NATIONAL QUALITY FORUM

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MEDICAID INNOVATION ACCELERATOR PROJECT COORDINATING COMMITTEE

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THURSDAY
JUNE 8, 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, AA, BA, MA, 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:

KATE BUCHANAN, MPH, Project Manager
SHACONNA GORHAM, MS, PMP, Senior Project Manager
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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

*** present by teleconference**

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

8:52 a.m.

DR. TERRY: Good morning everybody. Before we get into today's agenda, we really went through a lot yesterday. And so, thank you. It was really, I think, very productive. But what I wanted to do is, I wanted to review our revised decision logic. Yay! So if you could just pull it. Hopefully, hopefully it makes more sense. I said I recommended that we do it first thing in the morning while we still can think.

(Laughter.)

DR. TERRY: While we are awake and alert, as they say. So the only change to this is where you get to ready for immediate use. And basically, it doesn't matter. We've taken out whether it's a measure concept or a measure. It is just whether it is really ready for immediate use. And that's going to be the question. And so at that point, it will just go on to the issue of whether it's important to different groups.

And at the end, I will say this. What

we're going to do after this meeting, because we have, as you know, shifted the definition of a measure to be a little broader. It's not just NQF's definition of a measure. You may remember, there was some discussion about that yesterday. And before it had to be, you know, we had to have evidence of testing. And now we may have evidence of testing. That's how we shifted to open it up a little bit. So I just wanted to let you know. So as we go through the first one, let's make sure this works - I guess is what I'm trying to say. And so we've taken out that part. It will either just go on as a measure, measure concept.

We're not worried what it is right now. We will then look at the concepts, we don't really need to for the most part, look at the measures. And then we're going to have a post haw. At that point, we will basically go over this again with the committee. So you will have another look and another way to weigh in on it. Okay. Yes.

MEMBER MCCANN: Could you clarify what impact, if any, does that have on surveys?

DR. TERRY: On surveys?

MEMBER MCCANN: On surveys and the statements within surveys?

DR. TERRY: So surveys, in this world, measures are not measures. They can have measures in them. And we always use the new CAHPS HCBS one. Which - it's a CAHPS survey and it's through Health and Human Services. And that survey has nineteen measures that are tested as measures. Some surveys - all right, so this is a true thing that happens with surveys. Surveys can be tested for the survey, for the scientific acceptability. And they do other testing to see whether it's the diversity of items or whatever.

And that is all validated, especially if it's a CAHPS survey. You know, it was validated. It had to be turned into AHRQ, whatever. So that's setting up a survey. But the measures within have to be also tested for reliability and validity. And that's what the

difference is between - thank you for asking that question - between surveys that maybe just have questions.

And you know questions are just not performance measures. They are, how are you, what do you think about, how do you feel today or whatever it is. So it has to be a measure measuring proportion of people who adopted dum de dum de dum, or however it is written. Does that make sense to people? And we talk about this and we also talk about tools. So tools - measures can be in surveys, right? But tools - and we've had tools. We've talked about the PHQ-9. Everybody knows the depression measure that's been out there, it's well-used.

That is, in a survey - I'm sorry. In a measure, the measure is - you start at this level, a nine and you go down to five, whatever. So there is a directional look at this measure. And so it's not just the tool. The tool just is an internal part of it. And this is something that I think there's been a lot of confusion

about. I thank you for asking that question, because I think - believe me, even at NQF we have multiple conversations about these two issues. Especially saying surveys are more and more important. So I hope that helps.

CO-CHAIR GOLDEN: Andrea, do you have a question?

MEMBER GELZER: Excuse me. This is Andrea. And I'm trying to raise my hand but I'm not sure if there's anybody at the other end. But I struggled yesterday because I felt like, okay. We've shifted. You know, we've changed the rules midstream. And when the TEP was deliberating, we were looking at both measures and measure concepts. I figure anything that we deemed a measure concept, or even considered that was a measured concept, would not get through that ready for immediate use. Because it's not an endorsed measure.

It's not, perhaps, been used. You want the logic modified a little bit in some manner to really be impactful for the population

we're discussing. I don't want to lose that in this discussion. So how do we keep some of those, what I would call concepts? And at least still get them to the report? Or will we? Maybe I'm making a mountain out of a molehill here.

DR. TERRY: No, I think it's a really good point. And as we look at concepts, that is one of the key issues. Is it kind of almost ready or planned to be used? So some measures that get through NQF have not been used a lot, but they're planned for use. So it could be ready for immediate use or planned for use. Now, the reason we don't have a lot of measure concepts is because that's part of the definition of what we're charged to do, which is to find measures or measure concepts that can be used quickly or now, tomorrow, in the states.

So I think as we look for some of them - you know, I think when we looked at the 3M ones that we looked at yesterday. We don't really quite know all the testing that's gone on for those. But it's used in four states right now.

And people are using them, they're finding it helpful. I've seen the data from the state of Texas. They post it up there on their website. So it's really, in essence, one of four or five states.

So those are concepts that are being used, they've been developed in some way. We just don't have that data. And you know that some of that is proprietary, really. Because it's a private company and we have not seen it. So that went through. So those are concepts that didn't, at this point from what we can tell, we don't have enough information. It's one of the problems when dealing with states is to get enough information on what states are using and what is truly enough testing or specs that we can find that are clear and specific. So I'm not sure I answered your question, Andrea. But I do think there will be concepts that will stay.

MEMBER GELZER: No, that's helpful. Thank you.

CO-CHAIR MOORE: Any other questions?

Oh, yes?

MEMBER MUSUMECI: Hi, this is MaryBeth from Kaiser Family Foundation. So caveat is, I'm not trained as a clinician. So I don't know all of the technical distinctions. But this discussion that we're having I think is particularly relevant when we get into the long-term care measures this afternoon. I wanted to raise some comments there for the reports. I was particularly troubled by the lack of community integration and re-balancing measures. And I know that is a function of those measures are still largely in development.

But there are things that states are, in fact, using that I had shared earlier. And I don't know why they fell out of the process. Whether it was because of this measure/measure concept distinction, or whether it was because of something else. But I do think it's really important for us to reflect that going back to the public comment that we heard yesterday. That it's particularly important to beneficiaries and

I had rescued the one that got close to it. But I think there's other things out there that didn't make it, at least to our level, and I don't know if the decision logic plays into that or what it is, but I wanted to raise it.

DR. TERRY: Okay. Thank you. I appreciate what you said. And you're not a lone voice, can I say, in that issue. So thank you. We've had several - you know, before the meeting, several people talked to us about this. Any other comments about that? I think we can just start -

CO-CHAIR MOORE: Barbara, do you have a question?

MEMBER MCCANN: Oh, I'm sorry.

CO-CHAIR GOLDEN: Actually, I just want to understand for the committee. You are making a fairly sizeable point about the formality of altering the flow. So does this have implications for future work, or is it because you want to have a firm justification for the end product? So I just want to understand

the context for - you know, we've been making decisions and we're getting to conclusions. But is there some strong meaning toward the fact that we made some alterations, small alterations to the flow?

DR. TERRY: To the decision logic?

CO-CHAIR GOLDEN: Right.

DR. TERRY: Yeah. Well, I think we - I don't think so. Because I think the voting, we tried to capture yesterday when there were issues - I think the only thing we did is you don't have to send it to a concept or a measure, you just have to say it looks like it's ready or planned to be used soon. I can't remember exactly what the high, medium, or low is. But when we looked at this before, we talked about it. And at the beginning, we accepted everything for a measure or whatever. So I think now that we have clarity on it, I don't think we missed anything.

CO-CHAIR GOLDEN: I'm just saying, is there some sort of precedent we're setting? And something for future work. That's what I was

trying to say.

DR. TERRY: I see. I see. Yeah, it's interesting. It gets into the issue of what's a measure, what's a measure concept and the specs that are involved in that. I think the precedent is kind of trying to figure that part out. And when you use decision logics like this - and the decision logic - so changing something midstream was truly adapting to making it clearer so we could move on. I think we were getting caught in this that we felt was unnecessary.

Because we can deal with after this, we can look at concepts. Because we have a broader definition of measures. We're going to do that and we're going to bring it back to this committee and see whether some - but we're not going to go back and save anything that didn't get through. Yes. Yes. I don't know if that helps.

So I think - we were just going to do a little summation of yesterday, if that's okay. Or should we just move on and - I think we

should just finish SUDs.

CO-CHAIR GOLDEN: Okay. That's fine. So yesterday we quit smoking.

(Laughter.)

CO-CHAIR GOLDEN: And today we start drinking.

(Laughter.)

CO-CHAIR GOLDEN: So we were on the last item on the second slide.

MS. MURPHY: Absolutely.

CO-CHAIR GOLDEN: Thank you.

MS. MURPHY: Good morning, everyone. Just to jog everyone's memory, we're on this last measure here. This is percent of patients prescribed a medication for alcohol use disorder. For reference, that is number sixty-three on your discussion guide. The measure is not NQF-endorsed, but came to us from ASAM.

The TEP unanimously voted - excuse me. Wrong note. The TEP noted the significant opportunity for improvement in the area that this measure addresses, as patients are not routinely

offered medication. And patients and families are generally unaware of these options. Some members of the TEP voiced concerns on the effectiveness of these medications for people with mild alcohol use disorders, but felt the measure addressed an important gap in care.

This is a reminder, I'm going to give a brief overview of these measures. And if anybody would like to pull it for further discussion, they may.

CO-CHAIR MOORE: Can I ask a question from the top? I noticed that the overall measure score is zero. Is that a typo error? Or is that actually what happened?

MS. MURPHY: So it may very well be a typo. I do remember that this measure and some of the other ASAM measures did have low scores, just because of the lack of publically available information on the measures. But of the measures that the TEP decided to retain for their conversation, I believe almost all of them were these measures. So it was that the information

isn't there, but then everybody knows that these are good, solid, measures.

MEMBER RYAN: They were measures that we - that the members - had an option to pull in even though they went below the score.

CO-CHAIR GOLDEN: So I'm looking at the numerator numbers. It's a little vague for my taste. But you're also capturing off-label use of medications. That's a little unusual. Can you describe that? Is that something that caused any troubles? That's in the numerator.

MEMBER AMSTUTZ: What I think would cause trouble - where it would cause trouble is that the clinical community can talk about the measure. But you wouldn't, you couldn't have anybody from the pharmaceutical industry talk about the measure. Right? If we're using off-label. But the question I was going to ask, an additional question, is how - you know, do we have a process for measures like this that require a little bit more definition? That require more definition?

CO-CHAIR GOLDEN: I'm sorry, you weren't here yesterday were you?

MEMBER AMSTUTZ: Not in person.

CO-CHAIR GOLDEN: Okay, great.

(Simultaneous speaking.)

CO-CHAIR MOORE: We're like, who is she?

(Laughter.)

MS. GORHAM: So Karen, just because you are a new face. You were on the phone yesterday. Can you introduce yourself?

MEMBER AMSTUTZ: Sure, hi. I'm Karen Amstutz. I'm the Chief Medical Officer for Magellan Health. My background, I have training in Internal Medicine and Pediatrics and have spent sort of ten years in an academic integrated delivery system environment at Indiana University. Followed by ten years at Anthem, and then some time in the provider delivery system transformation space before joining Magellan.

CO-CHAIR MOORE: Welcome.

MS. GORHAM: And just for our record

purposes, Karen was on the phone yesterday so she did complete her DOI.

CO-CHAIR GOLDEN: So let's go back to your comment about the clinical issues. Go ahead.

MEMBER AMSTUTZ: So I guess the question would be, if it does involve off-label, what implications does that have for discussion of the measure? I think if you're a clinical academic then you can discuss and use the measure. If you were sort of a pharmaceutical, if you were from the pharmaceutical industry, it would create some problems in being able to say hey, here's the measure that promotes the use of these medications. And yet at the same time, it's off-label and we're not allowed to have -

CO-CHAIR GOLDEN: I could even go further. Many Medicaid programs like mine would probably not cover or pay for an off-label use of the drug unless there was some strong evidence based approach. So I can see that could cause all sorts of odd conflicts and concerns.

MEMBER ZERZAN: Topiramate is one of the ones that is listed as off-label, though I'd argue that you'd probably pay for that without any prior authorization or not knowing what it's for. You know? We pay for that. Do I want it to be used for this? I don't know. But I don't care enough to stop it.

CO-CHAIR GOLDEN: I was just thinking the precedent of putting off-label drugs into a measure, that's all.

MEMBER KUY: From my perspective, in Louisiana Medicaid, we do a huge focus on what is the evidence behind it? Is it FDA approved? So unless there's extenuating circumstances where we can see there's a strong reason to, but usually we try to go on what the evidence is and what the FDA has approved.

MEMBER ZERZAN: Yeah, but I don't know that we'd even know - is Topiramate being prescribed for alcohol use or some other condition? I don't think there's any good way to even think about that. So I would agree that it

shouldn't be in there.

MEMBER PHELAN: Just reading on UpToDate - I don't know if anyone uses UpToDate. But clinically, I couldn't survive and practice medicine without UpToDate anymore.

(Laughter.)

MEMBER PHELAN: But they mention oral metaxalone, and they say exhibits as principle of fact. Efficacy - multiple med analysis, clinical trials, developments on metaxalone to produce alcohol consumption compared to placebo. And they mention that it may be efficacious in individuals who are genetically susceptible. Preliminary evidence says individual with some variant gene. And they mention some adverse side effects. So I think some of these have been studied. I don't think the people who submitted the measure would have submitted it if they didn't think there was some efficacy behind it. And I'm not sure it was a drug company that submitted it.

And because there's so little to do

with alcohol and drug abuse anyways, I'd kind of be in favor of including it as something in the toolbox. Just from my brief review on UpToDate, it looks like both of those have been used and there is some evidence that it does help. You don't have a randomized control trial yet, but if it is efficacious and it helps some people, it may be worth considering.

CO-CHAIR MOORE: I think that that brings up a broader point that I think we encountered yesterday a few times. Where it might be helpful in the future, if we were to go through this exercise again, to have a sense of the date in which this measure or concept was first formulized. And if there's been any edits to it - some type of chronological to be able to map it against our knowledge of other pieces that we might pull into it. Just a suggestion.

MS. MURPHY: So I think I can tell you that this measure came from a document - I believe it was last looked at in 2014.

DR. TERRY: I think it was on addiction

medication.

MS. MURPHY: So I guess the question is, do any of us feel uncomfortable enough to remove it? Or do we just keep it there?

MEMBER POWELL: Yeah, I know we've got around three minutes I think.

(Laughter.)

MEMBER POWELL: I used to work in financial management for a long time, so I'm a little uncomfortable with False Claims Acts issues. I'm not saying that any of these drugs would cause that. But I've worked on them, and I don't think you want to have a measure that says, use these off-label things. And then later there's an issue with it. What if there's a False Claims Act issue? And there's recovery and funding.

So what I would say - and I think there's been enough of these that have popped up that maybe we have a section that says, we've looked at these long and hard. There's a couple of them we really liked but we couldn't say, go

forward with. But we would like to see something like this and this is why. And you know, there's probably maybe three and four measures we've talked about here. Like, we really wanted to like it, but there was a fatal flaw and we couldn't.

But if something like this comes up in the future without these fatal flaws included, we would wholeheartedly say this is something that should go forward. So that's just a suggestion to help us maybe come up with an alternative solution.

CO-CHAIR GOLDEN: One question for you. I don't know if anybody knows. On the detailed specs on this measure, do they actually list the drugs or is it just a statement of an off-label use? I mean, somebody could prescribe vitamin B12 and say, I was doing that to treat alcoholism.

(Laughter.)

MS. MURPHY: Yeah so I think it just says off-label use. I don't believe that the

publically available information at least specifies.

MEMBER ZERZAN: It does say if there's enough meta-analysis to support off-label medication. It's still squishy. But at the end of the day, it's -

CO-CHAIR: So the question is, is this ready for use immediately? Probably not.

MEMBER RYAN: I'd just like to say that I'm not quite sure the instrument puts everything together as an off-label use. But you could, potentially, if a state wanted to look at what percent of people being treated for alcohol use disorder actually getting FDA approved versus non-FDA approved. I think that's worthwhile information that could be gotten. Which is are providers just not knowing what they need to be using. Are they not using evidence-based medications? And I think you might be able to stratify by what they're actually getting, if anything at all.

CO-CHAIR GOLDEN: So the other

question is, there are other measures for medications, opioids. So that's the only one for alcohol, and alcohol drugs?

MS. MURPHY: Yes. There's a very similar message that relates to opioid use, prescriptions for opioid addiction. I believe it's the next item we'll review.

CO-CHAIR GOLDEN: All right. Does anyone want to make a motion? Or we are going to shrug and move on? Seeing no hands raised, next item.

MS. MURPHY: Okay. The next item is, again, that similar measure. This is number sixty-four in your discussion guides. Percent of patients prescribed a medication for opioid use disorders. The TEP has numbered high on all decision logic criteria for this measure and discussed the measure's critical importance for providing high quality care in the twenty-first century. The TEP noted that this measure would be of the highest importance to state Medicaid agencies.

The TEP voiced mild concerns about the availability of measure specifications, but felt that the measure was critically important to reducing substance use disorders. They were very enthusiastic about this measure. If memory serves, they were very enthusiastic about this measure and the quality objective it addressed.

CO-CHAIR GOLDEN: So a question for the TEP as well. Drugs like buprenorphine needs to be coupled, usually, with counseling. So was there any concerns about a prescription-only measure that may not include the counseling component?

MEMBER RYAN: I think we addressed the fact that that's a state level decision. You know, not all states require that. So - especially in adults. In the pediatric, it's generally for your sixteen and seventeen-year olds. But for your eighteen and over, at least in Connecticut, it's not required. So it may be more of a state level requirement.

CO-CHAIR GOLDEN: You dropped your

instrument.

(Laugher.)

MEMBER KUY: I was going to say that in our state and Medicaid, we definitely want to cover MAT. But we don't have the funds. And we haven't been able to do the whole waiver stuff. So I think the evidence shows that you need to have MAT to be effective. But the problem is that not all states, and maybe even a majority don't actually fund it. When we were at the med meeting in Portland, we were talking about that. But I think the issue is that it would be like, a mandate that's unfunded.

CO-CHAIR GOLDEN: Deborah?

MEMBER KILSTEIN: Just a caution, again, that there may be limitations in terms of what entity can report this measure. So it may be reportable at the state level, but not at a plan level. Because if it's carved out of the 42 CFR Part 2, a plan might not even know if somebody is on MAT.

CO-CHAIR GOLDEN: Other comments,

concerns, or questions? Sheryl, you have something up or are you just -

MEMBER AMSTUTZ: It's Karen.

CO-CHAIR GOLDEN: Karen, sorry.

MEMBER AMSTUTZ: Yes. I think from a Magellan perspective and from our behavioral health sort of guideline perspective, I think we would iterate the comment about not pairing these with therapy. In fact, I think our feeling is you really need to surround the prescriber with some kind of case manager, care coordination, and therapy in order to make this approach work. And where I would have concerns, actually having been on the plan side and seeing how these measures impact plan behavior is there would be this huge push for prescribing without therapy. Without the concomitant therapy.

If you have a measure like this - because you take non-clinicians will take that as that. You know? Sort of the primary behavior that wants to get incented, and it gets very difficult for clinicians then to counteract that

perspective that it really needs to be not just the actual measure, but this other set of services.

CO-CHAIR GOLDEN: David?

MEMBER KELLEY: I think this is a very challenging issue. Again, because it's going to carve out issues and what not. Unless you're the state program and you have access to both the physical and data calls, you never really get the methadone folks. You basically get, perhaps naltrexone and buprenorphine folks. So, I mean, there are limitations. There's also value, I think, in looking at - and we do a measure that's very similar to this. After a lot of internal deliberation, we also have a metric that we really look at counts of admission and published a paper in the University of Pittsburgh where we've looked at.

The first question is what percent are actually on buprenorphine in that instance? And then we asked what percent actually had any behavioral health counsel, whether it was for

drug and alcohol or for mental health. So it's a very tricky issue. But if you don't start measurement somewhere, you're not going to get started. And sometimes you have to start very simplistically and just, as a health plan, I think it's really important to look at - here are the people who have a diagnosis of OUD.

And I'll tell you something - we've been doing managed care for twenty years. Some of our health plans are clueless. They don't even know how many people in the population have OUD. And they should know from claims. They may not know who's on methadone, but they should know from claims. So, they should also know - I'm sure they're watching their pharmacy costs because it's very expensive. But they should know who was on buprenorphine.

I think, to get a feel for your population of how many folks actually have the diagnosis. And it's probably a fairly low percent that are actually being treated with any form of MAT. Even though the limitations in the

physical health world, you may know from your pharmacy data who's on naltrexone or who's on buprenorphine. You have plenty of claims history from ED visits, inpatient stays that land on the physical health side. Motor vehicle accidents, trauma - you have a pretty good idea of who has OUD.

So it's kind of like - you have to start somewhere. And we're so far behind, I think, with these measures. And developing good measures to not have something in the portfolio that says, well here is the percent of our population that is actually getting medication. And you're not even getting - we look at duration. And have episodes that we have defined.

But this at least helps the managed care plan, the state program, really understand partially what has happened in the population. State can look at, you know, the behavioral health plans. And we can understand who's on MAT.

CO-CHAIR GOLDEN: Not so much as an accountability measure, but we've had too many -

(Simultaneous speaking.)

CO-CHAIR GOLDEN: Somebody is on the phone who wants to make a comment.

MEMBER SCHIFF: Hi this is Jeff. Good morning, everybody. I just wanted to agree with David. We serve in Minnesota about two thirds of our folks who have opioid use disorder who are on medication. And it is, I think, very much an evidence-based practice for those folks. And I think it would really be a problem if we didn't endorse - I'm looking at it as a goal for one.

And I think the second thing is, I think the literature is a little controversial, at least our buprenorphine folks tell us about how effective the counseling is. And so, even though I think all of us philosophically believe that counseling is an important part of this, I don't know that we can hold this back. Because it's not linked to counseling. Thank you.

