIR GOLDEN: That's slide 94? Okay.

**PARTICIPANT: And for people on the webinar, I'm unloading it now. Technology is being a little slow.**

**CO-CHAIR GOLDEN: Wow, that's a big measure set. Okay.**

**MS. MURPHY: So while that's loading up -- oh, it's loaded. So just a brief reminder on how we're handling this review of the total measure set now. So we will go through this list of measures that's on the screen in front of you. I will provide a brief synopsis summary of the TEP's rationale for recommending the measure.**

**If someone in the room or on the phone feels that the measure's unsuitable and they'd like to propose removing it from the set, that person should motion to remove the measure. That motion will need to be seconded in order to open the measure up for discussion.**

**Once the committee has discussed, we will call, the chairs will call for an up-and-down vote to remove the measure from the set. So we will not need to use the decision logic.**

Again, as a reminder, in those rationale, we ask that you do provide as detailed a rationale as possible for why you feel the measure's unsuitable. And to also try to base that rationale in something related to the decision logic so we can tie it back to all those criteria.

So we will start with the first measure on our slide. This is Measure number 44 on your discussion guide. The measure is Documentation of Signed Opioid Treatment Agreement.

The TEP unanimously voted high on all decision logic criteria for this measure, noting that the use of the signed opioid treatment agreement is a standard best practice among providers, but that the practice is rarely reviewed and enforced as a standard of care.

The TEP also noted that many EHRs already include a standard opioid agreement that can be easily printed and signed. The TEP commented that the measure would use chart

review, which can be expensive, but that individual organizations could decide if the measure was feasible for them.

Are there any comments on this measure?

CO-CHAIR GOLDEN: Concerns or comments, anybody raising your hands, phone or room? Next item.

MS. MURPHY: Next item. This'll be number 45 on your discussion guide. This measure is called Evaluation or Interview for Risk of Opioid Misuse.

The TEP again unanimously voted high on all decision logic criteria for this measure, noting that using a validated tool for evaluating risk of opioid misuse as the measure specifies aligns with the CDC recommendations. The TEP voiced concern on the fact that the measure applies only to those in treatment for longer than six weeks, rather than at day one.

CO-CHAIR GOLDEN: Comments or questions on this one? Concerns? Next item.

MS. MURPHY: Okay. The next measure is number 47 on your discussion guide, and it is NQF number 0004, Initiation and Engagement of Alcohol and Other Drug-Dependence Treatment.

The TEP again unanimously voted high on all decision logic components for this measure. I promise that was not the case for all of them. The TEP noted that the measure is in widespread use, and that the initiation of care that the measure addresses is an important need to CMS and to the field.

Additionally, the TEP noted that this measure offers a quick capture and treatment measure as patients are given access to treatment within 14 days of diagnosis.

CO-CHAIR GOLDEN: Comments, questions, concerns? Okay, keep going.

MS. MURPHY: All right, next. This measure is number 52 on your discussion guide. It is NQF number 1664, this is SUB-3, part of the SUB group of measures, as you can see in the discussion guide. We will also review SUB-1 and

SUB-2.

SUB-3 is Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge. The TEP discussed the fact that this EHR measure looks at whether a prescription or a referral was offered, not whether the prescription was filled.

The TEP would have preferred the measure to use claims data to determine whether a prescription was filled, rather than EHR to measure whether it was offered.

The TEP noted that this measure exemplified the need for more outcome measures in SUD measurement, as this could easily gamed for providers. Ultimately, however, the TEP noted that the measure would encourage physicians to consider medication assistance for substance use disorders and the underutilization of these treatments.

CO-CHAIR GOLDEN: Again, floor open for comments, questions, concerns? Hearing none, next item.

MS. MURPHY: Okay, we are flying ahead of my notes. Okay, the next is NQF Measure number 2152, this is number 53 on your discussion guide, Preventative Care and Screening, Unhealthy Alcohol Use.