CO-CHAIR GOLDEN: Final comments,

questions?

MEMBER HENNESSEY: Yeah, I would say that I agree. There's a real challenge in the opioid treatment community with not always seeing patients who need to be on MAT on it. And that although this would be ideal as a measure, to have say, another component that talks about whether or not the patient has also received counseling, I wouldn't not bring this forward because it's not an ideal measure. We could potentially note a preference for potentially in the future having a measure similar to what we have with tobacco. Where you've got screening, then you've got medication intervention and you've got counseling. And it's three sub-measures to the one measure. Maybe revising this measure in some way in the future to reflect that. Thank you.

CO-CHAIR GOLDEN: Anyone want to make a motion about this item? Ready to move on? Next item.

MS. MURPHY: Our next item is number

sixty-five on your discussion guide. Presence of screening for psychiatric disorder. The TEP felt that this measure concept - oh, and I should note that this was recommended as a measure concept. They felt that this concept addressed the quality issue of screening for co-morbid psychiatric conditions, which can often increase difficulties with childhood treatment, adherence to treatment, and other medical problems.

CO-CHAIR GOLDEN: Comments, questions? Anybody on the phone? Next item.

MS. MURPHY: The next item is number sixty-six in your discussion guide. Primary care visit follow-up. Again, this was recommended as a measure concept. The TEP noted that this concept provides discharge planning and continuity of care after detox, which can be used to hold the care team accountable and get people back into the primary care setting. The TEP noted that the referral to primary care that the measure addresses is a current area for improvement, and could reduce the use of

emergency services by connecting patients with primary care providers. The TEP also liked that the measure applies to all ages and is not limited to those eighteen and older. The TEP voiced concerns on the six month time frame, and felt that the follow up time should be one to two months.

CO-CHAIR GOLDEN: Comments? All right. Next item.

MS. MURPHY: Okay. Next item, number sixty-seven in your discussion guide. Screening for patients who are active injection drug users. The TEP again discussed the lack of clarity with this - oh, I say again but we haven't gotten to that one yet. The TEP discussed the lack of clarity with the measure concepts denominator and voiced concerns that the population may be under represented in the measure. The TEP was also concerned that the measure did not include a systematic screening, however noted that the HCV screening is an important quality issue that the measure addresses and voted to recommend.

When I say the lack of clarity with the denominator, I just want to note that that was a theme that came up a little bit. Oftentimes, they reviewed a lot of measures that they felt didn't have a clearly defined denominator. They kept using the word squishy to define it. So you'll hear that as we get through these last few measure concepts.

CO-CHAIR GOLDEN: Just for everyone's - to make sure you read the numerator. It's actually not screening for drug use, it's actually screening for hepatitis C. Is there an exclusion in this for people who already are hepatitis C positive? Okay.

MEMBER AMSTUTZ: And did you also discuss HIV screening as part of the - so hep C and HIV? No?

MEMBER RYAN: I think this is one example of, we would have liked to see HIV but the measure said HCV and we were kind of limited.

MEMBER SCHIFF: This is Jeff, is there a way to relabel a measure?

CO-CHAIR GOLDEN: Relabel the title?

MEMBER SCHIFF: Yeah.

MS. MURPHY: We have to use the measure as specified, unfortunately.

CO-CHAIR GOLDEN: So at the bottom of the denominator it says, GT and not - okay. That just means it's out. It's kind of an odd way of being a double negative. Okay. Comments or questions? Next item.

MS. MURPHY: Next item -

MEMBER KELLEY: I have a comment.

CO-CHAIR GOLDEN: David?

MEMBER KELLEY: I really do have - you know, we're side-barring over here. I mean, I really do have difficulty about hepatitis C. And for those of you that aren't in the midst of Medicaid and the lawsuits from the drug company - well, from the drug company. But they're paying the lawyers to sue us. It's basically from the drug company. And they have gouged the pricing on hep C. Why is hep C here and why not HIV? I mean, I'm being very serious. I don't

understand. You know, the measure, yes. It's very very important.

But I don't understand why HIV - I want to see HIV screening done in this population. I'm very serious. I wonder if the measure, was there - I don't know who the measure developer was. But was there some influence from the drug company? I'm just telling you, that's the environment that we deal with. And I am concerned that we have a measure out there that's focused just on hepatitis C, a treatable condition. We are not screening for a deadly disease that has - you know, it's treatable, but it's deadly. I don't understand the hierarchy of why this is in here.

CO-CHAIR GOLDEN: It came from PCPI, so I would say that's that how we work with them and not usually kowtowing to the drug industry and their influence. On the other hand, I will say that in our program if you are an active drug user, you're probably not going to get treated for hep C. It's one of the exclusions we use for

not treating somebody. Somebody that actively has an unstable psychiatric condition or actively using drugs - we usually don't treat until they're not. Because of adherence plus potential re-infection.

MEMBER RYAN: I wonder too if it just wasn't found in the universe of measures that they looked for, for HIV. Because it's considered almost standard of care now. And I wonder if that's why HIV wasn't included. Because it wasn't even available in the NR universe of measures that we had the opportunity to review.

MEMBER KELLEY: So it might be out there, we just don't -

MEMBER RYAN: Right. Right.

MEMBER KELLEY: We don't have it available to us. Maybe it's a sub-measure.

MEMBER RYAN: Yeah.

(Simultaneous speaking.)

MEMBER ZERZAN: Yeah, no. I agree with David. Especially because there's sort of an

urgency to treat HIV. There's not really an urgency to treat hep C. I mean, you'll still live for awhile if you don't get treated immediately. Whereas HIV can take you down that road really fast. There's a range.

CO-CHAIR GOLDEN: The only pushback would be on the public health side. Maybe the drug user would not share needles or what have you. They are aware that they are a carrier.

MS. MURPHY: So I -

MEMBER ZERZAN: I know, but that should be with HIV, too. I don't know. You know, needle exchange, other things. All of that is important. I don't know. I'll take a step and maybe David will second to remove this measure just because we want both?

MS. MURPHY: So I do want to apologize. There seems to be a mistake on the title. So the title - this also goes to the concern on the phone. It should read, annual hepatitis C virus screening for patients who are active injection drug users. It's a little different. I'm sorry

about that part being left off. It doesn't change the measure specifications, only the title. So take that into consideration.

DR. TERRY: Say that again, please?

MS. MURPHY: Sure. The appropriate title is, annual hepatitis c virus from HCV screening for patients who are active injection drug users. So just that first part about HCV, which is a little important for this issue. Sorry about that.

DR. TERRY: Still, it's twelve months though?

MS. MURPHY: Yes.

DR. TERRY: Can I just clarify something here? I just wanted to address the issue of sources. And just to go back a little bit. You know, we did an extensive look. And we looked at at least seventy-five sources. And we kept going out to people, including CMS and others to say, where else do we need to look? So yes, it could be out there somewhere. If it's not on some website or in some program - and a

lot of some of these came from that addiction association for specialty and addiction group medicine. But this one is PCP.

I just want to say that it could be out there, but we really did an extensive look. So I guess going forward, we - and we looked at seventeen states. Let me get that, seventeen states. But sometimes it's even hard to really find exactly what they have there. So I'm just saying that it could be out there but there was an extensive look, really. And we kept asking even this group, actually, at some point. Just so you have that information.

CO-CHAIR GOLDEN: So Julie - Judy. You made the motion. And you know, we have the five-step criteria. So which criteria do you think this would fail? Because that's sort of the way we work, dealing with removals. We can move to the next item and come back.

MEMBER RYAN: Can I just say?

CO-CHAIR GOLDEN: You know, this reminds me of the one that we did with the

screening of children with psychosis for urine screening. The HIV one. Because I think HIV has been -- it's in the standard of care if you're an IV drug user to be screening somebody for HIV. And I wonder if that's why that's not out there as a measure. Because it's like - it's kind of what we should be doing and we have hopefully have been doing for many years. So I wonder if that's why it didn't come up as a new measure. Because it's in the range of standard of care.

CO-CHAIR GOLDEN: I think hep C is a close second to that.

MEMBER ZERZAN: So I think it would fail either the second or the third one, because I'm not sure what - the opportunity for improvement or variation in care really isn't getting at the whole need for care that's there. And also, potentially the sort of efficient use of measurement resources. I think the most efficient is that you do everything that's needed for a person and not super piecemeal. And particularly in your program, actually in mine

too, had I suspected a number of other Medicaid programs that if you're actively an IV drug user, you won't get treated for HCV. And so, I don't know.

MEMBER HENNESSEY: Yeah, I'm a little bit troubled by the notion of just because this - we're talking only HCV as opposed to HCV plus HIV and maybe even you can look at some other high-risk co-morbidities with this condition. That we're going to just eliminate this measure. I mean, I believe the AMA PCPI started looking at this measure back in 2008. So this is not a new measure. And so, it's sort of like saying, okay.

We're not going to approve the diabetes composite measure because it's leaving out testing for certain other co-morbidities associated with this. I'm troubled with the notion that people who have a substance use disorder are not going to be screened for this condition, or we're going to reject this measure just because it doesn't include a number of other co-morbidities as a composite measure.

MEMBER ZERZAN: I suppose I could also withdraw my motion, then CMS has heard that I am uncomfortable with this. And I don't want to prolong discussion.

(Laughter.)

CO-CHAIR GOLDEN: We have a request to withdraw. Is everyone okay with that?

(Laughter.)

CO-CHAIR GOLDEN: Michael, are you still on?

MEMBER PHELAN: Yeah. I kind of feel this is kind of like throwing the baby out with the bath water. I think this is a good measure to keep in the wheelhouse. I'm really surprised there's not an HIV measure somewhere in the universe. And I'm trying to look right now on some websites that has either the standard testing or the U.S. Preventative Task Force, CDC guidelines. They're all exactly the same, you know? HIV, there's a couple of high-risk groups.

And this is one of those really high-risk groups that you really want to be testing.

And I'm sort of surprised. And I'd like to ask that we reach out to some of these other organizations and say, is there universal testing? Because we're trying to do a measure set for Medicaid patients and I'm almost certain there is one. As I'm looking at it, I'm like - it's just putting in the ICD-10 codes for HIV versus HSV.

CO-CHAIR GOLDEN: Does someone on the phone want to chime in?

MEMBER SCHIFF: This is Jeff. I think this should stay, but I'm waiting to see if Judy's withdrawal will hold.

CO-CHAIR GOLDEN: I think that at the moment, it's been taken off the table. Susan?

MEMBER WALLACE: I just had a question for folks that are more in this practice. So what I'm hearing is this should be standard of care. In my mind, the only thing that would take this measure away is if there's like a ceiling effect. It sounds like - and that was really, I think what the argument was with the other

measure that was the parallel you drew. About the children with the screening. So do we have the data on how what performance we have on this? Okay. So we don't really know if it's sufficiently sensitive for capturing variation.

CO-CHAIR GOLDEN: Deborah?

MEMBER KILSTEIN: I understand, is this measure really just getting at the public health issue? Because you're only talking about active users. There are many people who may have used in the past who should be tested if you're talking about HCV? Or potentially should be tested. But is this just getting at the public health issue of active users?

CO-CHAIR GOLDEN: I think we're getting into the Rorschach blot effect. You can interpret it as you wish, I guess. In many ways. It's an imperfect measure but as I think David was saying earlier, it's a concept as a start somewhere of measurement.

DR. TERRY: I just had one comment. We'd be willing to, before our coming call, see

if we can find a measure that speaks to HIV. And you know, something that would be appropriate. I think it's an excellent suggestion. And maybe because it is standard practice, as was said. It may be talked out but it's truly worth taking a look.

MEMBER RYAN: And this was a measure concept. We didn't recommend it as a measure. We recommended it as a measure concept. So I think we recognized that there were problems with it but wanted the concept somehow retained.

CO-CHAIR GOLDEN: Okay. Are we ready for the next item? Okay.

MS. MURPHY: All right. Next item. Number sixty-eight on your discussion card. Substance use disorder penetration, AOD. I will also note that this was recommended as a measure concept. The TEP discussed this measure squishy denominator.

(Laughter.)

MS. MURPHY: Admitting that it's not clearly defined. But they agreed that the

measure focuses on a very important issue in substance use. Addressing the under-treatment of substance use disorders, and that the measure is desperately needed with the potential to advance SUD treatment very quickly. I'll also just note as you can see in the discussion guide, this measure was in use in Washington State.

And you can see what they mean by this squishy denominator here for those who don't have it pulled up. The denominator reads, including the denominator, all individuals in the eligible population with a substance use disorder treatment need.

CO-CHAIR: Hello? Yes, Deborah.

MEMBER KILSTEIN: My one question is, if we look at this measure, isn't three and four going to address the same thing? That the other measure that we talked about, where we had a concern that it did include treatment? And this one - I mean, counseling. Where this one does include counseling? So if we were to accept this, is this a better measure than the other one

that we already discussed?

MEMBER RYAN: Can I address that?

CO-CHAIR GOLDEN: Yes, please.

MEMBER RYAN: The treatment is much more than brief intervention in the office setting. We're talking about inpatient residential treatment, methadone, other medication-assisted treatment. So it's really either residential or a specific drug treatment as opposed to the other one that we talked about which was really brief intervention in the primary care setting. So this is a much higher level of treatment.

CO-CHAIR GOLDEN: So one might argue that if it's a measure concept, by throwing this into the toolbox, you'll at least get people thinking about doing a measurement on something on this topic with some ideas. That gets really kind of loose. But that could be a function as well as some of the output of this project. So, you know.

MEMBER HAMBLIN: Just to add for what

it's worth, in terms of this squishy denominator. I believe it's David Mancuso at Washington State, who developed this measure. And he's done pretty extensive research in his state on this. So I'm fairly certain he could provide additional detail on the denominator. And I'd be happy to help with that if necessary.

CO-CHAIR GOLDEN: I guess the question for Peg is going to be - is squishy going to be in the lexicon for the report? I mean, is that now an official Intuit term? We need to get an official definition somewhere. Like a toolbox. Any other comments on this one? Next item.

MS. MURPHY: Our next item is number sixty-nine in your discussion guide. Substance use disorders, percentage of patients aged eighteen years and older with a diagnosis of current alcohol dependence who are counseled regarding psychosocial and pharmacologic treatment options for alcohol dependence within the twelve month reporting period.

The TEP noted that this measure

concept's unclear denominator - they noted that the measure concept had an unclear denominator but were unsure of a better way to define it. The TEP also noted that the measure concept may actually measure whether a patient remembers receiving counseling, rather than whether or not they have received the counseling. The TEP also discussed the twelve month time frame and agreed that ideally, the time frame would be more immediate. And they also felt that the concept was not particularly powerful, but addressed an important issue.

CO-CHAIR GOLDEN: Comments and questions on this one? Next item.

MS. MURPHY: Okay. Next item is number seventy in your discussion guide. This is measure - this was also recommended as a measure concept. Substance use disorders. Percentage of patients aged eighteen years and older with a diagnosis of current substance abuse or dependence who were screened for depression within the twelve month reporting period. The

TEP noted that the recognition of the dual diagnosis included in this measure concept was an important practice that should be standard. They also noted that the measure would require chart review in most cases, which may not be the most efficient use of resources for states. But that states could decide for themselves whether they wanted to use the measure.

CO-CHAIR GOLDEN: Anyone? Next item.

MS. MURPHY: So I think we have just one more - sorry, one moment.

CO-CHAIR GOLDEN: One more slide there.

MS. MURPHY: Oh, there we are. This is number seventy-one in your discussion guide. The percentage of adolescents twelve to twenty years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user. Discussion on this measure, again, brought up the TEP's objection to measures of just tobacco use, which do not include other nicotine products or marijuana.

The TEP noted that particularly in the adolescent population, it is important to screen for use of these products in addition to tobacco. The TEP agreed that the measure of tobacco is still important as it is a significant driver of cost, and that the adolescent population is important to reach, given that they are often excluded from other measures of substance use based on their age.

CO-CHAIR GOLDEN: Any comments? Keeping you busy, Tara. Next item.

MS. MURPHY: So those are all. We've gone through the whole set. These last two on the side you see here are ones that we reviewed yesterday, and that were selected by a member of the Coordinating Committee for reconsideration. So they have been added. Unless anybody would like to address these again, we can move on.

CO-CHAIR GOLDEN: I think we had one item pulled.

MS. MURPHY: Yes. So if everybody is okay with those two measures that were discussed

yesterday, we have one item that was pulled for further discussion. And we can go to that.

CO-CHAIR GOLDEN: So do we have to do a formal vote on the whole set?

MS. MURPHY: We'll do that after we've discussed this measure that was pulled.

CO-CHAIR GOLDEN: Okay, that's fine.

MS. MURPHY: So we'll decide whether or not that will be included and following that decision, we'll vote on the entire set. So that measure that was called for discussion was NQF measure 2597, substance use screening and intervention composite. This is number fifty-four in your discussion guide. And just as a reminder, I believe one of the objections was to the composite nature of the measure, but I will turn it over to the Coordinating Committee. And I believe the person who pulled this off was Susan.

MEMBER WALLACE: So my concern with this measure was that it was framed as a composite measure, but it looks like it's a

compound, sort of a compound numerator. As we've been going through this discussion, I kind of wanted to hear the rest of the measure set before discussing it. And I think I've counted no less than seven or eight different measures on this set that had that kind of a compound. Like, they're capturing two different distinct care processes. Whether it's screening and intervention or intervention and treatment.

I don't know that I want to pull this measure. I mean, certainly if I use that rationale that puts seven or so measures in play - and I think that's kind of ridiculous. But I guess I would like it reflected in the report that if we can move towards more precision with the measures, where we are capturing more singular care processes. And if we really want to kind of raise the bar, I think that's usually why we add the intervention to the screening, we can just capture the intervention piece. Because it just makes it very hard to distinguish where the problem is from an improvement perspective.

CO-CHAIR GOLDEN: So we have a general - I think we have a general sense of angst in the group about a lot of these measures. But to get back to your motion - I was going to ask you - if you wanted to continue with the motion, if there was one element of the five steps that you think it would fail? If not, we might want to say well let's just shrug and move on.

MEMBER WALLACE: I think for me, in light of reviewing the rest of the measure set, I do not want to continue with the motion.

CO-CHAIR GOLDEN: Okay. So there was a request to withdraw your motion, and if that does not upset the person who seconded it - why don't we consider it withdrawn? Unless we have other comments. Okay.

MS. MURPHY: Okay. If there are no other comments, we have our SUD measure set to vote on. So we will now turn, once again, to our clickers. And just as a reminder, this will be a straight up and down vote. The question is, do you recommend the SUD measure set to CMS'

Medicaid Innovation Accelerator Program?

CO-CHAIR GOLDEN: I guess I have a question. Who's on the phone? How many people do we have on the phone?

MS. MURPHY: Oh. Are there any comments on the phone before we vote?

CO-CHAIR GOLDEN: No, no. I meant how many of our Committee members are on the phone.

MS. MURPHY: We have four members on the phone today.

MEMBER GELZER: And we're ready to vote.

(Laughter.)

MS. MURPHY: Thank you. I apologize. We only have three members on the phone right now.

CO-CHAIR GOLDEN: So we're missing one member?

MS. MURPHY: We're missing one. But we do have a quorum, so we can take the vote.

CO-CHAIR GOLDEN: Vote time.

MS. MURPHY: Please remember to select

on your clicker, one for yes and two for no.

CO-CHAIR GOLDEN: And the Co-Chair is not here, so there will be one less vote.

MS. MURPHY: Okay. The measure set passes.

CO-CHAIR GOLDEN: Okay.

MS. MURPHY: I'm sorry? Oh, one hundred percent of the members of the Coordinating Committee voted to recommend this measure set to CMS.

CO-CHAIR GOLDEN: One hundred percent voting. There are two missing.

MS. MURPHY: Sorry. So we received nineteen votes from the Committee. We are missing two members. But we still have a quorum so the votes will stand. And nineteen of the nineteen who cast votes selected yes.

CO-CHAIR GOLDEN: Thank you. Do you need to do public comment at this point, or do we need to move on to the next items, or take a break?

MS. MURPHY: We need to do a public

comment time.

CO-CHAIR GOLDEN: Okay, public comment time.

MS. MURPHY: Operator? Will you please open the phone lines for public comments?

OPERATOR: Okay. To make your comment, please press star, then the number one. There are no public comments at this time.

CO-CHAIR GOLDEN: Okay. Seeing that I have been abandoned to my left and my right, and we're going to the next section. Let's take an early break and then we will reassemble for the next tranche which will be - I guess PMH. Good. Okay. So let's take a - what time is it now? It's now 9:51 a.m. Let's restart at ten.

(Whereupon, the above-entitled matter went off the record at 9:52 a.m. and resumed at 10:04 a.m.)

CO-CHAIR MOORE: All right, everyone. We are going to get started with the next set. Do you want to - yes.

MS. BUCHANAN: Thank you, Jennifer.

So as you guys are well familiar with the slide, you will be evaluating new measures. Because for PMH, we had two new measures up for submission that TEP did not review. Additionally, there are six measures recommended from other TEPs. And some of these we have gone through previously, so we can really speed through that. And then lastly, we do have two recovered measures by Coordinating Committee members. We are also not going to address the belated measures. So we will hopefully be able to get through this within two hours. But I want to -

CO-CHAIR MOORE: Well, and speaking on the time. Shaconna, do you want to give a quick update on how we're going to flex the agenda?

(Laughter.)

MS. GORHAM: We are so flexible that we're going to do a little re-shuffling. We will start PMH now. Hopefully we will finish PMH before the break. But if not, no worries. We will take a break for lunch at about 11:45 a.m. We may do a working lunch. I know that you all

have a lot of travel arrangements and some flights that need to get out. So we could possibly do a working lunch to accommodate those earlier flights. Then we will come back, finish - we will start LTSS, go through LTSS and finish. If we have not finished PMH, then we will go back and finish PMH.