One member of the TEP noted that the 24-month time frame used in this measure could be problematic because Medicaid patients often do not have sustained enrollment for 24 months, especially within one health plan. The enrollment concerns the extent to both enrollment in Medicaid and enrollment in a singular MCO as both would impact the ability to measure the same patient over 24 months.

Other TEP members noted, however, that the variability across state Medicaid programs could mean the churn is not a problem, or could mean that the churn is not a problem in other states. That is to say, they felt it wasn't the case in all states, and that it could still be suitable for states that would use it.

The TEP was also concerned that the

24-month time frame created a two-year lag in the availability of the performance data, which prohibits rapid quality improvement. Ultimately, the TEP discussed the ability for the measure to continue to capture data on a patient across multiple providers within the two-year time frame, and decided that the measure addressed a critical quality issue.

In further measure discussions, the TEP noted that other similar screening measures were preferred over this measure.

CO-CHAIR GOLDEN: And what was the issue about the 24 months it's being done?

MS. MURPHY: So the issue with the 24 months was that there was, some members of the TEP felt that patients often don't stay, they may not be on Medicaid for 24 consecutive months. And so the measure, they may not be --

CO-CHAIR GOLDEN: What is the 24-month requirement? I'm sorry.

MS. MURPHY: That would be in the measure specifications, which I can pull up.

MEMBER RYAN: To be screened at least once.

CO-CHAIR GOLDEN: Okay.

MEMBER RYAN: Within the last 24 months.

CO-CHAIR GOLDEN: Okay, that's -- HEDIS measures do that all the time. There's a requirement for continuous enrollment or X number of months per year or something like that.

CO-CHAIR MOORE: But this isn't for high-risk patients, so I'm not sure I would screen everybody for this. For me, there's not a trigger. Percentage of patients age 18 years or older screened at least once within the last 24 months for unhealthy alcohol use. It doesn't say because they're at high risk or they've exhibited.

CO-CHAIR GOLDEN: That's all right.

CO-CHAIR MOORE: 52.

MEMBER ZERZAN: I'd like to say I think alcohol use in general in our society is highly underdiagnosed. And so I don't need a

trigger.

I'll also say my good colleague Dr. David and I did a project about rehospitalization, and most physical health hospitalizations were related to substance use. And I think probably the biggest chunk of that was alcohol. So I say screen everybody, and I don't care if you're at risk or you're telling me what to do.

CO-CHAIR GOLDEN: Again, sometimes it's best not to be democratic, right. Okay. All right, other comments, questions, or concerns? Next item.

MS. MURPHY: Next one, so I believe we're at 2597. So this NQF Measure 2597, this will be number 54 on your discussion guide. And this measure is Substance Use Screening and Intervention Composite. And I believe these were the two measures you were discussing earlier, Sheryl.

So for this measure, the TEP unanimously voted high on all decision logic

criteria for this measure. And also noted that this screening measure is preferred above other screening measures that the TEP recommended, including NQF 2152, Preventative Care and Screening and NQF 2599, Alcohol Screening and Follow-up for People with Serious Mental Illness.

The TEP preferred this measure due to its more comprehensive approach to screening and brief intervention. The TEP was concerned that the definition of illegal substances differs across states. For instance, marijuana is no longer illegal in certain places, so it wouldn't be included as an illegal substance.

There were also concerns about the perception of illegal, and how oftentimes people may not perceive marijuana to be an illegal substance, yes, and therefore under-report its use.

MEMBER WALLACE: I have a question about this measure, and actually the previous one too. So when I'm looking at the numerator statement, what was mentioned before where you

have and this and this both in the numerator statement.

This is denoted as a composite measure, but when I hear composite measure, I think two simple measures that go together versus one measure that has a compound numerator.

And I'm concerned about both the previous measure and this one because screening and intervention might be two different problems. And so if the measure doesn't allow for that drilling down on the provider's part, that's just a flaw.

CO-CHAIR MOORE: Or there isn't a provider who can do that. I mean, that's a common thing that would come up that in rural areas that if you screen, then what do you do with it? I mean, do you have someone on site who's able to -- that doesn't mean you shouldn't have a measure, but I think that's a good point.

CO-CHAIR GOLDEN: Are you concerned enough to pull it? That's the question on the table, do you want further discussion, you want

to pull it from the consent calendar?

MEMBER WALLACE: I guess I wouldn't mind if anyone else had an opinion on it.

CO-CHAIR GOLDEN: Consent calendar. Essentially before you is a consent calendar of measures that you can pull. Do you want to pull it off the consent calendar for further discussion?

MEMBER PHELAN: But just for discussion later. It's not like it gets pulled off for good.

MEMBER WALLACE: Yes, I wouldn't mind tabling it for the discussion. I guess when I'm -- in my mind --

CO-CHAIR GOLDEN: So there's a motion to pull this for further discussion off the consent calendar. Do we have a second?

MEMBER RYAN: I just want to mention that this is one of the only ones that has any intervention at all mentioned. It's all screening. That was kind of pretty much not very many of them in the outpatient setting have a lot

of intervention.

MEMBER WALLACE: Yeah, and I think that's why I'd like to further discuss this. Because I think I'd have a better sense of how I feel about these measures once I see the whole set, and if their sort of their value outweighs.

CO-CHAIR GOLDEN: So do we have a second about pulling this off? We have a second, so it's off the consent calendar for discussion, okay. Next item.

MS. MURPHY: Okay, next item, NQF number 2599, Alcohol Screening and Follow-up for People with Serious Mental Illness. This is number 55 on your discussion guides.

The TEP felt that this measure focused on a gap in care for a high-risk population who often doesn't seek or receive care. That includes substance use screening as result of their mental illness.

The TEP noted that this measure was similar to the previously recommended measure NQF 2152, Preventative Care and Screening Unhealthy

Alcohol Use, and voiced concerns over recommending too many measures with similar numerators and different denominators, which could lead to redundancy and an inefficient use of resources.

The TEP also noted that by having a measure that has a denominator that focuses on people with serious mental illness, states can decide to more easily target that high-risk population and can compare disparities across states, which may not be available if states were to simply stratify a broader measure as variation among the states would limit that comparison.

CO-CHAIR GOLDEN: Same thing, comments, questions, concerns. Next item.

MS. MURPHY: The next item is number 56 on your discussion guide, NQF Measure number 2600, Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence.

The TEP noted that this measure addresses a high-risk population similar to the

previously reviewed NQF measure number 2599. Similar to the previous measure, by using a measure with a specific denominator addressing the high-risk population, data can be compared across states with greater accuracy than if states were to simply stratify a broader measure for serious mental illness.

CO-CHAIR GOLDEN: Anybody? Next item. The NQF 2605.

MS. MURPHY: Yes. So number 2605, this is number 57 on your discussion guide. NQF Measure number 2605, Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence.

The TEP unanimously voted high on all decision logic criteria for this measure, noting the importance of the issue that the measure addresses. The TEP discussed how the measure would be important to help plans by ensuring that patients receive follow-up care after an emergency department visit to minimize patients bouncing around in the system and not getting

care for their problem.

CO-CHAIR GOLDEN: Don't hear anyone. Now, before you go to the next item, it's five to five, so a couple things. One, there may be some housekeeping. We have a dinner for tonight, and you know where it is, so you can tell us where it is.

MS. MURPHY: Yes, our dinner is at PJ Clark's. In for a treat. It's right down the block. If you head out of the building and make a right, and then make another right on K Street, it's one block down across the street. We will --

CO-CHAIR GOLDEN: Where is it related to the hotel if we all go back and freshen up?

MS. MURPHY: I have to say I'm not quite sure where you're staying.

CO-CHAIR GOLDEN: Go left one block out of the hotel. Okay.