CO-CHAIR MOORE: And the reason for that is because our wonderful TEP Chair has a conference call that she must take. So we're going to kind of go back and forth a little bit to support her. Not because we're trying to make everyone crazy.

(Laughter.)

MS. BUCHANAN: And so - speaking of our wonderful TEP Chair, I'm going to turn it over to Dr. Maureen Hennessey to do a little bit of overview of the TEP's discussion and some of the themes that arose during our in-person meeting. Maureen? Oh, on the phone? Maureen?

MEMBER HENNESSEY: Okay, good. We've got the right slide. Good morning. My name is

Maureen Hennessey and I'm the Chair for the TEP for Integration of Physical and Mental Health. First, I just wanted to acknowledge the contributions of the other individuals who have served on this TEP.

Angela Kimball, who's with the National Alliance on Mental Illness representing consumers and their family members. Dr. Virna Little, with the Institute of Family Health. Dr. David Mancuso, with the Washington State Department of Social and Health Services. Dr. James Schuster, with UPMC - that's University of Pittsburgh Medical Center, insurance division. So I want to thank them very much for their contributions in reviewing forty-four measures, which is what the TEP reviewed. Are you having trouble hearing me?

DR. TERRY: Yeah. Thank you.

MEMBER HENNESSEY: Is this better? Would you like me to repeat or is this good enough?

DR. TERRY: Keep going.

(Simultaneous speaking.)

MEMBER HENNESSEY: They reviewed forty-four measures, measure concepts, and we recommended twenty-three measures and two measure concepts which we thought were promising. There were several key themes that I'd like to mention. The first is repeatedly, there was a discussion about the need to stratify measures by condition. And the thinking there is that by doing that, we are more able to identify health disparities, when we are identifying both primary and secondary diagnoses. We can stratify the data. We can look at the data more carefully to identify health disparities and formulate targeted interventions.

Another theme that arose was the need for greater specificity in measures to address the targeted population. For example, there's one measure referred to as follow up post-ED visits for mental illness. And it doesn't include some of the follow up interventions that should be included when assessing follow up.

Case in point are wraparound services like assertive community treatment, which is a very important resource to have available for people with severe mental illness and persistent mental illness.

And then finally, this was a huge issue. The ease of measure collection was a theme throughout our discussions. Specifically related to electronic health records and paper records. Uniformly among those of us who have worked in the Medicaid field, the sense was having to use paper records to collect data was a burden in a number of ways.

One, it's a burden in terms of cost. Second, it's a burden in terms of the providers of clinical services frequently don't like having to go through the process of an audit. They have to collect the records, which is more expense. They also are concerned about the fact that this is sensitive behavioral health information that others have access to. And so there was a strong preference for measures that could have primary

opportunities through either electronic health records or claims for the data to be submitted electronically. Thank you.

MS. BUCHANAN: Thank you very much, Maureen.

(Laughter.)

MS. BUCHANAN: So as you can see on this slide, we received two late submission measures for consideration. The first is number one hundred and five in your discussion guide. So I'll give people a moment to find it. It's a little farther down than where we were. So measure number one hundred and five, postpartum follow up and care coordination. And so as we can see, this measure measures the percentage of patients, regardless of age, who gave birth during a twelve month period who were seen for postpartum care within eight weeks of giving birth.

They received a breast feeding evaluation education, postpartum depression screening, postpartum glucose screening for

gestational diabetes, and family and contraceptive planning. So the numerator is patients receiving follow up at postpartum visit. Denominator is all participating patients regardless of age who gave birth during the twelve month period. This is an AHRQ measure and is currently in use in PQRS. And so I wanted to give people - I'll turn it over to Jennifer to facilitate any discussion around the measure.

CO-CHAIR MOORE: Any comments? Concerns? I have to disclose that I love this measure.

(Laughter.)

CO-CHAIR MOORE: I did not work on it. But it makes me so happy to see this, or concept, I should say. Is that true? Is it a concept or do we know?

MS. BUCHANAN: It's a measure.

CO-CHAIR MOORE: Measure. Okay.

MS. BUCHANAN: Maureen?

MEMBER HENNESSEY: I'd be glad to talk a little bit about it, too. I actually was the

one who found this measure. Unfortunately found it after we had gone through the process, and so brought it forward. And the agreement was to bring it to this Committee. I really like this measure, too. Because I think that there are a number of ways in which depression is overlooked for women after pregnancy, after they give birth. And also I like the fact that it has a number of other components to it regarding breast feeding evaluation and post-glucose screening, family and contraceptive planning. So it really is an example of integration of health with behavioral health with a group of individuals who are at risk for depression. Thanks.

CO-CHAIR MOORE: I would ask if there's any thoughts from any of the health plans. Because I do sit on the NQF Perinatal Committee, and there was not this comprehensive of a measure. But a similar measure that came up that was endorsed by our group. And the health plans had expressed concern about the eight week - or - I can't remember if it's exactly eight weeks, but

the short time frame postpartum. I just wanted to see if there was any thoughts on that that needed to be discussed.

MEMBER GELZER: Can you hear me?

CO-CHAIR MOORE: Yes, I can.

MEMBER GELZER: Oh, good. Good, good. So this is - my question first, is where is this currently in use?

MS. BUCHANAN: It's in use in PQRS.

MEMBER HENNESSEY: Yeah, the Physician Quality Reporting System, which is now changing to MIPS. But many of the PQRS measures have gone over into that. And I believe this one has as well. PQRS is a well-known and widely used measure set by physicians.

MEMBER GELZER: So I love this measure as well. I'm just wondering - yes, I love the measure. And it will address a lot of the inner conception care issues. That said, I know that postpartum follow up rates are just getting the HEDIS metric to improve. It has been challenging. So this may be a little bit of a

high bar, but I think it's certainly an aspirational one. And if it's ready for prime time, then I think we should go with it.

CO-CHAIR MOORE: Kathryn?

MS. BUCHANAN: There's a call on the line.

CO-CHAIR MOORE: Oh, there's a call on the line? That's what that new thing is? Okay. We've got a new system. Was that Andrea that wanted to -

MEMBER GELZER: Yes, I'm sorry, it was Andrea.

CO-CHAIR MOORE: And then another one, Jeff?

MEMBER SCHIFF: I just wanted to say that this is really quick and maybe minor, but a lot of women postpartum are not necessarily on Medicaid at eight weeks. Sometimes it cuts off at six weeks. I don't think we should change the measure, but I think that it's a little incongruent with some of the other measures as far as time frame - just to let people know.

CO-CHAIR MOORE: Okay. Deborah?

MEMBER KILSTEIN: I appreciate that there's no early time frame like there is in the current HEDIS measure, so it allows early postpartum visits. My only concern with this is that obviously this would have to be chart review. So unless there's electronic medical record access, it's generally going to require a chart review.

MEMBER ZERZAN: It says here that it's an EHR only measure.

CO-CHAIR MOORE: Okay.

MEMBER AMSTUTZ: Yeah, I think I like this measure only because it's an EHR only measure and not chart review. We have bundled payments that include everything, and we don't have - I mean that's kind of why our postpartum rates are kind of crummy, because we don't have any good sense of the data. And this is one way to start to get at that.

CO-CHAIR MOORE: Okay so it sounds like everyone is okay with it. Unless we have

something to discuss that's in opposition, let's move on. Is everyone comfortable for that? Oh. We have to vote. Sorry.

(Laughter.)

MEMBER SIDDIQI: This is Alvia Siddiqi and I'm sorry, I called in a little late. I just wanted to add, especially for the commentary round of this measure in the discussion state - to make a note that there are states - for example, here in Illinois where we do have a specific closed bill for postpartum depression screening. And in some states, you can actually create a separate quote for the postpartum visit. So you can eventually make this a claim-based measure as well. So I do think there's opportunity there.

CO-CHAIR MOORE: All right. Thank you for adding that.

MS. BUCHANAN: Okay. So before we begin voting, I do want to draw everyone's attention again to the revised decision logic. For people on the phone, I have pulled up the

immediate use/revised immediate use question. For everyone in the room, it's in front of you on a handout. It's on the second page. And so we have changed the immediate use question to now be binary. So it's only relevant to non-NQF measures. Because we know that all NQF measures are ready for immediate use.

So it now reads, is this non-NQF measure or concept ready for immediate use? Under yes, it can either be a fully developed measure that includes detailed specifications and may have undergone scientific testing and is currently in use or in planned use in states. Or it can also be a measure concept that includes a description, including a numerator and denominator and is currently in use or planned to be in use in states.

So I want to emphasize now at this new immediate use question, we are able to encompass both measures and measure concepts for recommendations that won't be lost. But we will not be reviewing for NQF measures. Under no, the

two requirements for no are - is the measure or measure concept that is not in use or planned use in the Medicaid population? Or it is a measure concept with no indication of a numerator or denominator. So I just wanted to take a pause because this is different from what we had yesterday, and see if there are any questions or concerns regarding this updated immediate use criteria.

Wonderful. So with that, we can actually start with the voting. And for that, I will turn it over to my colleague Miranda.

MS. KUWAHARA: All right. This is postpartum -

CO-CHAIR MOORE: We can't hear you.

MS. KUWAHARA: Can you all hear me? Is that better? This is postpartum follow up and care coordination. This is the first step in our decision logic. To what extent does this measure or measure concept address the CMS quality measurement domains and/or program area key concepts? For high, please select one. Medium,

select two. Or low, please select three. Polling is open.

MEMBER SIDDIQI: This is Alvia again. I don't have online access right now. So I'm just going to voice my vote, I'll wait a few seconds. It's two.

MS. BUCHANAN: Two? Thank you very much, Alvia.

MS. KUWAHARA: Ninety percent of the twenty voting members selected high. Ten percent selected medium, and zero percent selected low. Moving on to the next step. To what extent will this measure or measure concept address an opportunity for improvement and/or significant variation in change? For high, please select one. Medium, select two. Or low, please select three.

MEMBER SIDDIQI: This is Alvia. And I would say two.

MS. BUCHANAN: Received, thank you.

MS. KUWAHARA: Seventy-five percent of the twenty - we captured twenty. Seventy-five

percent of the twenty voting members selected high. Twenty-five percent selected medium. And no members voted low. 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 low, please select three.

MEMBER SIDDIQI: Alvia, two.

MS. BUCHANAN: Thank you.

MS. KUWAHARA: We had twenty-one votes come in. Fifty-two percent of those twenty-one votes selected high. Thirty-eight percent selected medium. Ten percent selected low. We will move on to the next question. And again, this is the first time that we are looking at our binary option. This is - the question is, to what extent is this measure or measure concept ready for immediate use?

Using the new questions - and I'll read them aloud for our first vote today. If this is a fully developed measure that includes detailed specifications and may have undergone

scientific testing and is currently in use or planned to be used in states. Or, is a measure or concept that includes a description including a numerator and denominator, and is currently in use or planned to be used in states? Select yes. If this is a measure or measure concept that is not in use or planned for use in the Medicaid populations or is the measure concept with no indication of numerator or denominator, please select two.

MEMBER SIDDIQI: Alvia, one.

MS. BUCHANAN: Thank you.

MS. KUWAHARA: Okay, so, for those on the phone, our clickers are not working.

Would you all mind casting your votes once more. Let's see if it works this time?

CO-CHAIR MOORE: So, are we trying this again?

MS. KUWAHARA: Yes, reselect your number. Yes is one, no is two.

We're still waiting on one more vote. There we go.

Ninety-five percent of the 21 respondents selected yes; five percent selected no.

Okay, for our final vote, to what extent do you think measure is important to state Medicaid agencies and other key stakeholders?

For high, select 1; medium, select two; and low, please select three.

Voting is now open.

Alvia, say your vote?

MEMBER SIDDIQI: One.

MS. KUWAHARA: Thank you.

MS. BUCHANAN: One moment, our slides are being a little finicky.

MS. KUWAHARA: So, I'm going to clear these votes. It was obvious that it passed for high, but we don't know how many votes were actually captured. We're going to try this once more. This is the last step in our decision logic.

The question is, to what extent do you think this measure is important to the state

Medicaid agencies and other key stakeholders?

For high, select one; medium, select two; or low, please select three.

MS. BUCHANAN: And, everyone who is presently on the phone, we received your votes the first time. So, no need to type them in again. Thank you.

CO-CHAIR MOORE: Unless they changed.

MS. BUCHANAN: Unless they changed.

CO-CHAIR MOORE: We have to re-vote. No, just this last one.

MS. KUWAHARA: We're still waiting on two more votes.

MS. BUCHANAN: If you can just click again, just to make sure yours was captured.

And, remember, when you are clicking to point it at Miranda, not at the screens in the front.

MS. KUWAHARA: We're missing one vote.

CO-CHAIR MOORE: Someone in the room? Okay, everyone, hit your clicker one more time, point it at Miranda.

MS. KUWAHARA: There it is.

All right, technology has betrayed us. So, we're going to go to a hand vote for this question.

So, the question, to what extent do you think this measure is important to key -- I'm sorry, to state Medicaid agencies and other key stakeholders.

For high, please raise your hand.

MEMBER SIDDIQI: Alvia, high.

MS. KUWAHARA: So, medium, please raise your hand.

For low, please raise your hand.

MS. GORHAM: So, obviously, it wasn't our voting slides. We still are missing one person so let's do this one more time.

Please raise your hand very high and keep it up. We are missing one person, we should have 21 votes.

MEMBER GELZER: And, you still have our on the phone, right?

MS. GORHAM: We have the votes on the

phone.

MS. KUWAHARA: And, for medium, please raise your hand.

We have 18 votes for high and 3 votes for medium. This measure will be recommended for inclusion in the PMH measure set.

MS. BUCHANAN: Great, thank you so much.

So, with that adventure, we're going to do this again.

So, the next measure we're looking at which is newly submitted is actually Number 104, so it's just right above the last one we looked at on the discussion guide.

And, this is Parkinson's Disease, Psychiatric Systems Assessment for Patients with Parkinson's Disease.

And, as we can see, this is all patients with the diagnosis of Parkinson's disease who were assessed for psychiatric disorders or disturbances.

And, the examples are psychosis,

depression, anxiety disorder, apathy or impulse control disorder at least annually.

And so, the denominators are patients with the diagnosis of PD.

As we can see, this is used in PQRS. It is a -- it does rely on claims, administrative, EHR and registry data.

And, the steward is the American Academy of Neurology Institute.

And so, I'll turn it over to Jennifer to facilitate any discussion.

MEMBER HENNESSEY: I'll be glad to speak to this.

This was another measure that came to my attention after our TEP review had already occurred.

The reason why we were interested in this when we had a discussion, but did not vote on it was because of the comorbidities, the behavioral health comorbidities that are often associated with this medical condition, meaning Parkinson's disease.

And, that includes not only depression and anxiety but sometimes impulse control disorders and sometimes even psychosis. And sometimes these may be a reaction to certain kinds of medications side effects but it can also be a component of the actual neurological condition.

And, this is used by -- this is a PQRS physician quality rating system measure.

So, did want to bring it to the group's attention, particularly since we're focusing on integration of physical with mental health.

CO-CHAIR MOORE: Bill?

CO-CHAIR GOLDEN: So, one concern is in terms of priority if this is predominantly a Medicare disease. I'm not sure there are many patients with this disorder in Medicaid.

And, while we might be covering their hospitalizations as a dual, I'm not sure we would be getting the information as from the Medicaid side for their outpatient work.

CO-CHAIR MOORE: I didn't see who was first, Judy or Deborah, so you guys can fight it out.

MEMBER ZERZAN: I agree.

I also noticed that this is in nursing home care settings. And so, I'm not sure that it really fits in this measure set.

I think a lot of as hospitalists have come around SNFs have come around and I think that this is really a small -- a super small number. So, I don't think it's appropriate for inclusion.

CO-CHAIR MOORE: Deborah?

So, is that a motion? Judy, is that a motion?

MEMBER ZERZAN: Yes, it is.

CO-CHAIR MOORE: Oh, this isn't a removal?

MEMBER ZERZAN: But, this isn't a removal. I think this is just like dually included. So, I think do nothing.

CO-CHAIR MOORE: Okay. Any comments

on the phone?

David?

MEMBER KELLEY: Quick question. Is this -- how is this gathered? It says administrative. Is it EHR? I don't know how you would get this from a claim, so it must be either chart review or EHR only. I'm not sure how you -- and the numerator, how do you gather that from, I don't know, an ICD-10 claim for somebody with Parkinson's? I'm just -- anyone know?

MEMBER ZERZAN: It says, claims, administrative, EHR, registry as the data sources. So, I agree, it would be hard, especially the care setting is nursing home SNF and so, yes, it would be hard, I think. It does say other, but other doesn't include home or -- yes.

CO-CHAIR MOORE: Are we ready to vote?

MS. BUCHANAN: So, this is Measure Number 104 in your discussion guides, it's Parkinson's Disease Psychiatric Symptoms Assessment for Patients with Parkinson's Disease.

For our first vote, to what extent does this measure or measure concept address the CMS quality measurement domains and/or program area key concepts?

For high, please select one; medium, please select two; or low, select three.

Polling is now open.

And, Alvia, if you don't mind, just say your vote?

MEMBER SIDDIQI: Sure, Alvia, two.

MS. BUCHANAN: Thank you.

Andrea, can you go ahead and cast your vote via the chat?

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

Moving on to the next vote, to what extent will this measure or measure concept address an opportunity for improvement and/or significant variation in care?

For high, select one; medium, select two; or low, please select three.

Voting is now open.

MEMBER SIDDIQI: Alvia, three.

MS. BUCHANAN: Thank you, Alvia.

So, guys, we're going to scratch these voting clickers. They're not doing it for us.

So, we are going to be moving forward on hand votes so that we can speed this along.

So, everyone who's on the phone, we did receive your vote on this. So, we will count that. But, are going to ask everyone to raise their hands super high for the rest of it.

MS. KUWAHARA: So, again, we are asking to what extent this measure or measure concept address an opportunity for improvement and/or significant variation in care?

For high, please raise your hand.

CO-CHAIR MOORE: It shows that four committed yet.

MS. KUWAHARA: For medium, please raise your hand.

And, for low, please raise your hand.

All right, we're missing one vote.

MS. MURPHY: We have a quorum. Okay, we're going to move forward.

So, the results are 4 for high, 11 for medium, 5 for low. That gives us greater than 60 percent approval. So, we'll move on to the next one.

MS. KUWAHARA: So, our next vote, to what extent does this measure or measure concept demonstrate efficient use of resources and/or contribute to alignment?

Please raise your hand for high.

MS. BUCHANAN: And, people on the phone, if you can just type in your responses, one for high, two for medium, three for low. And, Alvia, if you don't mind saying yours aloud.

MEMBER SIDDIQI: Sure, Alvia, three.

MS. BUCHANAN: Thank you.

MS. KUWAHARA: Medium, please raise your hand.

And low.

MS. MURPHY: Thirteen members selected low, 7 members selected medium, so this measure

fails and will not be recommended for inclusion in the PMH measure set. Zero votes for high.

MS. BUCHANAN: Okay, so, we will be moving on then.

So, the TEPs recommended six measures from other program areas for consideration and you'll notice on this list that some of those look very familiar which means we will not have to go through them as extensively as we would like to or, I'm sorry, as we need to.

So, the first one is Adult Access and this is one that we've reviewed before.

The BCN TEP passed this. The -- sorry, CC passed this for BCN.

For SUD, the Coordinating Committee decided that they will just reconsider it at the end if we wanted to include it.

I want to take a pulse check and see if that's what they want to do for PHM as well is to, at the end, say if they want to plop it in.

So, it looks like I don't see any disagreement, so then, we can move on.

And so, the next one is also one that people have assessed before and, if you want to look on your discussion guide to refresh your memory, it's Number 74, it's Clinical Risk Score.

And, the Coordinating Committee reviewed this for BCN. They failed it on the first criteria.

And, the first criteria as we now are very familiar, is that it's to what extent does this measure, measure concept address a critical quality objective of the CMS quality measurement domain or any of the key concepts?

And so, the Coordinating Committee thought it didn't do so for BCN. And so, wanted to ask if they wanted to vote with regards to this measure on PMH?

So, is that a yes or a no?

MEMBER WALLACE: My recollection yesterday was that there was almost no information available on this measure. And so, that was why we couldn't put it forward.

I would expect that if we vote on it,

that it'll have the same outcome for this group.

MS. BUCHANAN: Okay, so the Coordinating Committee is deciding not to vote on Clinical Risk Score.

Okay, so that moves us on to 106 which is the Clinical Risk Score, nope, 106, which is Referral to Community-Based Health Resources.

And, I believe this is one that was also looked at and it was failed by the CC on the first criteria, again, with regards to beneficial complex care needs.

As we may recall, this has very little information which is why the Coordinating Committee, I think, did not pass it.

But, did want to check in with people and see if they wanted to vote for it for PMH.

MEMBER WALLACE: Anyone want to save it?

CO-CHAIR MOORE: I don't.

MEMBER HAMBLIN: And so, this is Allison.

I don't want to save it, but I think

it would be good for the report to reflect that this concept is really important for future development of better SNF measures for inclusion.

MS. BUCHANAN: Thank you.

MEMBER SIDDIQI: I agree. This is Alvia.

But, I think given this specific topic that we're looking at with behavioral and physical integration, I think this may have relevance. So, maybe if we could go ahead and vote on it, I think it would be helpful to include that in the report.

MS. BUCHANAN: Okay. So, meaning that people do want to vote on this. Okay, so we're going to do a hand vote because we're not doing clickers right now.

And, I'll turn it over to Miranda.

CO-CHAIR MOORE: So, should we give -- do you have notes to refresh everyone's memory on the discussion on this? Because we did vote on this yesterday.

MS. BUCHANAN: So, the discussion on

Measure 106, and it's Referral to Community-Based Health Resources, and the issue was that the denominator specification was a problem. It was not specific enough to kind of encourage or be able to accurately measure improvement.

And, if we pull it up, we can see that the nominator states population by ZIP Code, by gender, et cetera.

So, people felt that was just -- lacked specificity.

CO-CHAIR GOLDEN: So, can I ask if -- this is almost like a reconsideration. So, can I ask if we want to do this again? Why? What's the rationale for doing it a second time? You're saying you want to vote on it again?

MS. GORHAM: So, Alvia just made a comment that this measure is more suitable for PMH versus BCM when we originally discussed it.

This measure was originally at the TEP meeting discussed at the -- during the LTSS breakout. LTSS referred it to BNC and PMH.

You reviewed it yesterday for BCN and,

for those reasons that Kate just mentioned, failed the measure.

But, Alvia would like to discuss it for PMH for the reasons that she stated.

MEMBER HENNESSEY: Could you also clarify for me, please, is this -- this measure had an overall measure score of .75, so I thought it didn't meet the threshold score.

MS. BUCHANAN: So, that is correct, but it was referral from a different TEP.

MEMBER HENNESSEY: Thank you.

MS. BUCHANAN: And so, it didn't -- yes.

MEMBER HENNESSEY: Thank you for the clarification.

MEMBER ZERZAN: So, I think with Allison --

MEMBER SIDDIQI: So, the specificity with regard to who these community-based health resources are, I don't think there's any specificity there to behavioral health.

So, even aside from the measurement

issues and the denominator issues, there's a specificity issue.

So, I wouldn't think we would want to be re-voting on this one.

MEMBER ZERZAN: Yes, I was just going to say that, while I agree with Allison, this is an important measure that I wish was better.

I think this measure will still be voted down because there's not enough information and I think it would particularly fail is this measure ready for immediate use.

And, I would say no because it's -- the data source in one place says EHR but then further down says charts and paper record and EHR.

And so, I'm not totally sure and tracking this is really --

MEMBER SIDDIQI: This is Alvia.

And, I agree now that I'm looking specifically at the denominator and numerator. It definitely needs further refinement.

But, I do think, you know, at some

point, if it -- goes with health conditions and denominator with a specific target of, you know, somewhere about where we would want to see this type of work occur, it would be helpful.

Especially as EHRs are now moving to integrate, you know, social determinate health barriers and referrals to community resources and their EMRs as part of meaningful use and the future of meaningful use.

So, I side with not voting on it, I would just hope that our comments could reflect the need for further refinement of this measure and the support for the concepts behind it.

CO-CHAIR MOORE: And, I would like to propose a procedural agreement on -- so, if we have measures that we have voted on yesterday to have removed, why don't we do like a motion and have someone second it if they want to re-vote and then we can move this a little bit faster.

MS. BUCHANAN: That sounds great.

CO-CHAIR MOORE: Allison?

MEMBER SIDDIQI: And, I'll remove my

motion to vote on it today.

MEMBER HAMBLIN: Just one suggestion --

MEMBER SIDDIQI: And remove the comment to reflect the context of support, that'd be great.

MS. BUCHANAN: All right, thank you.

MEMBER HAMBLIN: In terms of a place to look for measures in this area in the future, I would think that the CMMI Accountable Communities for Health given that this is a big focus in that work might be a place to identify measures in the future.

MS. BUCHANAN: Okay, thank you.

MEMBER MOHANTY: This is Sarita.

Just following up on all of your comments and is there going to be an ability to include some comments on this? Are we --

MS. BUCHANAN: Yes, so we --

MEMBER MOHANTY: -- how will those be --

MS. BUCHANAN: We had discussed this

yesterday. For each of the measures, they're taking comments, both those that are -- and concepts -- those that are voted as a recommendation and those that are not and CMS will get all of that information.

So, yes, thank you.

MS. BUCHANAN: Okay, so I think we're ready to -- oh --

MEMBER PHELAN: I just want to add a comment on the substance abuse disorder, how this could tie in because referral community-based resources also can be for substance abuse -- substance use disorders as well and I want that to be reflected.

Because I think this is a critical area that is not well measured, not well studied. And, especially from an emergency medicine perspective, I am always trying to find the resources, either through my social work or through my own contacts like where people can get those kind of --

Because, a lot of times, the health

networks that you're involved in just do not have the resources to do it, but some of the community-based resources do have.

And, so I just want that, again, to reflect that it crosses multiple different categories here.

CO-CHAIR MOORE: Okay, thank you for that.

MS. BUCHANAN: So, are we ready? Okay, great.

So, the next measure we have that was recommended by another TEP is Number 72 in your discussion guide, so that will be scrolling back up.

And, it is Adherence to Anti-psychotics for Individuals with Schizophrenia. And so, once again, Number 72 on the discussion guide.

As you can see, this measure does not have a numerator or denominator in it. It does -- the description is a RAND Section 2701 ACA-proposed measure, percentage of patients with a

schizophrenia diagnosis who received an anti-psychotic medication that had a proportion of days covered for anti-psychotic medication during the measurement period.

CO-CHAIR MOORE: So, if it's a proportion, there has to be a numerator and denominator.

CO-CHAIR GOLDEN: So, I have a question. If I'm not mistaken, isn't this already in a core measure set? So, somewhere it's being used or something like it is being used. So, I'm a little puzzled by that.

(Off microphone.)

MS. BUCHANAN: So --

(Off microphone.)

CO-CHAIR GOLDEN: Okay, but I know I'm -- we're using something like this, so that's why I'm kind of puzzled.

MS. GORHAM: It's not in the core set, though. The measure in the core set is Use of Multiple Concurrent Anti-Psychotics in Children and Adolescents.

CO-CHAIR MOORE: Maureen, can you turn on your microphone?

MEMBER HENNESSEY: I see this here in the measure description and the specifications say NQF Number N/A. But, then, on here, my discussion guide, I've got NQF Number 1879, Adherence to Anti-Psychotic Medications for Individuals with Schizophrenia as a HEDIS measure.

So, are we talking about two different measures here? If you could clarify please?

MS. BUCHANAN: So, that's a great question. I know this was referred to by the LTSS TEP and I wasn't -- and so it looks -- this looks to be a RAND developed measure, but wasn't exactly sure.

MEMBER HENNESSEY: Yes, we've actually got another measure, I believe that was approved by the TEP that's called NQF 1879, Adherence to Anti-Psychotic Medications for Individuals with Schizophrenia, and that is a HEDIS measure in the health plan measure set and it is a measure for

individuals who are served by Medicaid.

So, I'm wondering if there may be some --

MS. GORHAM: So, let me -- I looked at the child core set, I apologize.

So, in the adult core set, Adherence to Anti-Psychotics for Individuals with Schizophrenia is actually an NQF-endorsed Measure Number 1879, but it is a CMS measure and not a RAND measure.

So, I'm wondering whether the information for this in the discussion guide isn't correct.

MEMBER PHELAN: Let's just pay someone, I think the RAND was the initial -- yes, at CMS pays people, so it may have been RAND that was paid to develop this measure, CMS didn't develop the measure because it sounds too similar, I think they're the same.

CO-CHAIR MOORE: Maybe what CMS asked RAND to do is to look at its applicability to the ACA components. No? Okay.

MS. GORHAM: We're trying to pull it up in all of this right now.

CO-CHAIR MOORE: Deborah, I'm sorry.

MEMBER KILSTEIN: Given that the HEDIS measure on this has already been accepted, we need a motion not to accept this one?

MS. BUCHANAN: What is the process for that? Is there -- do we vote or --

CO-CHAIR MOORE: So, what it appears is that this measure was referred by TEP but did not have the NQF measure number attached to it.

MS. BUCHANAN: The PMH TEP did review NQF Number 1879, which is Adherence to Anti-Psychotics with Individuals with Schizophrenia and did recommend it.

So, it appears that there was just a confusion. This measure should not have been reconsidered. It was referred without the NQF number which is what led to the confusion.

CO-CHAIR MOORE: So, it's not a separate measure?

MS. BUCHANAN: It looks to be not a

separate measure so it looks to be that we can just skip this one.

CO-CHAIR MOORE: Okay.

MS. BUCHANAN: Because it's already included.

CO-CHAIR MOORE: All right, so is everyone comfortable with that? Okay.

CO-CHAIR GOLDEN: So, it's a fake measure.

MS. BUCHANAN: Okay, so thank you for bearing with us on that.

So, the next one we are going to go to is on Number 89 on your discussion guide and it is NQF Number 1922, HBIPS-1, Admission Screening for Violence Risk, Substance Use, Psychological Trauma and History in Patient Strengths Completed.

And so, if we look at this measure which I'm pulling up --

CO-CHAIR MOORE: Could you just mention what number?

MS. BUCHANAN: This is Number 89.

And so, the description of this measure is the proportion of patients admitted to a hospital-based inpatient psychiatric setting who are screened within the first three days of hospitalization for all of the following, risk of violence to self or others, substance abuse, psychological trauma history and patient strengths.

And, the denominator is psychiatric inpatient discharges. The numerator is psychiatric inpatients with admission screening within the first three days of admissions for all of the following which is the risk of violence, substance abuse, psychological trauma.

And, the data set is EHR and paper records. It is a joint commission measure and it does not appear right now to be used in any related programs, but people around the table may have some additional information.

CO-CHAIR MOORE: But is NQF-endorsed?

MS. BUCHANAN: It is NQF-endorsed.

CO-CHAIR GOLDEN: So, just a question

for you. You say it's EHR only, so it has -- are you saying that it has e-specs or is it just something --

Because it's like -- it's almost like a check box here as opposed to a narrative. That's what I'm trying to understand.

CO-CHAIR MOORE: But, what I'm reading on the guidance documents, it says EHR only but then paper records and you scroll down and it says paper record, medical record, EHR, pharmacy, laboratory, registry and pharmacy.

So, I'm not sure that it's just EHR only. Maybe there's an option for that.

MS. KUWAHARA: So, just to provide some clarification, when it says EHR only, that means it's not designated as a hybrid measure.

CO-CHAIR MOORE: Got it.

MEMBER ZERZAN: So, it looks like that this has a current rate of 89.7 percent which is pretty darn good. And, if it's a JCO measure, my guess is that it's probably happening already.

And, as we had a sidebar, we're like,

if you don't do this, this is like malpractice. Like, really? What psychiatry unit is not going to do this?

So, I guess I would -- even though this is all important clinical stuff that should be done, it seems like there's not a gap here.

CO-CHAIR MOORE: But, I think we're being charged --

MEMBER SIDDIQI: This is Alvia.

And, I would try to look it up online as well and it looks like, you know, these are pretty much things that are already done on intake, except for the patient strengths piece, which I'm a little confused about. I'm trying to get a better understanding of what that includes.

But, I haven't been able to find anything in terms of where it's being used as an actual measure as opposed to what's already done on a straightforward intake screen at a psychiatric hospitalization.

CO-CHAIR MOORE: Yes.

MEMBER PHELAN: So, just reading the

evidence here in the evidence link, it says that there's been an improvement since the rate has gone up and there's about a 10 percent gap still. Is that still merit continuation? I know it's an important part.

MEMBER ZERZAN: If I had anything that was measured at 90 percent in Medicaid, I would feel fantastic.

(LAUGHTER)

MEMBER SCHIFF: This is Jeff.

I just want to ask, you know, if our purpose is to put forward a set of measures that states can pick as they want to, if there's a state where this is a lower rate or where they want to emphasize the need for parts of this because it really would be a composite where you'd probably get individual parts of the measure, I would advocate for it thinking that it would still be worth including.

CO-CHAIR MOORE: Barbara?

MEMBER MCCANN: Yes, having worked at the Commission for nine years of the Joint, as we

like to call it, you know, the measures that are being removed now are actually at 98, 99 percent.

This is an acute care hospital. So, I'm speaking in support of it as, I know it's incredibly high compared to Medicaid, but this is not typically high enough as to when we tend to take measures out.

MEMBER WALLACE: I would just want to echo that, the fact that it's moved, you know, that we've seen a significant improvement in performance and there's at least, I don't know if there's any indication of where it's, you know, the curve flattens. I'm not really sure if we have that level of detail available.

But, to me, that says it's a sensitive measure that can drive practice and it's a pretty powerful argument.

CO-CHAIR MOORE: I think the charge of this Committee is not -- we started when we try to launch this, then just today and yesterday, but we wanted to start with looking at gaps and we were re-directed that that's not the intention

of this Committee.

So, what we're doing is we're looking at these measures and asking ourselves, can they be applied to the Medicaid population? And, can we recommend them for consideration in this space?

Not whether or not if it fills a gap, although we instinctively go in that direction. So, I just want to round us back around the scope of work.

So, are we charged with a vote?

MS. KUWAHARA: All right, we're going to do another round of hand votes.

This is Measure Number 89 in your discussion guides, NQF Number 1922, HBIPS-1, Admission Screening for Violence Risk, Substance Use, Psychological Trauma and History in Patient Strengths Completed.

We are at vote number one, to what extent does this measure or measure concept address the CMS quality measurement domains and/or program area key concepts?

For high, please raise your hand.

MS. BUCHANAN: And, for people on the phone, please type in your vote. Thank you.

MS. KUWAHARA: For medium, please raise your hand.

(LAUGHTER)

MS. KUWAHARA: For low, please raise your hand.

I'm sorry, 16 members voted high, 4 voted medium and 1 voted low.

So, for our next question, to what extent will this measure or measure concept address an opportunity for improvement and/or significant variation in care?

Those who vote high, please raise your hand.

MS. BUCHANAN: And, once again, everyone on the phone, please type in your answers. Thank you.

MS. KUWAHARA: Medium, please raise your hand.

And low.

Six members voted high, 10 members voted medium and 5 voted low.

For our next question, to what extent does this measure or measure concept demonstrate efficient use of resources and/or contribute to alignment?

For high, please raise your hand.

Medium, please raise your hand.

And, low.

Two members voted high, 14 members voted medium and 5 members voted low.

For our next question, to what extent do you think this measure or measure concept is ready for immediate use?

I'm sorry, this is an NQF-endorsed measure, so we will be skipping this.

To what extent do you think this measure is important to state Medicaid agencies and other key stakeholders?

For high, please raise your hand.

Medium.

And, low.

Six members voted high, 9 members voted medium and 4 members voted low. This measure will be recommended for inclusion in the PMH measure set.

MS. BUCHANAN: Great, so as you can see on our next measure, we are -- this is NQF Number 1888 which is Number 88 on your discussion guide, which feels very fitting.

And, this -- and so, this is Number 88 in our discussion guide, NQF 1888, Workforce Development Measure Derived from the Workforce Development Domain of C-CAT.

As you all remember, we discussed this yesterday and we voted with regards to the benefit of the complex care needs.

The Coordinating Committee voted it down on the opportunity for improvement criteria. And so, opening it up, if people want to vote on it again for PMH or not.

CO-CHAIR MOORE: And, if you want to make a motion to re-vote, speak now or we will hold the vote from yesterday.

Anyone on the phone?

Hearing no opposition, we shall move on.

MS. BUCHANAN: Wonderful, thank you.

And so, as you can see here, we have -- so the reconsidered measures, we were also -- we -- there was one that we did not originally include that we are put in a handout, so there will be three reconsidered measures.

And so, wanted to start with the first two, though. And, the first one is NQF Number 2602, Controlling High Blood Pressure for People with Serious Mental Illness. This is Number 97 on your discussion guide.

And, as you can see here, the description is the percentage of patients 18 to 85 with serious mental illness who have a diagnosis of hypertension whose blood pressure was adequately controlled with the measurement year.

And so, I'll provide -- before we open up for discussion, a little bit as to why the TEP

chose not to include this one.

And so, the TEP expressed concern that to create this numerator in the measure an NCO must look at claims, EHR and paper records and that if an entity chooses not to look at one of these data collection processes, that they may get a lower score as a result of not maximizing the data.

The TEP also felt the definition of serious mental illness was too narrow. It included at least one acute inpatient visit or two outpatient visits for schizophrenia or Bipolar I disorder or at least one inpatient visit for major depression during the measurement year and a diagnosis of hypertension.

So, they failed the measure on the efficient use of resources criteria.

And, this measure was retained by Cheryl Powell.

MEMBER POWELL: Yes, so, I actually -- I took all of the measures that we had and I shared them with the Truven team, so a lot of the

background and wealth of information that we have across mental health and behavioral health and we really focused on this one partly just the importance of the physical health issues related to individuals with mental health often ignored and to a great cost for individuals.

And, given that the category is integration of physical and mental health, we really thought most of the measures focused on one or the other.

And, this one was more of an actual integration across the two of them which we really liked.

So, that was why we asked for it to be reconsidered.

MEMBER SIDDIQI: And, this is Alvia.

I was just going to add that there's definitely a significant gap here in variation in terms of, you know, when we prioritize these conditions, often times, the blood pressure is not being adequately managed and addressed.

And, I would say even for patients

that don't have BHA comorbidities, that this is something that folks struggle with.

But, what we've done as well as create a great registry around this, and so, as you see in the measure specifications, the data source can be claimed, but you do need to often times look at, you know, a registry as well if you're going to look at, you know, whether or not the blood pressure recorded accurately reflects, you know, what the blood pressure is for the patient.

But, I do think it is -- there is an ongoing gap here and I agree that this would make sense in this specific domain.

CO-CHAIR MOORE: So, again, I want to remind us that we're not looking at gaps, we're looking at whether or not this measure can be used in the Medicaid population.

And, before I start calling on people in the room, we are going to reinstate the three minute rule to keep us moving.

So, Maureen?

MEMBER HENNESSEY: Yes, I would just

briefly say that the TEP certainly thought that it represented integration of physical with behavioral health.

Their concern was that it includes paper record and there was a strong lean on the part of all the members towards electronic data collection.

CO-CHAIR MOORE: Okay, thank you.

Karen?

MEMBER AMSTUTZ: So, I just wanted to say that I think the concept, you know, we had this conversation about OUD with it not being -- being an imperfect measure, but being actually one step along the pathway.

And, I think this is important from that perspective.

CO-CHAIR MOORE: Great.

John?

MEMBER SHAW: Just a technical note and this is a note for staff, for any measure that says major depression, there should be a technical note for use to CMS that indicates that

there is significant coding differences between ICD-9 AND ICD-10.

So, you can't use the two together. You can't have a benchmark from 9 and apply it to 10. You can't have a time period that spans both 9 and 10. It has to be one or the other.

CO-CHAIR MOORE: Yes, again, I think that goes back to --

MEMBER SHAW: There was something yesterday we --

CO-CHAIR MOORE: -- you know, the response to have a date and to be able to look at this chronologically.

David and then Bill. And, just to let everyone know, we have about one more minute left for discussion. And, I'll hold everyone to it so you've got about 15 seconds.

MEMBER KELLEY: I think the measure is important. Health plans already measure blood pressure on huge numbers of individuals without behavioral health conditions. I think it's a poor excuse not to make this a measure.

I think it's vitally important. These individuals die at a much younger age. They have the high frequency of this comorbidity. I think it's essential.

CO-CHAIR MOORE: Okay, thank you.

Bill?

CO-CHAIR GOLDEN: Yes --

CO-CHAIR MOORE: Or, I mean, Katherine?

CO-CHAIR GOLDEN: So, this is a note to CMS and the NQF. I have deep concerns about many of the depression measures because the title and the description talks about major depression and, very often, it includes depression NOS which is not depression. So, it is not a good measure and I --

It's one of those things that drives me crazy as a measure user that depression NOS is not depression, not MDD, and that's a significant problem with our measurement system.

CO-CHAIR MOORE: Thank you.

Maureen?

MEMBER HENNESSEY: I was just agreeing with that and it's another reason why we have concern about efficiency of the measure as well.

CO-CHAIR MOORE: Okay, great.

Anyone on the phone?

All right, no one else in the room.

MS. BUCHANAN: All right, we'll be taking another -- since these are reconsidered measures, as of our process yesterday, we're going to vote whether or not to include it or to not include it in the measurement section, so we need someone to first to vote to include and someone to second and then we'll do a vote aye or nay.

CO-CHAIR GOLDEN: I'll vote.

MS. BUCHANAN: Okay, anyone second?

All right, and so, we have Michael voting and David seconding.

And so, this measure is -- the vote is to include NQF 2602, Controlling High Blood Pressure for People with Serious Mental Illness into the PMH measure set.

So, if you want to include it, it's -- please raise your hand for yes or type yes in.

MS. KUWAHARA: And so, we're just waiting on one more phone one.

MS. BUCHANAN: So, we have three for yes.

MS. KUWAHARA: And no, please raise your hand.

Okay, 17 voted yes, 3 voted no. This measure will be recommended for inclusion in the PMH measure set.

MS. BUCHANAN: Wonderful, thank you so much.

So, moving on to the next retained measure and this is Number 85 on your discussion guide.

And, this is NQF 0710, Depression Readmission at 12 Months.

And, I want to go through, but prior to discussion, some of the reasons the TEP voted not to include this measure.

And so, the TEP said that, in their

experience, an organization will do a PHQ twice a year but the organization often does not do anything with the score to reduce readmissions in the population.

So, it does not translate into systems or outcome change.

One of the members of the TEP actually mentioned that's why his state does not use this measure.

They were also concerned about the measure reliance on paper records. Overall, they decided not to pass the measure based on an efficient use of resources criteria.

They encouraged initiatives to look at electronic development to capture data with regard to not only screening for depression but using a standardized instrument such as the PHQ-9, but also the monitoring for depression in terms of readmission.

And, I believe this was retained by David Kelley.

MEMBER KELLEY: So, again, this is --

I consider this to be an outcome metric where you're actually looking, as I understand the metric, where you're really looking at, here is depression at baseline and then, X months later.

And, it really allows you, from a population standpoint to have an understanding of how effectively depression is being treated. And, depression is very common in the Medicaid population, probably under treated and under assessed.

So, I just felt that this would be a reasonable measure to consider and to offer up.

I do understand that I think there are administrative issues with anything that requires something like PH-9 being done twice, but, again, I think as we look at outcomes and think in terms in away -- sometimes to get outcomes to actually dive deeper.