MS. MURPHY: Yeah, we -- I'm not quite sure where you guys are staying, but. Oh, yes, then yeah.

CO-CHAIR GOLDEN: No, we're at the Hyatt.

MS. MURPHY: And go left, it's right across that street and that's it. It's right there, right on the corner. It's on 16th and K.

CO-CHAIR GOLDEN: And that's at six o'clock, okay.

MS. MURPHY: Five-thirty, actually.

CO-CHAIR GOLDEN: Oh, five-thirty. Well, it's a good thing I asked, okay.

MS. MURPHY: Yes. And we'll all be walking over from here. If anybody will be lingering around, we can walk over together.

CO-CHAIR GOLDEN: Okay, so that's, any other housekeeping before we move on?

MS. MURPHY: Well, we will need to open for public comment once discussion formally closes.

CO-CHAIR GOLDEN: That was my next item, yes. So do you want to do public comment now, or after we do all the slides?

MS. MURPHY: It is up to you. I do

have to tell you that we are not quite close to being done with SUDs. So now might be as good a time as any.

CO-CHAIR GOLDEN: See, I thought we'd do public comment to end the day, and then the next question would be to the group do you want to do another slide or push them over to the morning. So I would suggest we do public comment now, see if anybody has any comments, see what's there. Because that's comments for the whole discussion up to now.

MS. MURPHY: Yes. Well, we would need to, so just, we would need to open for public comment again once we conclude our additional discussion. So we may as well just hold off.

CO-CHAIR GOLDEN: Well, I may not be here in the morning. So let's give people a chance. I have a feeling there will not be a torrent of comments. Yeah.

MS. MURPHY: Okay, so, okay, so we'll do public now and end for the day.

CO-CHAIR GOLDEN: Let's do public

comment now, and then we'll make a decision.

MS. MURPHY: Okay, so we might be doing public comment twice. So that works. Operator, are there any public comments on the phone?

OPERATOR: And at this time, if you would like to make a public comment, please press star then the number one on your telephone keypad. Again, that's star one to make a public comment.

MS. MURPHY: I don't think we have --

OPERATOR: We have no public comments.

CO-CHAIR GOLDEN: Okay, so I played that card right. So now the question is how many people want to do another slide of measures for discussion for today? How many people want to quit? Let's do another slide.

MS. MURPHY: Okay, so I just want to add one thing for the record. We did receive just a brief comment a while back from a member of the public asking around the materials that we've been referencing. And we have noted that

those are available on the project page and can be accessed on the National Quality Forum website.

So our next measure, NQF Measure 2940. This is number 59 on your discussion guide. This is Use of Opioids at High Doses in Persons Without Cancer. So this is, you'll remember we discussed a very similar measure to this earlier today.

The TEP initially voted to note recommend this measure, but ultimately re-voted following discussion on NQF Measure 2950, Use of Opioid for Multiple Providers in Persons without Cancer.

The TEP initially noted concerns with the validity of the measure, given the different time frames in the numerator and denominator, but ultimately found that the measure addressed an important critical issue that is relevant, very relevant to states.

CO-CHAIR GOLDEN: Again, comments, questions, concerns. Next item.

MS. MURPHY: Next item. This is number 6060 on your discussion guide, NQF Measure number 2950, Use of Opioid from Multiple Providers in Persons without Cancer.

The TEP voiced concerns about the potential unintended consequences of using this measure, given that the measure of success would not and should not ever be to reach zero percent, and therefore there is no clinical basis for what the percentage of this measure should reach.

The TEP agreed that this population measure addresses an important issue and provides a good option to states for states to benchmark opioid prescriptions among multiple providers. The TEP also noted that the measure could make a difference in reducing the number of patients prescribed both opioids and benzodiazepenes.

CO-CHAIR GOLDEN: I'm not sure where the benzos come in, but that's okay. And the numerator's four prescribers and four pharmacies. Any comments or questions? Next item.