And, it is administratively more burdensome, but, in my mind, that benefit outweighs the cost and the burden to the providers.

CO-CHAIR MOORE: Maureen?

MEMBER HENNESSEY: Yes, I think that it might also be helpful to elaborate a little bit more on the discussion that the TEP had regarding this measure.

There is another measure that was approved by the TEP that I'd like to make sure everyone is aware of and that factored into our decision which is to say there is a first-year measure in HEDIS that has been approved by NCQA and is now being used by health plans.

It is a first-year measure, so therefore, I guess it would be considered a concept.

But, it is a HEDIS NCQA measure. And, in that measure, it is an -- it uses the PHQ-9 but it is an eMeasure, so it's an electronic measure.

Also, it looks at not only remission, but also response. So, it has more subtlety in terms of gradation and it also starts with age 12.

So, the Committee, when they looked at this measure, was aware of the other measure and which is called Depression Remission or Response for Adolescents and Adults. And, in that context, really looked at this measure through the concerns that were identified.

CO-CHAIR MOORE: That's really helpful, thank you for adding that. We have some --

MEMBER ZERZAN: So, that's number --

CO-CHAIR MOORE: -- I'm sorry.

MEMBER ZERZAN: So that's -- I just have a question, that's Number 76. It's rated way lower --

CO-CHAIR MOORE: There's someone on the phone who's waiting --

MEMBER ZERZAN: Okay.

CO-CHAIR MOORE: -- that was before you.

MEMBER ZERZAN: It's way lower than the other one so, I'm just --

CO-CHAIR MOORE: Okay, can we go to

the person on the phone and then we'll go to you. Thank you.

MEMBER SIDDIQI: So, this is Alvia.

I just wanted to explain that we're actually using this measure and this is a measure where CMS and the MMSP programs around ACOs as well as, you know, obviously the future with MIPs.

This is one of the measures that's part of that CMS core set. And so, it is a measure that most systems are not necessarily doing very well in. It does require a lot of work and effort.

But, we've created a registry around this. We are doing specific education around this. We are improving behavioral health and physical, you know, integration around this to try and really support the measure.

So, it is certainly doable. I agree with the comments earlier that sometimes the measure specifications may need revision, but I certainly wanted to explain that the measure is

being very widely used and it is a measure that does have good use in programs around Medicaid.

CO-CHAIR MOORE: All right, thank you.

Okay, Judy?

MEMBER ZERZAN: So, I'm confused. The one that -- this one, which I agree is widely used, Number 85 has a pretty high overall measure score. But, the one that was included, which is Number 76, has a very low measure score.

And so, I don't quite understand why that would be the case and I was hoping, Maureen, you could maybe talk about it or maybe there was some confusion on the part of the Committee about which one this was.

MS. BUCHANAN: Hi, Judy, this is Kate, I'm happy to take this one.

So, for the -- as Maureen mentioned, the depression readmission or response for adolescents and adults, it's a first-year HEDIS measure which is why it ranked low because we just didn't have a lot of information yet.

MEMBER ZERZAN: Got it.

MS. BUCHANAN: But, the TEP voted to include it because it's an outcome measure that extends beyond screening and looks at an individual's response to treatment. So, they liked that aspect of it.

The reason it did score lower is due to its first year in use.

CO-CHAIR MOORE: Okay, we're starting to run out of time, but Deborah?

MEMBER KILSTEIN: Yes, again, I would just question the efficiency of adding another measure that's very similar to a HEDIS measure that, at least from a plan perspective, they're already going to have to report now. So, if they're NCQA accredited, it just seemed to be inefficient to have two measures that are very similar.

CO-CHAIR MOORE: Okay, great.

Maureen, did you want to make one more comment before we --

MEMBER HENNESSEY: I would just say that was a factor in our review process, thank

you.

And, this measure, by the way, this is the Minnesota Community Measurement organization for 76. I believe that's also an endorsed measure or maybe it's not in the eMeasure component that's endorsed, but the paper has been endorsed in the past.

CO-CHAIR MOORE: Okay, thank you.

MEMBER HENNESSEY: Thank you.

CO-CHAIR MOORE: To keep things moving along, does anyone have anything to add or questions that hasn't already been expressed?

MEMBER KELLEY: Just a quick question. So, the HEDIS measure can be an EHR measure as well as a paper measure?

MEMBER HENNESSEY: It is an electronic measure. It is an eMeasure, yes. It's one of the -- one of, I think, two eMeasures that have been developed by NCQA addressing HEDIS. One addresses the use of the PHQ-9 as an electronic measure for screening.

And then, this measure actually looks

at whether or not --

And, they re-administered, I believe, it's in about four to five months and they're looking at whether or not there's been either remission or just a response to treatment using the PHQ-9 and it's electronically captured.

Thanks.

CO-CHAIR MOORE: Yes. So, David, your argument was that you would like to have a paper measure also?

MEMBER KELLEY: In the interim and I think to offer up both so that that option is available. And, I'm a huge proponent of eMetrics, but in the interim, my concern would be that a lot of folks would fall out because they're not able to electronically submit.

CO-CHAIR MOORE: Okay.

MEMBER SCHIFF: This is Jeff.

Just we use this measure in Minnesota in our ACO model.

CO-CHAIR MOORE: Okay, thank you.

MS. BUCHANAN: So, this is going to be

-- we're going to have someone have to do a motion to vote to include and then someone second.

MEMBER KELLEY: I'll move.

MEMBER SIDDIQI: This is Alvia.

I vote to include this measure.

CO-CHAIR GOLDEN: I'll second.

MEMBER KELLEY: I would second.

MS. BUCHANAN: Okay. And so, this is a vote to include NQF 0710, Depression Remission at 12 Months into the PMH measure set.

All those who would like to include either, either type yes into the chat box or please raise your hand.

CO-CHAIR GOLDEN: A procedural question.

MS. BUCHANAN: Yes?

CO-CHAIR GOLDEN: So, why aren't we going through the five steps?

MS. BUCHANAN: Because this is a retained one and we had talked yesterday about how the TEP had already gone through the decision

logic.

CO-CHAIR GOLDEN: Okay.

MS. BUCHANAN: So, if you would like to include it, please raise your hand or type yes into the chat box.

If you would like to vote no, either type no in the chat box or please raise your hand.

MS. KUWAHARA: Sixteen members voted to include this measure in the set and 5 members voted not to include this. So, this measure will be recommended for inclusion in the PMH measure set.

MS. BUCHANAN: And, just to add a little bit of context, some of the reasons that the members chose to include it was that it's widely reported right now. And, although there was a preference for eMeasures, they would like a paper measure in interim, giving people the option.

And so, we are now going to actually go for another measure for reconsideration which

was not on the slide set.

So, you all have received information on Behavioral Risk Assessment for Pregnant Women, BHRA.

So, I'll pull it up for people on the webinar. I want to give people an opportunity to review it and we will pull this up right now.

CO-CHAIR GOLDEN: Jennifer, are you ready for a comment?

CO-CHAIR MOORE: Is she going to read it first or --

MS. BUCHANAN: Yes, so I just want to, because it was included on here --

(Simultaneous speaking.)

MEMBER ZERZAN: Can our CMS colleagues confirm this is in the child core set? So then, anything that's in the core set, I think is reasonable to include.

CO-CHAIR MOORE: Okay, before we get into comments, we have to give her a chance to do an introduction.

(Off microphone.)

MEMBER GELZER: I'm sorry, we can't hear.

MEMBER SIDDIQI: No, we can't hear.

CO-CHAIR MOORE: I know, they're switching seats right now before they start up.

MS. BUCHANAN: Okay, so, there we are.

So, everyone on the call who's a member of the CC should have received this as an email as well.

And so, this is measure -- Behavioral Health Risk Assessment for Pregnant Women, BHRA. And, it is not an NQF-endorsed measure.

The description is, the percentage of patients, regardless of age, who gave birth during a 12-month period, seen at least once for prenatal care who received a behavioral health screening assessment that includes the following screenings at the first prenatal visit, screening for depression, alcohol use, tobacco use, drug use and intimate partner violence screening.

And so, this is a measure that the PMH TEP did review. So, one of the concerns and why

they voted it down was they voted it down on efficient use of resources.

They felt that the EHR didn't have the ability to capture a lot of the data that this measures. And so, they were concerned about the resources that it would use.

I will also say that it is, as we talked about in the Medicaid child core set, and that Sheryl Ryan was the one who retained this.

And so, it's -- I will open it up for discussion.

CO-CHAIR MOORE: So, Judy, did you want to start first?

MEMBER RYAN: Well, I asked to retain this one mainly because it addresses a really important population that we really don't have any other measures on.

We had no measures in our substance use TEP for pregnant and prenatal, post-natal women who are getting prenatal care or immediate post-natal.

So, I thought that was really

important.

Plus, we're also seeing really high rates now, increasing rates, of use of alcohol and other drugs among pregnant women, pregnant adolescents and so, I felt that this is really an important population that we really needed work on.

I know the ACOG has recommendations but we also know in the data that this is not being done consistently. So, and this is a way to hold people accountable for something that needs to be done.

Plus, it's a measure that's currently in use in part of the child core set. So, for those reasons, I wish we'd had in our SUD TEP because we probably would have voted for it. But, that's why I pulled it out to get it on there.

CO-CHAIR MOORE: Okay, thank you.

Bill?

CO-CHAIR GOLDEN: So, in theory, this is great. The downside everybody needs to be

aware of is that, some of the screening has become criminalized so that if you screen positive for drinking or drug use, you could lose your child, you could have -- it could potentially drive people not to go seek prenatal care.

So, nice thing to be preventative, on the other hand, we have some punitive aspects of how this would be applied.

CO-CHAIR MOORE: Maureen, did you have your --

MEMBER HENNESSEY: Only to note that one of the things that I get concerned about is that there's more screening sometimes for postpartum depression than there is for pre-partum which is a significant oversight.

And also, noting again, it is part of the Medicaid child core set.

CO-CHAIR MOORE: Thank you.

David?

MEMBER KELLEY: As I'm reading the spec, it looks like, you know, it's EHR but it

looks also like questions can be obtained either directly from the healthcare provider or in the form of a self-completed paper or computer administered questionnaires results should be documented in the medical record.

So, it sounds like if there's a -- the reason I'm asking this, is because we've developed a registry for this. Actually, we used CMS funds to do that in our Quality Grant.

So, I'm kind of pseudo interpreting this that it's EHR, but it could be registry as well. I'm just -- that's more of a question.

But, one comment, I do agree that even -- oh, I didn't read down far enough, good.

The other -- my other comment is that, even though we're doing something similar in postpartum, I agree, this is essential in prenatal care, that first visit to screen, especially for drug and alcohol.

We're seeing a lot of NAS babies and really screen and look for substance use to sort of prenatally is vitally important because then

you can get mom into treatment and you're treating two people.

CO-CHAIR MOORE: Okay, anyone on the phone?

MEMBER GELZER: Hi, this is Andrea, can you hear me?

CO-CHAIR MOORE: Yes.

MEMBER GELZER: So, this one just -- and it's just a gut, is this -- this is not NQF-endorsed, correct?

CO-CHAIR MOORE: Correct.

MEMBER GELZER: I think it's a great measure, but my concern here is, we're -- are we going to first be recommending incorporating this in a Medicaid population?

And, somehow, my gut is telling me, well it should also be for a commercial population and is this somehow suggesting that these issues, you know, that poor pregnant women should be screened because they're different than commercial women?

Obviously, we know that serious mental

illness is higher in a Medicaid population, but somehow, it's just -- it's rubbing my gut wrong that we should be including this here.

It's the right -- unless we recommend that this should also be included for commercial populations somehow.

CO-CHAIR MOORE: That's not our charge.

MS. GORHAM: So, I just wanted to provide a little bit of information.

So, as you all know, we just had our Medicaid Task Force meetings for the child and adult core sets. And, just because it has been brought up a couple of times, this measure is on the child core set.

However, the task force members recommended for removal to CMS this year. And, the states did not -- they are not reporting this measure widely. So, it is one of the lowest reported measures in the core set with only four states reporting.

So, just a matter of information since

it has been brought up.

CO-CHAIR GOLDEN: And also the punitive issue. I won't collect it because of the punitive.

CO-CHAIR MOORE: And that varies by state to state, you know, whether or not women are prosecuted, whether or not, you know, there's claims of child abuse for coming forward on that. And, that's actually a report that we're going to be releasing on June 22nd, but that is --

Maureen?

MEMBER HENNESSEY: The one other thing I would bring to the attention of this group is that part of this screen is partner violence screen and women are particularly vulnerable to partner violence including death by violence during pregnancy.

CO-CHAIR MOORE: Thank you.

And, Sheryl?

MEMBER RYAN: I also want to point out, it's alcohol as well as tobacco. So, you know, at the very least, we should be looking at

those two with people.

I have states, and this is very state specific about the criminality, if you've got a state that is a criminal venue, you just ask about alcohol and drugs and you say to the person, you shouldn't be using the other stuff.

But, you know, but at least we get those, you know, at least we would involve those two.

CO-CHAIR MOORE: And, we're not -- this is -- our vote is not a requirement, it's a recommendation to CMS.

Karen?

MS. LLANOS: I was just going to say, so, recommendations made to the child and adult core set still have to go through an internal review process. So, Shaconna's context, we should just take as factors because we don't know if it actually will get pulled out or not.

I will say, though, you might want to think about saying something like, if it's pulled out, then maybe this gets pulled out as well.

But, you would probably want to match with what we've got in our child and adult core sets.

CO-CHAIR MOORE: Okay, thank you.

One more comment, Maureen, before -- okay, great.

So, we need a -- anyone want to make a motion to keep this or add this I guess is the question?

MEMBER SCHIFF: This is Jeff.

I move to add it.

MEMBER SIDDIQI: And this is Alvia.

I second.

CO-CHAIR MOORE: And that's to add this measure to the --

MEMBER SCHIFF: Yes.

CO-CHAIR MOORE: -- list.

MS. BUCHANAN: Okay, so we have a motion and a second.

So, would the Coordinating Committee like to recommend measure -- Behavioral Health Risk Assessment for Pregnant Women, BHRA, into the PMH measure set?

Please either type yes or raise your hand right now to indicate you would like to include this.

MS. KUWAHARA: Eighteen members voted to include this measure in the PMH measure set, 2 members voted not to. So, this measure will be recommended for inclusion in the PMH measure set.

MS. BUCHANAN: And so, wanted to -- so, it looks like the Committee wanted to include this as they feel it's a really critical aspect of care.

And, I wasn't sure if there was anyone else who wanted to kind of provide any other additional rationale for its inclusion?

CO-CHAIR MOORE: Allison?

MEMBER HAMBLIN: I'm not sure if this goes as rationale, I just wanted to reflect from the Committee's perspective, Karen's comment about recommending alignment with how the core set inclusion plays out.

MEMBER SIDDIQI: This is Alvia.

And, I just wanted to make a comment

earlier as well that, what we've done in our system is also recognize that most women who are seeking and having prenatal care are not necessarily having all of these screenings done, especially around opioid use disorder in particular.

So, we've actually created a computer-based training module and included that as part of our clinical integration program to get providers to really understand and learn of the screening tools and really try and promote screening for this population.

And, this is a very vulnerable population, so I do think there's definitely a high need and applicability in Medicaid for sure.

CO-CHAIR MOORE: Thank you.

And, I want to do a time check. I know Maureen needs to leave in a few minutes.

MS. BUCHANAN: So, yes. So, yes, actually, this is great timing because, as you can see, well, in a second when we go through it, we are not going to be reviewing the related

tables as the Coordinating Committee discussed yesterday. We're going to recommend all of these measures to CMS and defer to their judgment on which ones they prefer or would like to include all of them.

I will note that these charts will be included in the appendices of the report. So, just wanted to move that.

And, that gives us a break in between all of this voting.

And, I think that we -- so we have a break lined up.

MS. GORHAM: So, can we go to opportunity to -- for public comment and then we'll grab our lunch and take a break.

But, let's do opportunity for public comment first.

MS. BUCHANAN: Operator, could you please open the lines?

Additionally, if you would like to type a comment into the chat box, staff will read it aloud and we will hold the commenting period

open for at least 20 seconds.

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

CO-CHAIR MOORE: John, I'm sorry.

MEMBER SHAW: Just a quick comment, if we're looking at all of these measures as a block, one thing that could be missing is notes for use. So, things like any of the measures with major depression should indicate the time frame between the two coding systems and what's the mechanism for us to have the Committee make comments pro and con for use.

Like, in the last measure, you may want to look at the overall spec, but be cognizant of reluctance of people to respond because of criminal justice issues.

CO-CHAIR MOORE: Thank you.

MS. BUCHANAN: And, it looks like there is someone in the public who has their hand raised. If you could please either hit star one or type your question into the chat box because

we see you, but don't know what you're asking yet.

OPERATOR: And, we do have a public comment from Junqing Lui for NQCA.

DR. LUI: Hey, good morning. This is Junqing Lui at NCQA. Could you hear me?

MS. BUCHANAN: Yes, we can.

DR. LUI: Great, thank you.

So, I just wanted to help to clarify the depression measure in HEDIS. If you already covered this, I apologize because the phone wasn't very clear on my end during the discussion.

So, the measure, outcome measure included in HEDIS is the depression remission or response at six months for adolescents and adults. So, that's different from the one on the screen that's remission at 12 months. I just wanted to help to clarify that.

Thank you.

MS. BUCHANAN: Thank you very much.

Are there any other public comments?

OPERATOR: There are no public comments from the phone lines.

MS. BUCHANAN: Okay, great. Thank you very much.

So, yes, now we're going to break for lunch.

MEMBER SIDDIQI: What time will we reconvene?

MS. GORHAM: All right, so, we're going to take a 15 minute break so we can reconvene at 12:00 and have a working lunch per our Chairs.

So, we'll take a break now and reconvene at noon.

MEMBER SIDDIQI: Thank you.

(Whereupon, the above-entitled matter went off the record at 11:45 a.m. and resumed at 12:06 p.m.)

CO-CHAIR GOLDEN: So, we are stopping the behavioral integration/physical health integration group. We are now going to do the LTSS group. And the good news is there isn't a

lot there, but we still have to get things done.

So, let me turn it over to Shaconna.

MS. GORHAM: Thank you.

So, actually, we are going to start -- we are now on Slide 120, and we're going to start with just the overview of the TEP meeting. So, I'm actually going to turn it over to Barbara McCann.

MEMBER McCANN: I want to begin with acknowledging the great folks that I got to work with and continue to know.

Diane McComb from Delmarva, which is probably one of the best QIO foundations that have supported home and community-based services.

Judit Olah from UC Health, Dr. Robert Schreiber from Hebrew SeniorLife, and the most wonderful patient I have ever worked with, Janice Tufte, who was actively engaged, receives HCBS services and is just a pleasure to work with.

Let me make a few opening comments. We had only 22 measures to review and we recommended six as measures, and seven -- an

extra one, excuse me, an additional one as a measure concept.

Let me go through the themes of these measures, because I think they're critical. There is an incredible lack of measures. And many of the measures that you look at are medical measures that are being adapted for people in LTSS and HCBS.

And where medical is, you know, presentation for a short period of time, acute, et cetera, this is life care and it's incredibly, incredibly different.

There is an absence of common language among the providers of LTSS. We can barely speak to each other without having to do hand signs, I think, to say about the information we're trying to exchange. So, total absence of common language in a process.

You know, it's almost embarrassing for me to say after 30 some years in the field, there are no standards of practice.

There are no standards of practice

from the psych nurse that sees someone in a trailer in Montana, to the special needs LPN that does hourly care for a child on a ventilator at home, certainly not for the aide or chore worker who keeps the 98-year-olds going in Century Village in Florida, let alone developmentally disabled and other disabled individuals who are seeking an active life. So, I'm sorry to say that they don't exist. They don't exist.

This is primarily a paper-documented process. If you said "EHR," you'd only get few responses. So, I guess I'd save a lot of time.

We are used to having to enter data into portals, and that is how health plans and others are working with us now.

Many people forget. So, let me bring this to your attention. The delivery of skilled services, which is defined by each state practice law, this becomes a big deal in these measures, is the data on OASIS is actually collected.

So, the once-a-time -- once-a-month cath change, the once-a-week or every-two-weeks

med admin box that has to be taken care of, is done by a registered nurse in a certified home health agency and OASIS is collected.

There is 16 years of OASIS data sitting somewhere on skilled Medicaid that has never been looked at, to my knowledge. Never been looked at.

The other process I'll just bring in, because I think it's also a challenge for us is, as we go forward, electronic visit verification is being introduced in a number of states. It's mandated across all states in 2020 if the 21st Century Cures Act gets regulations written to implement it.

There is no standardization in any aspect of what goes into the EVV across the country or state to state. So that, I just want to emphasize just in what bad shape we are.

Although, everybody makes their decisions about life and health that we've all talked about this morning at home, and we know nothing about what goes on. And that's just a

professional, personal remark. It's sad.

So, I -- I hope this is the spur to move, and move quickly, because the MCOs, the managed care organizations, are moving to value-based purchasing.

The states are moving to value-based purchasing and they turn around and assume that all the sophisticated measurement development that exists in other areas exists in home and community-based services, and it doesn't.

And so, when we say we're going to work on it, that's lovely, but too bad. We're creating it right now. I mean, that's how quickly it's going. So, a plead for more measures.

So, with that, we don't have very many to go through --

(Laughter.)

MEMBER MCCANN: -- in the process.

MS. GORHAM: All right. Next slide.

So, as Barbara said, we do not have a lot of measures, not only on our bloc, but also

as far as late submissions. We had no late submissions. We had no measures recommended from other program areas.

There was the measure NQF 1888 that the TEP members, during the April meeting, did not have an opportunity to discuss. And so, they wanted that referred to the CC, but we have already discussed that measure with BCN, and also with PMH.

So, unless there is a motion to discuss -- rediscuss and vote for LTSS, then I think we can move on.

(Pause.)

MS. GORHAM: Okay. So, hearing no motion, we'll move on.

There were two measures for reconsideration. So, again, these are measures that the TEP reviewed, but decided they were not suitable for the LTSS measure set. And so, I'll go through those.

The first one is NQF 0097, Measure of Medication Reconciliation. And just to refresh

your memory, this was considered yesterday for BCN. You all agreed with the recommendation for the BCN set, but let me tell you why the LTSS did not think that this measure was suitable.

So, while the TEP members thought this measure was critical, they recommended it for BCN and PMH, but did not think that the measure for the LTSS population really could apply this measure.

So, the LTSS populations could do this in niche, hot opportunities with contracts, but access to electronic outpatient records would be necessary. And often access to those records are not usual for the population.

The measure would be of greater value in the LTSS population if the medication was reconciled with what individuals had in their home, and that is not what this measure specifies.

So, with that, I'll turn it over to Karen and Susan who are lead discussants and recommended the measure for consideration.

MEMBER AMSTUTZ: This is Karen Amstutz, and I'll just go first. And having, you know, not had the advantage of thinking about this in the context of the complex population measure, I do want to say what I was thinking when I recommended this.

Many -- or some states are beginning to implement what they call LTSS programs, but they're fully integrated. And so, they're rolling in the entire constellation of covered benefits to managed care and asking them to manage across an entire continuum.

So, what was on my brain as I was reviewing this, was Virginia's, quote/unquote, LTSS managed care plans that they're, you know, the plan that they're moving, you know, that they're implementing, and that's a fully-integrated program. So, that's what was on their mind.

When we think specifically, though, about the introduction that was given and really thinking about managing just the LTSS benefit, I

can see, you know, sort of the perspective of why this would not apply given that it really is about managing the medical and pharmacy benefit, but wanted to just share that perspective.

I do think it is the single, probably most important contributor to community tenure in this population. And so, that was the other factor that played into my, sort of, recommendation that we add this back into the discussion.

MEMBER WALLACE: And I would echo a lot of those thoughts. My thought was the reason I wanted to make sure it was reconsidered, was that is just such an important concept to this population and something so critical to their safety in the home and their ability to stay in the home that I felt it was worth reconsideration.

There were, I think, three or four medication reconciliation measures that were on the original consideration list. This is the strongest of them. None of them made it to the

recommended list.

CO-CHAIR GOLDEN: So, a question since I'm -- you know the field better than I do. As we go toward we're playing around with trying to make this community part of accountable care, the notion of having all of these agencies having care plans on their patients, is there such a thing as centralized care plans, because you could see the care plan should have a reconciled med list.

And you can see that that could potentially be electronic, so here's my question: Does that exist or is that the notion of the care plan for these agencies, still a notion in development?

MEMBER MCCANN: A care plan does exist for, I would say, routinely for any individual who is receiving what's called "skilled care." So, the care of a nurse, a therapist, et cetera.

Once you get to personal care or what we call "chore services," you have a service plan. And in most Medicaid programs, an RN is

required to supervise once monthly.

And what I wanted to offer is that in the PMH measures that were given to us yesterday, there's actually what I think is a better medication reconciliation measure. And it actually reflects current practice in the home, and it only requires an RN. It doesn't require a doctor or an outpatient medical record.

And if I may, I'd just like to quickly refer to it. It's NQF 0419. And it's in the medical record. So, most of us think we have a medical record in at least those getting -- they're at the point where they need skilled services whether it's for catheter change or whatever else.

So, it's those that are 18 and older. So, it leaves out the many children we care for, but the eligible professional. So, that gives us the flexibility of who's in the home, which is greatly needed, to document current meds on them, prescriptions, over the counter and herbal, and vitamins and minerals, which includes what Dr. Oz

said last week and becomes a big issue for interaction, unfortunately.

So, it's -- we actually have the ability to do -- this is current practice in home health to do this range and to write it down. Now, it sits in the house, but at least it's been reconciled.

CO-CHAIR GOLDEN: Okay. So, again, two more questions for you --

MEMBER MCCANN: Yeah.

CO-CHAIR GOLDEN: -- just so I understand the universe --

MEMBER MCCANN: Please.

CO-CHAIR GOLDEN: -- that we're dealing with.

More of an aside, sometimes state nursing laws can do goofy things to --

MEMBER MCCANN: This is the state nursing law's impact who does this tremendously.

CO-CHAIR GOLDEN: Yeah. It's strange stuff, but that's for happy hour some other day.

The second question, though, is, in

this universe of care, so you say you have people getting home services like cleaning and cooking as opposed to more skilled, so you start getting into these kind of measures about med reconciliation.

Now, when we start looking at these measures, do we want people who are -- for all people getting any service whether it's cooking or meals, or just people with skilled services?

Because I'm just trying to look at who's looking at --

MEMBER MCCANN: Susan and I are looking at each other.

CO-CHAIR GOLDEN: I'm just kind of curious.

MEMBER MCCANN: I'm a medical social worker, but I'll vote for -- I don't know who's looking at it if they're getting chore services or personal care until there becomes a medical event.

CO-CHAIR GOLDEN: So, when you looked at these measures -- I'm just trying to get --

MEMBER MCCANN: Uh-huh.

CO-CHAIR GOLDEN: -- understand what you were dealing with. Did they subdivide the populations depending on what level of skill set or what kind of services they were receiving?

MEMBER MCCANN: No. There was no stratification based on populations. And several of the populations, there's nothing, developmentally disabled, special needs children.

You're trying to grab something and try to make it apply across populations.

MEMBER WALLACE: I think the struggle is that this -- so many -- so, home and community-based services are offered. They're not only fragmented on the national level, but, like, in the state of Ohio we have seven or eight different benefits.

MEMBER MCCANN: Uh-huh. Waivers.

MEMBER WALLACE: Or waivers. I mean, so it's a waivers, versus state plan, versus skilled care through Medicare. It's just -- so, even for any, you know, even within a state

trying to figure out a measure that would work across the board.

So, it's really -- I mean, what you're saying is we need to start somewhere. We need to grab, you know, grab something, see if it can work, you know. Make a recommendation, see if it can work, you know, that can be pulled into a few of those programs. And that will be, you know, some forward movement, but it's finding the most likely to adapt.

CO-CHAIR GOLDEN: Cheryl, you had a comment?

MEMBER POWELL: Yes. Looking at this from the perspective of a Medicaid program rather than looking at it from the perspective of the individuals providing care in the home under the Medicaid program, I think this is an incredibly important measure.

This is, you know, reconciliation for those individuals, the home and communities -- receiving home and community services. And I like both, because I think there's a need over

time. But I think a state and others looking at state programs would want to know this about the population being served in a home and community-based waiver services.

And it being able to measure that on the program level, by the waiver level, or however they would want to measure it would be an important quality indicator of the overall -- how the overall program is working for those individuals.

Especially given that they often have fewer direct interactions potentially with skilled -- with physicians or nurses and things, and maybe more having their care given to them or medications given to them by others who are -- who are not typically clinical.

So, the interaction between the clinical programs and the long-term services and support for those individuals, I think, is incredibly important.

So, looking at it from a Medicaid program perspective and measuring based on that,

I would highly recommend that we keep this.

CO-CHAIR GOLDEN: Karen.

MEMBER AMSTUTZ: So, I would -- I want to just add to Cheryl's comments on the Medicaid plan level.

I think we have -- if you have an integrated Medicaid plan where we have one health plan managing both, you know, the medical pharmacy benefit and the LTSS benefit, most states are actually requiring not just a service plan, but also a care plan. So, they're actually already requiring that.

And, you know, from a measure set perspective, then, whether it's at the program level, the waiver level or the plan level, this gives you the assurance that the service plan coordinator, who may not be -- may be non-clinical and the care management, you know, care plan coordinator, are actually talking, you know, talking to one another.

I think in the instance where you actually have carved out LTSS benefit management

and potentially even two health plans, this measure maybe also has importance or may be even more important, because you're coordinating across disparate programs.

So, just -- but I understand the challenges that we're asking of the service plan coordinators in a fragmented environment and I think all of us recognize that that will be challenges and that's our improvement opportunity.

CO-CHAIR GOLDEN: Deborah.

MEMBER KILSTEIN: I agree that it's important, but I also wanted to raise the carve-out issue especially if it's a dual eligible and it may be a Medicare plan or a Medicare fee-for-service and the managed long-term care services and support plans may or may not have access to that data.

So, I think at the very least there just needs to be a note or recognition in the report that while the measure may be important, you also have to take into account who you're

asking to report it and whether they actually have access to the data to be able to record it.

So, for example, this may be great on a state level, but it may not have been on a plan level, because they may not have the data to report.

CO-CHAIR GOLDEN: John.

MEMBER SHAW: Yeah, I like looking at both of these measures, the one Barbara said to pull over from PMH, as well as the one under discussion here, because the denominators are different.

The one to pull over is eligible outpatient people already in the community. The number 32, or NQF 0097, is a transition measure from the hospital.

And that is a much higher risk, because hospitals tend to have their own formulary and they switch drugs around and it's confusing.

And I've had -- we've cared for both of our mothers at home and that's been a major

time consumer for family, too.

CO-CHAIR MOORE: I have a -- I'd like to make a request. LTSS is not my area of expertise. And I really appreciated Deborah's comment about the dual eligibles.

So, as we go through these measures for those who have expertise in this, if you could speak to the applicability of these measures to the dual eligible population, because that's a huge area for Medicaid.

I do know that much and I would appreciate that context just for my own knowledge as we go through the voting process. So thank you.

CO-CHAIR GOLDEN: MaryBeth.

MEMBER MUSUMECI: So, hopefully, along some of those lines, I spend a lot of my time looking at Medicaid for people with disabilities, including the duals.

I completely appreciate that there should be a caveat that if the information is not there, it doesn't have access, then it's not

feasible.

However, the trends that we're seeing is definitely towards integration on the Medicaid side across physical, behavioral and long-term care, as well as Medicare and Medicaid integration.

We survey all 50 states every year and look at their waivers. And this is definitely -- states are not only moving to managed care for long-term care, but they are -- when they do that for these populations, they're trying to bring everything in or at least increase the integration and coordination.

So, I do think this is in terms of -- the way the future is going in terms of giving states options, that would be a reason to include this.

CO-CHAIR GOLDEN: So, after Cheryl's comment, I'm going to come back and say, "Where are we?" So, let's -- Cheryl.

MEMBER POWELL: Sure. Just to add onto that, there's certainly a movement forward

to get all the data to entities. There are many demonstrations.

And I believe, and I was trying to look it up, and I apologize I didn't find it, that this is one of the core measures in the duals demo.

I created this and I think that it is, but now I'm trying to remember was it removed?

(Laughter.)

MEMBER POWELL: And also recommended by the NQF Dual Eligibles Committee as well. I mean, it may be one of those things that you strive for. Some states have all that data and some plans do and they can integrate it all and report it. Others may have difficulty with that, but I don't think that that's a reason for us not to recommend it.

And particularly for duals for their care, it's incredibly important.

MEMBER MCCANN: It is in the duals --

MEMBER POWELL: I thought so. Okay.

MEMBER McCANN: -- demo, because we do

it with the -- we're doing that, yeah.

CO-CHAIR GOLDEN: So, this measure -- is this measure, you're saying, in actual use right now, or is it going to the NQF for approval? Help me out here.

MEMBER POWELL: No, it was -- there's a -- there was a similar workgroup within NQF that recommended immediate, short-term and longer term measures and measure gaps.

This is one of the measures that was recommended for years from a group like this to CMS for use within duals programs at CMS and that states could also pull from for those programs.

CO-CHAIR GOLDEN: So, we will make a decision about med reconciliation. I would suggest if you don't have it in front of you, just look at the specs and numerator/denominator. So, it's all discharges and --

MEMBER WALLACE: I have a question.

Are we able to also consider the measure that Barbara mentioned, the additional one for incorporation? Because I do like the

idea of -- well, it's not balanced, because I know that we can have, you know, overlapping measures and it doesn't have to be a balanced set, but I see the utility in both, but it wasn't one of the ones that was put before this group.

MEMBER MCCANN: Yeah.

DR. TERRY: So, just let me understand. So, it's gone through PMH and it passed. It was -- right? Is that what you're saying?

MEMBER MCCANN: It's on this list.

DR. TERRY: Yeah, but you know the outcome of it -- actually, we don't know that yet, do we?

MS. BUCHANAN: So, the PMH TEP reviewed 0419, recommended it. It will be -- when we talk about the final measure set following LTSS, it will be reviewed, but it is included in their recommendations.

DR. TERRY: So, that would be easier --

MEMBER MCCANN: Okay.

DR. TERRY: -- because it's already gone through the process. So, I think we could actually look at that measure as well, but -- unless somebody has any concerns, it's really just another look at a measure that's gone through in another program.

CO-CHAIR GOLDEN: So, we have 097 in front of us, right, to talk about. And, again, I'm just trying to get -- it was good to get a little orientation here.

The denominator says, "All patients who are discharged," which is not a functional denominator definition.

Do we have enough specifications or concept here to even apply it to LTSS, is my question. And I'm a little bit --

MEMBER MCCANN: That was the reason why our group had problems with it. We didn't know where it was discharged from and that it appears to be limited to the physician's office at that point.

CO-CHAIR GOLDEN: Susan, you have

something you want to add? Are you --

MEMBER WALLACE: No.

CO-CHAIR GOLDEN: Oh, Cheryl. Yes.

MEMBER POWELL: I think, again, looking at how a Medicaid agency might use it with an HCBS program population, it would, by definition, be limited to those who are in that waiver program who are discharged from the hospital.

So, it's probably one of those where it wouldn't be used exactly like this. But given the program that it's applied to, it would be limited to the right population.

MEMBER MCCANN: And if I could comment, it's the medication list in the outpatient medical record. Now, this is a good example of how we can't talk to each other.

In home and community-based services, we would not think that that would apply to home and community-based services and that we would not have access to that. That would sit in a physician or clinic office and that was the basis

upon which we voted no.

CO-CHAIR GOLDEN: Okay. Are we ready to vote or ready to table this to happy hour, I guess.

Anybody else have any comments?

(Pause.)

SPEAKER: Someone has to do a motion.

CO-CHAIR GOLDEN: Okay. We need -- first, we need a motion for reconsideration.

MS. GORHAM: We have it. It's being reconsidered now --

CO-CHAIR GOLDEN: Okay.

MS. GORHAM: -- but we need a motion to vote. And then a second to vote to include.

CO-CHAIR GOLDEN: Well, I mean, that's the same thing, so we already have that. So -- and to do this, we would have to go through all five steps?

MS. GORHAM: So, no. So, yesterday we decided that if it already went through the decision logic in another program area, that we just had to take an up or down vote and just --

we have rationale, we've had plenty of discussion, so we have good information for the report as to why we want to --

CO-CHAIR GOLDEN: And this was approved for the other set?

MS. GORHAM: Yes.

CO-CHAIR GOLDEN: Thank you. Okay. Okay. Ready to vote?

All in favor, raise your hands.

MS. BUCHANAN: And so, also, people on the phone, please type in "yes" or "no" and we will capture your vote.

MS. GORHAM: And for record purposes, we are voting for NQF 0097, measure of medication reconciliation, which is number 32 on your discussion guide.

MS. BUCHANAN: Okay. Those who vote no, please raise your hand.

(Voting.)

SPEAKER: And I didn't vote, because I can't figure out how to vote.

(Laughter.)

CO-CHAIR GOLDEN: I believe our charge is you can't abstain.

MS. GORHAM: We have a quorum.

CO-CHAIR MOORE: I'll vote yes in recognizing that all the comments that have been made will be passed along.

MEMBER MCCANN: Can I make a recommendation that it be noted that as part of the challenge in the use of the measure, that there's clarification between home and community-based and outpatient.

CO-CHAIR GOLDEN: Yeah. I think that this measure has -- the concept moving forward will be given to the states for them to figure it out.

MS. BUCHANAN: And, also, we just need to, for record purposes, to have Tara and Miranda say the votes.

MS. KUWAHARA: 18 members voted to include this measure in the LTSS measure set. Two voted no. So, this measure will be recommended for inclusion in the LTSS measure

set.

CO-CHAIR GOLDEN: John.

MEMBER SHAW: Another note to put in for use.

MS. BUCHANAN: Can you use your microphone?

MEMBER SHAW: Oh, sorry. Another note to put in for use is if we're looking at trends, we've moving towards value-based payment and bundling across settings over time that's patient centered.

And so, some of the information availability between different settings should theoretically go away in that construct.

SPEAKER: Okay. That's a good point.

MS. GORHAM: So, I also think that this would be a good place to -- Barbara mentioned 0419, NQF measure 0419, which is number 83 on your discussion guide.

So, if we look at that --

SPEAKER: Can you hang on for one second? We're having a little conference over

here.

(Pause.)

CO-CHAIR GOLDEN: So, there is a request that we had already approved measure 83; is that correct?

MS. GORHAM: No. So, number 83 is NQF 0419. And that is the measure that Barbara just recommended.

That measure has been reviewed for the PMH TEP and you all will decide whether or not it should stay on the PMH measure set, but let's leave that alone right now.

And so, right now we want to look at --

CO-CHAIR GOLDEN: Well, I would suggest that we -- when we look at it later on, we then also consider it for both -- both sets.

MS. GORHAM: Okay.

CO-CHAIR GOLDEN: Okay. We'll just do them both. I mean --

CO-CHAIR MOORE: Do you want to do it now then?

MS. GORHAM: Yeah. I think because we already are having discussion about it now and because we will need rationale behind it, that we have the discussion and just take that up or down vote whether or not we want it in, but we do need to have rationale behind it.

MEMBER SHAW: Another point is it's part of the bloc for PMH. And so, we're really not discussing it because of that. So, this is the opportunity to discuss it.

MS. GORHAM: Exactly.

CO-CHAIR GOLDEN: Okay. So, what number is it?

CO-CHAIR MOORE: 83.

MS. GORHAM: Number 83 on your discussion guide. NQF 0419, Documentation of Current Medications in the Medical Record.

So, we have had a motion to discuss and a second. So, we can discuss and then we can take a vote.

MEMBER MCCANN: I'll so move.

CO-CHAIR GOLDEN: So give me a second

here while I noodle through this. So, technically -- I just want to make sure we know where we are.

So, technically we have yet -- this is yet to come up. This was approved by the other TEP, correct?

MEMBER MCCANN: Right.

CO-CHAIR GOLDEN: So, it's only now to be -- so, when it comes up later in the day, it would be up for extraction if there was objection. So, we won't have to go through the five steps for this measure. Fine.

So, the measure -- the motion on the table would be to include this, assuming it's going to be approved for the other group.

Okay. That's fine. So, let's open up for discussion.

Barbara, do you want to make any comments about it?

MEMBER MCCANN: Yes. My comment is this currently, actually, reflects the state of practice in home health.

So, it would be typically done also for Medicaid and it is broader and focuses on what is known in the home. It's broader than current prescribed medications.

CO-CHAIR GOLDEN: Okay. Other comments or questions about this item?

(Pause.)

CO-CHAIR GOLDEN: All right. All in favor of including this measure, raise your right hand.

MS. BUCHANAN: And people on the phone, please type in your vote on NQF 0419, Documentation of Current Medications.

(Voting.)

MS. KUWAHARA: So, have zero nos.

CO-CHAIR GOLDEN: Okay.

MS. KUWAHARA: So, we have 18 yeses, zero nos. So, this measure will be recommended for inclusion in the LTSS measure set.

CO-CHAIR GOLDEN: What's next?

MS. GORHAM: Okay. So, the next measure is Percentage of Short-Stay Residents Who

Were Successfully Discharged From the Community. And that is number 41 on your discussion guide.

And let me just state the rationale for not including, according to the LTSS TEP meeting. While the TEP members again thought this measure was critical, they did not think it pertained to LTSS.

A stay over 30 days likely diminishes the likelihood of folks returning to the community. So, not a good measure -- this is not a good measure, they felt, of quality particularly for the younger population.

We had a few members of the CC who wanted to discuss this, including Christine, who is not here today, MaryBeth, Deborah, as well as Cheryl. So, I will hand it over to either one of you.

(Comments off record.)

CO-CHAIR GOLDEN: I'm sorry, so is it Deborah or David? It's David. Okay.

MS. GORHAM: If one of you would like to start the discussion?

MEMBER KELLEY: So, from my standpoint, as a Medicaid program I think one of the key elements that you really want to look at, because these are typically waiver programs that our friends at CMS always ask us to look for ways of measuring and improving cost effectiveness as per the waiver, I think this is an essential metric in determining who actually moves back into the community.

And whether that's long-term or short-stay residents, the biggest concern is always folks will leave -- these patients will leave an acute care hospital or acute rehab, they'll land in a SNF and they sit there.

And one of the -- supposedly one of the key ways to not only save money, but actually place patients where they really want to be, is to move them out into the community, to rebalance them into the community.

And some may question whether that is cost effective. I believe it is, but it certainly -- my mind is very member/patient-

centric, because most individuals really do not want to be in a nursing home. Their goal is to get home or into a safe community setting.

So, I thought that this even though it's not a perfect measure, that it is certainly a very important one to Medicaid long-term support service managed care programs.

CO-CHAIR GOLDEN: So, David, who is the accountable party that you're measuring here? Is it the hospital? Is it the plan? Who would be the unit that would be getting the data feedback?

MEMBER KELLEY: So, I got booted out of wifi. I was trying to pull up the spec. I believe it is that we would expect our plans to report this. And they would know, because there would be -- in our model, there would be service coordinators that would be working with these individuals.

If they are, quote/unquote, nursing home eligible, because now they've been dumped into a nursing home because it's the path of

least resistance for many hospitals, there should be service coordinators that would be working with these individuals to find out what their needs are, find out what they really want to have happen to them, and then help move them back safely into the community.

So, it would be the health plan that would be measuring this activity and documenting that, indeed, they have moved back into the community and have remained there.