MS. MURPHY: Okay, our next item is

number 50 on your discussion guide, that's NQF number 1661, SUB-1 Alcohol Use Screening. This is again in that SUB series of measures.

The TEP noted the similarities between this measure and the previously reviewed tobacco measures, TOB measures, which we will discuss shortly.

The TEPs discussed that while alcohol is less of a cost driver than tobacco, alcohol intervention generates proportionately greater cost reductions within the first year, mostly as a result of reduced readmissions and a reduction in the complications that care teams experience when dealing with a patient with an alcohol use disorder.

And just to clarify my previous statement that it's similar to the tobacco, other tobacco measures. It's similar in the way that they're constructed with a series, in a series of measures. It obviously, this is addressing alcohol use and the other will address tobacco.

CO-CHAIR GOLDEN: Going once, twice?

Next item.

MS. MURPHY: This TEP is airtight, Sheryl. You did a good job.

Next measure is number 51 on your discussion guide, NQF number 1663, SUB-2 Alcohol Use Brief Intervention Provided or Offered, and SUB-2a, Alcohol Use Brief Intervention.

The TEP agreed that this measure addressed an important quality objective, but noted that part 2a of the measure, which focuses on the provision of a brief intervention, is the most useful component.

The TEP noted that the numerator, which includes patients who received or refused brief intervention, is confusing and seeks to measure two separate items at once. The measure is used in conjunction with a previously recommended measure, NQF number 1661 SUB-1, Alcohol Use Screening.

CO-CHAIR GOLDEN: So what did they say was confusing?

MS. MURPHY: Sorry, they thought that

the fact that this kind of has two parts to it, this 2 and 2a, and that they seemed to be measuring two different things at once was a little confusing.

I think it was specifically around the fact that it measures both intervention that was provided and intervention that was refused. It's not necessarily an exclusion. It's included in the numerator, which I think they thought was a little odd.

MEMBER RYAN: It was confusing because one of the numerators is the number of patients who received or who refused a brief intervention. So as opposed to 2a, which was the number of patients who received a brief intervention.

You know, maybe somebody refused to have the intervention. Doesn't mean the provider didn't attempt to, after screening, to give that. So I don't know whether they were trying to capture that, but that's --

CO-CHAIR GOLDEN: I think they're trying to capture intent to treat. And then a

lot of patients will say they're not ready.

MEMBER RYAN: Or, you know, don't talk to me about it. Then at least it's a provided --

CO-CHAIR GOLDEN: I think most of the time if you're not ready for treatment, it's not worth.

MEMBER RYAN: Right.

CO-CHAIR GOLDEN: Comments, questions, concerns. Okay, one more.

MS. MURPHY: Okay, the next item, I'm sorry, was that 163? Okay, so our next one is NQF Measure 1654, and this is measure 48 on your discussion guide. This is Measure TOB-2, Tobacco 2, Tobacco Use Treatment Provided or Offered, and the subset measure TOB2a, Tobacco Use Treatment.

So this is again that series that we said that was similar to the SUB measures we just discussed.

The TEP noted the use of EHR data as potential challenge for implementation of the measure, but ultimately decided that the addition of the corresponding fields to the EHR was not a

significant burden to hospitals. One member of the TEP discussed the critical issue that the measure addresses as tobacco as the leading of preventable death in the U.S.

The TEP also noted that the hospital setting could advantageously capture patients who may otherwise not receive care, and/or potentially experiencing the negative consequences of their tobacco use.

CO-CHAIR GOLDEN: Once again, comments, question?

MEMBER PHELAN: I'm just not sure where the difficulty in pulling this from the medical record would be or from getting it from -- because this is all billable stuff, the tobacco cessation counseling. So I'm not sure that's a barrier to this measure at all.

MEMBER HENNESSEY: Yes, and it is typically captured in meaningful use in an electronic health record.