Not just moving them back, but there is the whole idea of keeping them there since; A, they're safe, but they don't bounce back into either hospital or into -- back into a SNF nursing facility.

CO-CHAIR MOORE: So, I'm going to point out that it does state that there's a -- it's part of the five-star quality rating system. So, it is the managed care plans.

(Simultaneous speaking.)

CO-CHAIR GOLDEN: So, David, again, on the denominator. The way you're envisioning

this, are you talking about people who live in a community, get admitted to the hospital and go back to the community? Are you talking about --

SPEAKER: This is why clickers don't work.

(Laughter.)

SPEAKER: For those on the phone, we just had a major spill of water on the clickers.

CO-CHAIR GOLDEN: The measure, David, is spec'd -- the measure is spec'd for people in a nursing home, correct -- oh, who are not?

MEMBER SIDDIQI: This is Andrea. So, these are individuals that perhaps were in an acute care hospital and ended up in a nursing home as a short stay.

And obviously we want to get them back to the community rather than keeping them in chronic care in a skilled facility, right? I mean, is that the very basic idea of this measure?

MEMBER AMSTUTZ: So, I think one of the things -- this is Karen Amstutz -- that we

may be getting confused here, because the measure actually talks about Medicare instead of Medicaid --

CO-CHAIR GOLDEN: Yeah.

MEMBER AMSTUTZ: -- is that there's sort of two ways that benefit -- skilled nursing facility benefits are covered.

One is because it's medically necessary under your Medicare benefit, and that's a distinctly different situation than what we're talking about in folks who have a nursing facility benefit covered under the LTSS benefit.

MEMBER MCCANN: Great. If I can make a comment, the -- under Community First, right, Choice, there's certainly an emphasis to move folks from the nursing home into the community.

The TEP struggled with this, because it doesn't reference that they receive LTSS or home and community-based services in the numerator or denominator.

So, it would -- I guess it would have to be reported based on any claim, not

necessarily for home and community-based services, that occurs after discharge from the SNF, in this case, or long-term -- that's when you go into the Medicaid hospital, so nursing home benefit. So, that's where we got lost.

So, it assumes -- you would hope that if they went home on the waiver to get them home, they would receive home and community-based services to keep them there, but this doesn't address that.

CO-CHAIR GOLDEN: MaryBeth.

MEMBER MUSUMECI: So, a couple of technical things. First, for the original reasoning about the 30 days versus the 90 days, I completely agree that if you can get people home sooner, it's more likely you're preserving your community supports.

However, when money follows the person, which is the demonstration grant to transition people back was reauthorized in the ACA, one of the changes was is that they changed it from a 30-day stay to a 90-day stay. So,

they're recognizing that.

And I can tell you from years of experience of sitting in these meetings and trying to work with folks getting them home, 30 days goes by real fast and it's really hard to get the services in place. So, to me, that wouldn't be a reason to toss it out.

On the Medicare piece, many of these people are duals, but not all of them are duals. So, you could have a Medicaid-only person in this situation.

And moreover, just -- this one is very important to me for not only having something about rebalancing, but also about the message that we're sending overall.

You know, I've worked with folks on the ground for about 17 years. And I would say the number one thing that I hear, you know, you can't say anything is a hundred percent. Certainly there are folks where institutions are preferable or needed, but across the board from seniors to people with physical disabilities,

traumatic brain injuries, spinal cord injury, IDD, what parents hope for their kids with special needs, the number one thing is "I want to be supported in the community and I want to get back to the community."

And I felt like while this may not be perfect, this is the only thing that's there. And we are sending a message about what we're valuing and measuring and sending a message to beneficiaries about what plans and providers and states should be looking at by recognizing this.

The other thing is I do know that there are states, Tennessee and some other states, who do look at their long-term care balance and don't have that overlay of are you getting -- I mean, I think it's assumed that you're not going to be discharged to the community unless you have appropriate services in place to make it safe and give you the supports that you need, but the measures are simply number of people who leave institution and don't go back, or amount of dollars spent in the

institution versus community. So those, to me, aren't reasons to set this apart.

And then I just -- the overarching comment is, as I said earlier, I just think it's really important to note in the report that we recognize that this is a gap area and this is something that needs to be further developed. Because the movement that we're seeing, you know, it's not enough just to have a care plan.

That measure is not really satisfactory for someone who is depending on supports for very basic daily activities.

You could have a care plan and it doesn't meet your needs and the power differential sometimes in those care plan meetings is not where it needs to be. So, I just think that's an important area to recognize.

And the movement now, actually, is towards people saying not only are we rebalancing, but, also, what does that level of community integration look like? Are people not in isolated settings?

So, for all of those reasons, we have convened an expert group and did a report at Kaiser a couple of years ago on this that included states' health plans, beneficiaries kind of across the board, and this was -- the number one focus was rebalancing measures.

CO-CHAIR GOLDEN: Okay. We're going to have to wrap this up soon.

So, Karen, you have something?

MEMBER AMSTUTZ: Yeah. I'm going to go back to saying I really think this measure is about moving someone -- is about Medicare patients and is not about long-term services and supports patients, B.

So, and the challenge just to sort of quote from the MedPAC report on skilled nursing facility, is that the medically necessary Medicare nursing -- skilled nursing facility stays pay for a disproportionately larger amount of revenue to the skilled nursing facilities than do the number of days that someone stays in. So, those patients are considered especially

valuable.

So, as someone is getting discharged out of post-acute care and going into -- and, remember, Medicare is only covering these for people that need a medically necessary skilled nursing facility. They're not covering long-term services and supports. They're not covering the situation that MaryBeth just talked about.

And so, because they're so valuable, the skilled nursing, there has to be some measures to really get the nursing homes focused on getting these patients back to their -- whether they're going back to their custodial -- their LTSS benefit or whether they're actually going back home, that's what the focus of this measure is on.

So, I think that the -- we need a measure like this, though, that looks at once you've qualified for LTSS benefits if you've been put into a non-community setting, how fast does it take us to move, you know, how fast does it take the system to move you into the community?

So, we need that concept, it's just not this measure.

CO-CHAIR GOLDEN: Deborah.

MEMBER KILSTEIN: Just a comment that this is a little bit more difficult in terms of administering this measure; one, because the claims data and who holds it. And then, also; two, some of the exceptions would require probably an evaluation, either the chart or something else in terms of whether it was an unplanned admission. So, it's not just claims data.

CO-CHAIR GOLDEN: Jennifer.

CO-CHAIR MOORE: This is very quick.

I just want to acknowledge, MaryBeth, and thank you for bringing a very important point to this discussion. And that is that we look at measures that are meaningful to the Medicaid beneficiary.

And I think that you made that point very succinctly and I do appreciate you bringing that to the conversation.

CO-CHAIR GOLDEN: Judy.

MEMBER ZERZAN: This measure includes Medicare fee-for-service enrollees only in the denominator.

So, I'm a little worried that while I super agree rebalancing in this transition is really important, I'm not sure this is the measure.

CO-CHAIR GOLDEN: Okay. David, you get the last one.

MEMBER KELLEY: So, when you look at Medicaid fee-for-service, and, again, this is how the metric is designed. However, once -- if we put this on the island and CMS gives guidance, they can say that this could be broadened.

So, within our waiver, our program we're going to operationalize in January, we're going to have duals, we're going to have people that are in Medicare, fee-for-service Medicare Advantage. Whether they're nursing home eligible or not, they're going to be in the program.

That managed care plan is going to be

responsible for them. Whether or not they're in fee-for-service, whether or not they're in Medicare Advantage, they are -- they're getting paid for them, they're going to be responsible for them whether nursing home eligible or not.

So, there are waiver programs and there are non-Medicare folks in those programs as well that have other types of disabilities.

So, you know, I don't want to get caught up on the Medicare fee-for-service. That's what this says. But as with other specifications, programs can look at this and they can broaden the definition, if they want to, or they can stick to the letter of the law, but it's a nice example of looking at rebalancing and actually measuring it.

And I would say that in our program, the majority -- majority of folks that come into a nursing home are -- Medicare is paying for them prime. But if they sit there for a long time, guess who ends up paying for them?

We, as a Medicaid program, get, you

know, I'll say -- we pick up the tab, shall we say.

(Laughter.)

MEMBER KELLEY: So, this is a way to make sure -- this is why we're doing our program is that we don't want those folks sitting there if they don't need to be there and they want to be back in the community.

This is one way. It's not a perfect measure, but it's one way of measuring that. And our managed care plans can do variations on the theme.

CO-CHAIR GOLDEN: So, I had declared that David was the last word. So, I know there may be other people wanting to come in on the end, but I think we need to start the vote.

So, is it a five-step process? Yes?

(Comments off mic.)

CO-CHAIR GOLDEN: Okay, because it's in -- what set is this in already?

MS. GORHAM: So, this was discussed and voted on the LTSS. Remember, LTSS did not

want it included. So, it has already been through the decision logic. So, we just need the up or down vote.

CO-CHAIR GOLDEN: I'm sorry, so --

CO-CHAIR MOORE: The motion would be to have it considered for inclusion after the TEP had decided not to include it.

CO-CHAIR GOLDEN: Okay.

MS. GORHAM: So, we actually have already had motions, because we have four --

CO-CHAIR GOLDEN: That's why I'm confused. So, the TEP had said no, this is for reconsideration, but I thought in previous voting we had done the five steps as opposed to an up or down vote.

MS. GORHAM: No.

CO-CHAIR GOLDEN: No.

MS. GORHAM: Because the last one we didn't do five steps. We did up or down.

CO-CHAIR GOLDEN: Well, no, that's because we had been approved by another committee.

MS. GORHAM: Right. So, remember yesterday we decided that for measures that have already went through the decision logic, that we would --

CO-CHAIR GOLDEN: Okay. I wasn't aware that we had done the decision logic on this measure here.

MS. GORHAM: The LTSS TEP did the decision logic on this.

CO-CHAIR GOLDEN: Now, I'm confused, because we had done reconsideration votes earlier in this meeting and we went through the five steps.

MS. GORHAM: We did for the first one, BCN. And you all because of the time factor, decided that as long as we -- if the measure has already been through the decision logic, for timing, that you would do an up or down vote --

CO-CHAIR GOLDEN: We did not decide that.

We decided had it been through the decision logic by the coordinating committee to

do an up or down vote, not if it had been through a decision logic of the TEP.

That was how we had structured -- at least that was my understanding as chair.

MS. GORHAM: No, because if it went through the decision logic as a coordinating committee, you wouldn't have to go back and revote. So, it was only the measures who -- that went through the decision logic with the TEP.

Because if it went through the decision logic at the coordinating committee, we don't have to go back and do an up or down vote. It will go through the decision logic and either pass or not pass.

CO-CHAIR GOLDEN: I'm sorry, I'm having a hard time with this. We may have to --

DR. TERRY: Can I just ask -- so, I know it's a bit of a time issue. So, let's just -- yesterday we did decide, as I remember, those who came up that we were going to take out after everybody looked at it again and it's just an up or down vote, because it already had been gone

through.

This is a little different. This is one that did not get through and it's now being asked to look at it again.

And so, I think yesterday we did take these to the decision, if I can remember. But, you know, anyway, we didn't do that earlier because it was a little different situation.

MEMBER MUSUMECI: Could we go back and look for a comparable -- in the record, the last time we did one of these and see what kind of vote we took?

DR. TERRY: Yeah. That would be helpful, yeah.

MEMBER KILSTEIN: And can we find out what of the five steps, where did it fail in the -- when the LTSS TEP looked at it? Because it -- they may agree that it was important, but just, you know, couldn't get it all the way through all five steps.

CO-CHAIR GOLDEN: Well, I mean -- okay. Again, I'm just looking at when we did the

first tranche of measures, you know, the first items we did was review of -- where am I here? Gee whiz.

MS. MURPHY: So, you might remember that when we started working --

CO-CHAIR GOLDEN: For reconsideration, and we went through the five steps for all the reconsideration votes.

MS. MURPHY: So, for the BCN program area, which was the first one we did --

CO-CHAIR GOLDEN: Right.

MS. MURPHY: -- that's when we ran into our time issue and realized that it was going to take a substantial amount of time to take all the reconsidered measures to the decision logic.

And then we changed it to an up and down vote depending on the committee for the measures that were identified for reconsideration.

If you'll recall, I made a statement about how we asked for a detailed rationale that

would hopefully be based in the decision logic and that was our kind of workaround for these time constraints.

And just as an example --

CO-CHAIR GOLDEN: No, I'm sorry. I disagree.

MS. MURPHY: Okay.

CO-CHAIR GOLDEN: I disagree. We did the -- we went through the detailed discussion of things that we extracted from the consent calendar. We went through the five steps for the reconsideration items.

MS. GORHAM: So, why don't I suggest we take a break. And so, we can confer between staff and chairs and come back in five minutes.

(Whereupon, the proceedings went off the record at 1:04 p.m. for a brief recess and went back on the record at 1:10 p.m.)

CO-CHAIR GOLDEN: All right. I think we've come to an agreement that yesterday we went -- all the reconsideration ideas went through the five steps and the items that we pulled from the

consent calendar was an up and down vote.

So, to be consistent, we should put this through the five steps and go from there. And I would say let's go ahead and do the voting now. And maybe we got into trouble, because we got tired of raising our hands.

MS. BUCHANAN: Okay. So, Miranda, would you mind taking us through NQF 0097?

MS. GORHAM: So, just to be clear, because we're -- even though we talked about percentage of short-stay residents and we were about to vote on that, we're going to vote on that, but we have to go back to 0097, because we would need to take that to the decision logic as well to be consistent.

So, just want to make sure everyone is on the same page.

DR. TERRY: So, which one are we going to do?

MS. GORHAM: So, we can -- because we stopped at the Percentage of Short-Stay Residents Who Are Successfully Discharged to the Community,

let's go to the decision logic for that, take a vote, but we will have to go back to 0097 and take a vote through the decision logic for that as well.

MS. KUWAHARA: Again, this is for measure number 32 on your discussion guide, NQF number -- 41. 41, I'm sorry.

Apologies. This is measure number 41, Percentage of Short-Stay Residents Who Were Successfully Discharged to the Community. We're going to do hand votes as the clickers are acting up a little bit.

So, for the first question, to what extent does this measure or concept address the CMS quality measurement domains and/or program area key concepts?

If you vote high, please raise your hand.

MS. BUCHANAN: And people on the phone, please just type in high, medium or low.

(Voting.)

MS. KUWAHARA: Medium, please raise

your hand.

(Voting.)

MS. KUWAHARA: And low.

(Voting.)

MS. KUWAHARA: 19 of the 19 voting members voted high. So, this measure will be recommended for -- I'm sorry, I -- let me get my bearings a little bit and move to the next one.

The next question is: To what extent will this measure or measure concept address an opportunity for improvement and/or significant variation in care?

Those who vote high, please raise your hand.

(Voting.)

MS. KUWAHARA: Medium.

(Voting.)

MS. KUWAHARA: And low.

(Voting.)

MS. KUWAHARA: Okay. 18 members -- I'm sorry, 15 members voted high. And three members voted medium. No members voted for low.

The next step is to what extent does this measure or measure concept demonstrate efficient use of resources and/or contribute to alignment?

Those who vote high, please raise your hand.

(Voting.)

MS. KUWAHARA: Medium.

(Voting.)

MS. KUWAHARA: And low.

(Voting.)

MS. KUWAHARA: Okay. Nine members voted high. Four members voted medium. And five voted low.

To what extent is the -- I'm sorry, we're skipping this question, because this is -- no. To what extent is this measure and measure concept ready for immediate use?

If you believe it's ready, please raise your hand for yes.

(Voting.)

MS. KUWAHARA: And we're just waiting

for Jeff to type in "yes" or "no."

(Pause.)

MS. KUWAHARA: And no.

(Voting.)

MS. KUWAHARA: 13 voted yes. Six voted no.

To what extent do you think this measure is important to state Medicaid agencies and other key stakeholders?

For high, please raise your hand.

(Voting.)

MS. KUWAHARA: Alvia, if you wouldn't mind typing in "high," "medium," or "low" instead of "yes" for this one?

(Pause.)

MS. KUWAHARA: Alvia, so right now we have you as a "yes," but we need to know if it was a high, medium or low. You can just verbally respond.

MEMBER SIDDIQI: Sure. High, I'm sorry.

MS. KUWAHARA: Good.

Medium.

(Voting.)

MS. KUWAHARA: And low.

(Voting.)

MS. KUWAHARA: Ten members voted high. Five voted medium. And four voted low. So, this measure will be recommended for inclusion in the LTSS measure set.

CO-CHAIR GOLDEN: Thank you. And thank you putting up for the vote. And Cheryl stands corrected. It was not Samuel Johnson, it was Ralph Waldo Emerson.

(Laughter.)

MS. GORHAM: Okay. So, let's go back to NQF 0097, and that is number 32 on your discussion guide. And we will take a vote through the decision logic.

(Pause.)

CO-CHAIR GOLDEN: Hold on. So, was this measure approved in another TEP -- another program?

Yes. So, another TEP had approved

this measure, so we just moved it into this measure. That's right.

That was the whole business -- that's right. This does not need the five steps, because it's in the consent calendar for the other group. So, this is fine. We don't need to do the five steps on this item.

CO-CHAIR MOORE: And we have voted on it.

CO-CHAIR GOLDEN: Right. And an up and down vote was appropriate, because it will be on the consent calendar in the next group that Jennifer will be doing when we finally get there.

So, we are in the journey to get there and won't need a five-step vote. Okay. So, we can move on.

CO-CHAIR MOORE: We may need a five-step program after this.

(Laughter.)

CO-CHAIR GOLDEN: Hey. I've already publicly talked about my dependencies here, so that's not a problem. So, let's move on.

Next item, what do we have? Tara is -- you're in. okay. So, we can move on. We don't need to vote.

SPEAKER: So, on to the other TEP measures.

(Pause.)

MEMBER SIDDIQI: Can't hear.

CO-CHAIR GOLDEN: No, we're just doing a referee consultation here. It is a secret, though.

MEMBER SIDDIQI: Thank you.

(Pause.)

MS. GORHAM: Okay. So, let's move on.

CO-CHAIR GOLDEN: There should be -- do we have any other measures in LTSS?

MS. GORHAM: Yes. We're not moving the program area yet. We need to move --

CO-CHAIR GOLDEN: You need to move it to --

MS. GORHAM: -- the rest of the measures for LTSS.

CO-CHAIR GOLDEN: Correct. So,

whatever Barbara has on the agenda for us, right?

MS. GORHAM: No. That's moved out and so there were no related measures in LTSS.

CO-CHAIR GOLDEN: Right.

MS. GORHAM: We just need to move our slide.

CO-CHAIR GOLDEN: Next slide. That's right.

MS. GORHAM: Okay.

CO-CHAIR GOLDEN: Okay. Now, we have --

MS. GORHAM: So, now we're looking at the measure set recommended by LTSS TEP members.

CO-CHAIR GOLDEN: Okay. So, we have -- this is presented to you as a consent calendar. So, again, like in other measures, extract the ones you want to have further discussion on or votes.

MS. GORHAM: So, what I'll do is go down the list and tell you why the LTSS TEP recommended the measure for the set.

You'll notice the first measure, the

Adult Access to Preventive/Ambulatory Care, was also discussed yesterday for another set. It is number 27 in your discussion guide.

And the reasons why the LTSS TEP recommended this measure; one, as a proxy for -- do people get where they need to be and are the services available?

It's not restricted to only dual-eligible populations, but should cross all the populations in the LTSS area.

It could also be effective concept for other -- for the other three program areas, which we've already discussed. It is a comprehensive approach, access to preventive and ambulatory care, identify long-term support needs and connects to physical and wellness needs.

The next measure, NQF 0326, can be found at number 34 in your discussion guide.

CO-CHAIR MOORE: So, can I interject real quick as a procedural --

CO-CHAIR GOLDEN: Yes.

CO-CHAIR MOORE: So, yesterday after

each one of these, we asked if people had any comments or concerns before we moved on.

CO-CHAIR GOLDEN: Right. That's correct, but we had already approved this measure. So, does anybody have any concerns?

MEMBER AMSTUTZ: Well, I just have -- I have sort of a concern/comment and I realize this has been discussed extensively.

This -- the definition of this measure is very broad. And it's probably broader -- it basically was originally intended to say, you know, patients in the commercial population that they access care in any way.

So, it looks at, like, any specialty, any urgent, any -- I think it may be -- it's very, very broad and it's not very specific. And so, I think it's great for saying, did the, you know, adults engage in the healthcare in any way.

I'm not sure it gets at what we want it to here.

CO-CHAIR GOLDEN: Yeah. I think comments along those lines were made yesterday as

well. So, that should be in the record.

MEMBER AMSTUTZ: All right. Thank you. I missed that.

CO-CHAIR GOLDEN: Okay.

MEMBER AMSTUTZ: All right.

CO-CHAIR GOLDEN: If nothing else, let's go to the next item.

MS. GORHAM: The next measure could be found at number 34 in your discussion guide, NQF 0326, Advance Care Plan.

For 65 and older, higher risk population, needed so individual can maintain personal choice, needed so the person can also remain in their home in the community. Individual can decide for themselves obviously is a great benefit of this measure.

Also, the LTSS providers had advanced directive discussions. So, it is consistent with the personal -- person-centric care.

CO-CHAIR GOLDEN: So, a quick question for Barbara in this.

Is the definition of an advanced care

plan clear in terms of what it means? I just -- I mean, the reason I ask is, when I saw the title, I was thinking complex care management as opposed to advanced directives and preferences in --

MEMBER MCCANN: You know, and my colleagues from CMS may have to help me on this.

CO-CHAIR GOLDEN: Yes.

MEMBER MCCANN: Advanced directives is different, we understand, than advanced care plan.

CO-CHAIR GOLDEN: Okay.

MEMBER MCCANN: So, this is more than just advanced directives; do you agree?

CO-CHAIR GOLDEN: But is there a definition of what an advanced care plan is? There is?