CO-CHAIR GOLDEN: All right, other comments, questions, concerns? Next item.

MS. MURPHY: Next item is number 49 on your discussion guide. This is NQF number 1656, TOB-3, Tobacco Use Treatment Provided or Offered at Discharge. And the subset measure, TOB3a, Tobacco Use Treatment at Discharge.

The TEP noted that this measure strongly overlaps with the previous measure, NQF 1654 TOB-2, and is a part of a series of tobacco measures by the Joint Commission. And the measure differs by focusing on the services that are delivered at discharge. They did ultimately recommend it in conjunction with those other two measures.

CO-CHAIR GOLDEN: Any concerns or people wanting to extract? Let's do one tobacco measure, and then we'll call it a day.

MS. MURPHY: So I think that was our last tobacco. We went through 1, 2, 3, right?

CO-CHAIR GOLDEN: Well, you have 3225.

MS. MURPHY: Sorry, sorry, yes. I was thinking the TOB ones. So 3225 formerly NQF number 0028. This measure is number 62 in your

discussion guide, and is Preventative Care and Screening, Tobacco Use Screening and Cessation.

The TEP unanimously voted high on all decision logic components for this measure, noting the well specified denominator and the critical quality issue that the measure addresses.

The TEP noted, however, that the measure should be broadened to include patients under the age of 18, as well as the use of other nicotine products including e-cigarettes. This was a theme that came up, that saying tobacco products doesn't really apply anymore, as e-cigarettes and marijuana and other products are just as popular.

CO-CHAIR GOLDEN: Comments, questions? Michael.

MEMBER PHELAN: This is an outpatient measure?

MS. MURPHY: We can check those specification.

MEMBER PHELAN: I did send a concern

when I was looking at all these measures that I did not see an outpatient measure for tobacco cessation. But this must be the corresponding outpatient measure.

MEMBER RYAN: The denominator has at least one preventative visit during the measurement period.

MS. GORHAM: And this measure, 3225, is a eMeasure, so it is the exact same measure as the 0028.

PARTICIPANT: 0225, this was formerly?

MS. MURPHY: This is claim space version, it's not the eMeasure version.

CO-CHAIR GOLDEN: Okay, final comments, questions, concerns? I think, as they say in sports, you've done good. I think we've earned our break and the staff a break. Thank you.

Question for the group. We will adjourn, the folks on the phone, we'll save you a to-go box. We can go mail it to you by FedEx if you want. Do you want, is it feasible to start

tomorrow at 8:45?

DR. TERRY: Yeah, that sounds good.

CO-CHAIR GOLDEN: So breakfast will be here in the morning. And so folks on the phone, why don't we start at 8:45 and continue with slides. I think we're kind of caught up or close.

DR. TERRY: Yeah, we're pretty good. I just wanted to say that we'll do a little summary, Jennifer and I, tomorrow morning of the day. We should finish the day, though, tomorrow, before we do the summary.

I think we have a few more things to do, so. We'll do that and we'll give you a little summary of where we are. And thank you everybody. And I think we have a few unresolved things we need to talk about too. So thank you very much.

CO-CHAIR GOLDEN: Final comments or questions from the group before we adjourn?

MS. MURPHY: Comment one more time.

CO-CHAIR GOLDEN: We have a public

comment floating out there, okay.

MS. MURPHY: Offer public comment one more time, since we discussed a few more measures.

CO-CHAIR GOLDEN: But can't we do that tomorrow? That's fine.

OPERATOR: Again, if you'd like to make a public comment, please press star one. And we have no public comment.

MS. MURPHY: Thank you, everyone. We will meet in the lobby downstairs in a couple minutes to head over for dinner, if anyone's interested in joining.

(Whereupon, the above-entitled matter went off the record at 5:09 p.m.)

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**W**

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 Coordinating Committee

Before: NQF

Date: 06-07-17

Place: Washington, DC

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

Neal R Gross

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Court Reporter