SPEAKER: In the measure specs, you mean?

CO-CHAIR GOLDEN: Well, just in general, yeah. I mean, will people know what this means?

MEMBER MCCANN: Yeah. It's --

CO-CHAIR GOLDEN: Okay.

MEMBER MCCANN: I don't know that it was ever --

CO-CHAIR GOLDEN: MaryBeth.

MEMBER MUSUMECI: It looks like it's in the notes. It says the aim of advanced care planning is to ensure that care near the end of life aligns with the patient's wishes, but I thought there was something else in here that led me to believe it was along those lines as opposed to service planning.

CO-CHAIR GOLDEN: Very good.

MEMBER MCCANN: This is just a practice, believe it or not, that does actually occur across home care, yeah.

CO-CHAIR GOLDEN: Okay. Any other comments, questions?

Okay. Next item.

MS. GORHAM: Number 39 on your discussion guide. I will give you a minute to get there. This is the Home and Community-Based

Services CAHPS measure.

So, it is part of the CAHPS suite widely used. This is the first tool available that accesses HCBS and focus on supports to live independently.

The blind and low-vision population may prefer phone -- and this is just a note from one of the TEP members -- may prefer phone, while other populations may find the survey a negative.

Overall the TEP felt that this was a good measure for the set.

CO-CHAIR GOLDEN: Comments, questions.

Judy.

MEMBER ZERZAN: So, there's a fair -- I just want to note there's a lot of overlap, like, about 70 percent between this set of measures and the National Core Indicators set of measures. I'm not sure that one is better than the other.

Colorado piloted the CAHPS -- what is now the CAHPS home and community services measures, and now we're doing the National Core

Indicators.

I sort of think they do the same thing and, in fact, we're doing a study that is going to be presented in August that shows whether they're different.

So, and one of the other sort of things, some are in person, some are by phone, some can be by mail, and we're also doing some stuff about response rates for those.

I'm fine with all of these things being on there, but I just sort of want to note I hope that in the next few years we figure out which one is best and then we can all do the same thing, if we want to.

CO-CHAIR GOLDEN: Okay. Comments noted.

Other comments, questions?

DR. TERRY: I just want to --

CO-CHAIR GOLDEN: Peg will go, and then Jeff. Okay?

DR. TERRY: Oh, I'm sorry.

Yeah, I just wanted to say that on the

HCBS CAHPS one, the measures are actually relied on, valid, they're measures that have been tested. That is a little bit of a distinction at this point in time.

So, that means it's not just the survey that's been tested, but also the measures. And I know we'll be -- I assume when we get to the NCI one and NCI-AD, you can talk about that, too, but those are -- I think they're in process of doing testing of some of their measures -- some of their questions and measures. Just wanted to make that comment.

CO-CHAIR GOLDEN: Jeff.

MEMBER ZERZAN: Jeff, either you can respond or I will.

CO-CHAIR GOLDEN: Go ahead, Jeff.

MEMBER SCHIFF: I'm just going to -- maybe you can respond to that first, Judy. Is that what you wanted to do, or whoever just said that?

MEMBER ZERZAN: It is Judy, but I'm giving you my time on the --

MEMBER SCHIFF: Okay. Great.

All right. I just -- I guess I was going to say I think that one of the challenges we have here is that the individual measures -- and sort of the validity and reliability of the specific measures.

I think what we need to note in the recommendation to CMS on this, is that NCI creates sort of a suite of measures that go into some background data that allows for cross-analysis.

So, the challenge that we have is we're taking individual measures, but we're not able to look at the ability of, like the NCI purports to do, to link the core set to background indicators so you can cross-tabulate the results across populations.

And I think we should make some note of that as we recommend these to CMS.

CO-CHAIR GOLDEN: So, I gather that there is not a desire to pull this for deletion, but to make note that new measure sets and new,

potentially better tools are in development and may be available soon.

How's that sound?

Other comments or questions?

(Pause.)

CO-CHAIR GOLDEN: Next item.

MS. GORHAM: All right.

MEMBER ZERZAN: Maybe I will say the NCI ones while they are undergoing NQF endorsement, have been around for a while, especially the NCI-DD. It has been around for decades and is very well validated. So, I think they're both good surveys and have validated measures.

And in the NCI-AD, there are the exact same questions as in the CAHPS. So, I also think that there's a fair bit of overlap in these two different things. But as Jeff said, they're slightly different.

CO-CHAIR GOLDEN: Okay. Next item.

MS. GORHAM: All right. In your discussion guide, please scroll to 33. And we

are now looking at NQF 0101. And I'll give you a minute. The name of that measure is Falls: Screening for Fall Risk.

And, simply, the LTSS TEP thought that this was a really critical issue for 65 plus. The falls make a difference in staying in the institution or actually coming home.

CO-CHAIR GOLDEN: Comments and questions.

(Pause.)

CO-CHAIR GOLDEN: Next item.

MS. GORHAM: All right. So, in your discussion guide, number 38, NQF 2483. This is the PAM measure. We also discussed this in BCN yesterday.

CO-CHAIR GOLDEN: And it was approved.

MS. GORHAM: And it was.

CO-CHAIR GOLDEN: Okay.

MS. GORHAM: The reasons why the LTSS TEP preferred this for our measure set, it answers how effective providers are engaging folks in the process and facilitating activation.

Also, where a person is when they come into LTSS and what the providers do to activate them to manage health and remain independent. So, we thought this was a good measure.

CO-CHAIR GOLDEN: Deborah.

MEMBER KILSTEIN: Yeah. I was trying to get my hand up before. I hate to do this going back --

DR. TERRY: Microphone, please.

MEMBER KILSTEIN: Going back to the falls, screening for fall risk, can someone from the committee talk about why we use this measure and not the Medicare stars measure? Because now you've seen, like, for health plans now they're going to be reporting -- if they are a D-SNF, they're going to be reporting on two different measures.

MEMBER MCCANN: I can comment on home care. It's screening that's done.

So, I don't -- I apologize, I don't know which stars measure you're talking about.

MEMBER KILSTEIN: For Medicare health

plans they -- for the dual-eligible SNFs, they have to report to Medicare on stars. And there is a measure on falls, screening for falls.

MEMBER HENNESSEY: Yeah. It's NQF number 0035.

MEMBER MCCANN: I think there's work that's important work that's being done under the IMPACT Act right now that will be not only functional scoring that will be available across all settings, as well as fall risk that will be harmonized across all settings.

MEMBER KILSTEIN: Okay. Just a concern about --

MEMBER MCCANN: I agree.

MEMBER KILSTEIN: -- alignment.

MEMBER HENNESSEY: I think I may be able to clarify that. If I recall the screening measure that your committee looked at is an actual screening, so there is a record of whether or not the patient has been screened for falls.

Whereas the -- reducing the risk for falling, the star measure, NQF 0035 is actually a

health outcome survey measure. So, it is a survey question given to consumers.

MEMBER KILSTEIN: Okay. Thank you.

MEMBER MCCANN: And just as a clarification, home care is unique in that we're not with them 24 hours, except with some Medicaid, and that's rare now.

And home care -- people receiving home and community-based services notoriously under report falls at home because of their fear of going to a nursing home.

CO-CHAIR GOLDEN: Okay. Any other comments?

Any motions to withdraw the motion?

Okay. Next item.

MS. GORHAM: So, let's go back to 38. And that is the PAM measure. And I already stated the reason why the LTSS members recommended this measure.

CO-CHAIR GOLDEN: And we've approved it in another group.

MS. GORHAM: Uh-huh.

CO-CHAIR GOLDEN: Next item.

MS. GORHAM: All right. So, number 28 in your discussion guide.

MEMBER GELZER: Hey, excuse me. Before we go on -- this is Andrea. With regard to the PAM in the LTSS measure set --

CO-CHAIR GOLDEN: Sure.

MEMBER GELZER: -- and, again, this may be beyond the scope of what we're supposed to be doing here, but I do think it's an important comment that in this population, the PAM scores and the questionnaire, it may be just as important to be giving that -- or doing that scoring with the patient caregiver if the patient themselves cannot accurately answer the questions.

So, I don't know if that's an expansion of the use of this tool or if this is even a relevant comment, but I think it is relevant that it's important that patient caregivers also are involved with this segment of the population. Thanks.

CO-CHAIR GOLDEN: I'll add that to the comments. It's a method of collecting the data. Okay.

MS. GORHAM: Okay. So, if you all are at measure 28 in your discussion guide, that is the Home and Community-Based Long-Term Services and Supports Use Measure Definition.

So, this is a concept the TEPs voted on. This is a concept useful for a system-level perspective more suitable. So, we initially had it in a domain and the TEPs thought it was better for the access domain.

It is critical for the community and it assesses states' efforts to rebalance, but does not address quality. It addresses placement from institution to the community, and it is a strategy for states to understand performance.

CO-CHAIR GOLDEN: Comments, questions.

(Pause.)

CO-CHAIR GOLDEN: Next item.

MS. GORHAM: Okay. If you scroll down one to number 29, Individualized Plan of Care

Completed, some of the comments made by the TEP members: Individuals need a care plan. It is important to align care preferences with care plans and address individual lifestyle goals. It is also important to communicate that this measure -- so, it's also important to communicate the measure in a way that non-medical laypersons would understand the measure.

There was some communication and discussion about the fact that the measure is very technical. And when one looks at it, it may not be understood by the layperson. And, also, this aligns with CMS' mandatory person-centered goals.

CO-CHAIR GOLDEN: This is listed as a claims measure; is that correct?

MS. GORHAM: It is.

MEMBER MCCANN: I don't know how you can pull this from claims.

CO-CHAIR GOLDEN: Yeah. There's some odd things there, but okay.

MEMBER MCCANN: Yeah. Right.

CO-CHAIR GOLDEN: Jennifer.

CO-CHAIR MOORE: We're on number 29, right?

MS. GORHAM: Yes.

CO-CHAIR MOORE: Okay. So, yesterday, if I recall, when we saw a denominator that had a generic population by zip code, by gender, et cetera, is a group we were concerned about that.

I also want to note that there is not a lot of information, so I feel in the dark about this measure and would like a little bit more context about how this was included in --

CO-CHAIR GOLDEN: Yeah. They said the measure source was a TEP measure -- was a TEP member and the staff notes retained by a TEP member. So, this was sort of like, I have a good idea during the meeting.

MS. GORHAM: So, a TEP member -- remember, we had recommendations come in from TEP members, CCs and so forth.

CO-CHAIR GOLDEN: Uh-huh.

MS. GORHAM: And so, a TEP member

recommended this measure. When she recommended the measure, she said that it was a very early concept.

She saved the measure, because, remember, TEP members had the opportunity to save measures. So, she also saved the measure, brought it back for conversation.

They discussed it and the TEP members, as a whole, if I remember correctly, thought that this was a really early concept, but they thought it was important.

MEMBER MCCANN: The only thing I can offer from the -- as a provider is in order to deliver Medicaid, you have to be Medicare certified.

As of, likely, January 2018, there will have to be a person-centered plan of care for every individual. And that becomes an issue of actually remaining eligible for Medicare payment.

So, as we talked about it on the TEP, this is an emerging, if you will, measure, but is

essentially a basic requirement to remain in the program at this point.

CO-CHAIR GOLDEN: It's right now in the cloud somewhere; is that correct?

MEMBER MCCANN: Is that how you would describe it? It is a -- the comment period just closed, but it is a condition of participating -- continuing to participate in the Medicare program.

CO-CHAIR GOLDEN: We have a phone comment.

MEMBER SIDDIQI: Yeah. This is Alvia.

I was just going to say that, you know, I like the idea that this was a measure concept that was being supported.

Because, as we heard earlier with long-term support patients, a lot of times, unfortunately, their care needs are readjusted when they're hospitalized.

And so, I do think that the approach of having an ability to have a care plan across the board accepted is very much applicable to

this population.

CO-CHAIR GOLDEN: We have another phone comment.

MEMBER MOHANTY: Yeah. Hi. This is Sarita.

I just wanted to add I agree with the last comment. I do -- I was a little confused. I know we've talked about the way the measure is defined, but, you know, it also talks about those with a high-risk score to have an individualized care plan.

So, that doesn't seem to correlate with what the denominator is describing. So, I feel that the measure is not quite developed at this point.

CO-CHAIR GOLDEN: Okay. And as we go through this discussion, if you're uncomfortable, you need to extract, if you want to do anything. If not, you know.

So, I have a hand over there. Cheryl.

MEMBER POWELL: I just wanted to make a comment in general that I'm hoping the report

can reflect the understanding that we have of the nascence of the developmentive measures for long-term care or for long-term services and supports.

They don't exist. This is -- we have thousands of medical measures --

CO-CHAIR GOLDEN: And I believe the chair of the TEP has made that comment as well.

MEMBER POWELL: Yeah. I just want to highlight it cannot be stated strongly enough. And, I mean, when it comes to measures for HCBS and long-term services and supports, much less trying to integrate them with anything else or across each other, there's just so little there.

There are a couple of measures that are emerging now. There are the National Core Indicators, there are the CAHPS measures for HCBS. But I think as a committee, it would be wonderful if we could encourage experimentation to find what works, but also continue the trend, because there are a number emerging now not for us.

They're too new, really, for us to

review here, but they are emerging and I think that just started in the last couple of years.

And I would really like us to be able to encourage that further development and highlight how important that is and some of the experimentation of measures and across so that we can really measure this.

It's incredibly difficult. It hasn't really been done. And I applaud the -- actually the inclusion of the idea, because I think it also highlights that nothing exists.

So, anyway, I just wanted to say I hope in the -- I hope that we can do that and I thank the TEP for looking at, like, the 20 measures, many of which actually relate to clinical issues, for doing the best they could.

CO-CHAIR GOLDEN: So, again, does anybody want to extract this measure?

CO-CHAIR MOORE: I would like to have just --

CO-CHAIR GOLDEN: Do you have a comment?

CO-CHAIR MOORE: Yeah.

CO-CHAIR GOLDEN: No. I want to know if anybody wanted to extract.

CO-CHAIR MOORE: I am on the verge of that.

CO-CHAIR GOLDEN: Okay.

CO-CHAIR MOORE: So, I don't want to say "extraction" yet, but I want to make a comment and hopefully there's clarification before I go to that step.

CO-CHAIR GOLDEN: Okay.

CO-CHAIR MOORE: This seems like more of a comment that should be reflected for the record, because this isn't a concept that we have a lot of information on or even a measure. It's very -- I put this in the same category as the comment about, you know, there's missing pediatrics, there's missing this, there's missing that.

I think in the spirit of what we've been doing and the comments that we're providing, I'm not sure that this gives enough information

to actually be meaningful as opposed to just standing in as a comment that this is needed, the community recognizes that this is needed, and encouraging the development of this similarly to the lack of pediatrics, lack of other pieces.

So, before I say "extraction," I'd like to throw that out and then push for us to consider that.

CO-CHAIR GOLDEN: Allison.

MEMBER HAMBLIN: So, I'm about to make that motion and I'm going to make it on the basis of equity with some of the other program areas that we discussed where we had similarly relevant concepts like referral to community resources that I think we all agree is important, risk stratification that we all agree is important, but the measure wasn't developed in a meaningful way.

And so, I would worry by making your exception here for a very loosely defined measure concept, we sort of give short shrift to some of the decisions that we made --

CO-CHAIR GOLDEN: So, if you make that motion, you would have to pick one of the four steps -- five steps it would fail. So, that would be helpful to think about.

MEMBER HAMBLIN: Okay.

CO-CHAIR GOLDEN: Barbara.

MEMBER MCCANN: Thank you. The individualized plan of care which is now going to be mandated for January, likely, is incredibly prescriptive as to the content.

This would -- this is one of the few measures that applies to every single population in Medicaid. And the specificity may not exist in the measure statement, but it exists in the regulation.

CO-CHAIR MOORE: I think I should clarify this isn't a measure right now.

MEMBER MCCANN: Right. Right.

CO-CHAIR MOORE: So --

MEMBER MCCANN: It's just like some other things that we have --

CO-CHAIR MOORE: Yeah.

MEMBER MCCANN: -- going forward with are not measures.

CO-CHAIR MOORE: But I -- but it's not even a well-developed concept yet.

MEMBER MCCANN: No, I disagree. I do believe the individualized patient plan of care is a well-developed concept well enough for it to be a regulation, which is certainly not my preference.

I would also ask the group to think about there is a total absence of standards of practice in this particular area of Medicaid.

This establishes one basic standard of practice. And if you do not do well on this in a federal survey or an accreditation organization survey, your ability to continue to bill is at risk, which means you wouldn't remain Medicaid or Medicare certified.

CO-CHAIR GOLDEN: Karen, you have some comments at the end there?

MEMBER AMSTUTZ: So, I just wanted to add that as you look at the whole concept and

have the discussion that you think about all of the levels of LTSS, including sort of thinking about the role of self-directed care.

I mean, the ultimate is an LTSS program where the individual who's receiving the services is really driving their care plan development, hiring and working with facility intermediary to find the folks they want to have be their caregivers and employing them on the schedule that they think is most appropriate within the context of the sort of plan of care needs. And there just hasn't been any discussion on self-direction, so...

CO-CHAIR GOLDEN: David.

MEMBER KELLEY: Again, I think within a lot of the current LTSS wavier programs, individual plans of care are mandatory. At least in Pennsylvania, ours, you know, there has to be an individual care plan that is submitted. And then we're actually going to be measuring that care plan to see if something -- to see if it's actually done.

I would say that in Pennsylvania with our current managed care plans with, quote/unquote, "straight up Medicaid," we have a program where our plans must report to us an integrated care plan between physical and behavioral health.

And actually posted on CHCS' website from a pilot, actually there is a template of what might encompass a good, integrated care plan between physical health and behavioral health. So, yes, we don't have all the formats.

I will also say that for our long-term support services program, we and other states are in discussions around making these -- the formats of these plans electronically available so that your earlier comment about being in the cloud, our plan is to put these things in the cloud.

So, to say that -- I mean, for any LTSS program for other populations, I mean, individual plan of care is -- I don't know how you operate without that.

CO-CHAIR GOLDEN: Okay. So, my

question here before we go too much further, does anybody want to make a motion to extract?

CO-CHAIR MOORE: I do.

CO-CHAIR GOLDEN: We have a motion to extract.

Any seconds?

Anybody second?

We have a second. Okay. We'll continue discussing. And you would extract because it fails which criteria?

CO-CHAIR MOORE: This measure is not ready for immediate use.

CO-CHAIR GOLDEN: Okay. Thank you.

Judy.

MEMBER ZERZAN: So, I just got in my inbox, a viewpoint from JAMA. "Personalized care planning is a promising strategy to improve person-centeredness and quality of care. Careful attention must be paid as to how it's implemented to ensure it adds value and to avoid having care planning become yet another burden for patients and clinicians that adds cost and complexity

without improving care."

I fully believe that everyone needs a care plan in this situation, but I feel like this, at risk of using the word "squishy," is not ready for prime time and what makes a good care plan is so important.

And given how we've voted on other measures, I know this is an underutilized area, but I think we've already given CMS that message and I worry about this going forward.

CO-CHAIR GOLDEN: And I -- I'll get to Deborah in a second. My concern, if there is one here, is that the description is a better statement of the denominator than the nominator.

The nominator, as written, is completely not appropriate for the description of the measure, but that's neither here nor there, I guess.

Deborah.

MEMBER KILSTEIN: I would also say that it's written to say that it's based on the data source's claims. You know, I don't see how

that would happen. Maybe other supplementary data sources that could be used, but it's not going to be claims.

CO-CHAIR GOLDEN: So, we have a motion and it's been seconded to extract to not forward. And it's based on failure to be ready for immediate use.

Okay. Any other discussions on the item?

(Pause.)

CO-CHAIR GOLDEN: Are we ready to vote?

Let's vote.

MS. KUWAHARA: So, this will be an up or down hand vote. Again, this is measure number 29 on your discussion guide, Individualized Plan of Care Completed.

If you would like to see this measure removed from the LTSS measure set, please raise your hand.

(Voting.)

MS. MURPHY: Alvia, to distribute the

question for you, it's to whether or not -- the vote right now is to remove the measure from the set.

MEMBER SIDDIQI: Okay. So -- okay.

MS. MURPHY: So, you -- yeah. Thank you.

MS. KUWAHARA: And if you would like to see this measure remain in the measure set, please raise your hand.

(Voting.)

MS. KUWAHARA: There were 11 members who would -- I'm sorry. 11 members voted to remove this measure. Nine members voted to keep it. And we did not reach the greater than 60, so the measure will remain in the LTSS measure set.

CO-CHAIR GOLDEN: So, you were saying it would take a 60 percent vote to remove something?

MS. KUWAHARA: Greater than 60 percent.

DR. TERRY: You're overturning, so it's going to be greater --

CO-CHAIR GOLDEN: Okay. I don't know. I'm just tracking the rules here. Okay.

DR. TERRY: Right. You're trying to keep us honest, I know.

CO-CHAIR GOLDEN: I thought it was 60 percent to approve as opposed to 60 percent to --

DR. TERRY: No.

CO-CHAIR GOLDEN: Okay. That's very good.

MS. KUWAHARA: And for record purposes, this was measure number 29 on the discussion guide, Individualized Plan of Care Completed.

CO-CHAIR GOLDEN: And I think, though, just the staff or CMS, I think attention needs to be given to the description of the measure, because it's not accurately recorded as what the measure should be measuring. So, I think it needs some work. So, I suggest some editing on this before it gets sent around.

Okay. Next item.

MS. GORHAM: All right. So, let's

look at number 31 in your discussion guide. And that is the National Core Indicators - Aging and Disability Survey. I'll give you a minute to get there.

And some reasons why the TEP decided to include this measure -- or concept, measure concept is what they actually voted on, this is currently used in states, 14 to be exact, it is critical importance to -- it is of critical importance to disability and aging populations.

It focuses on elements important to quality of life. It's parallel to other hospital-based surveys. This too allows for the voice of individuals to be heard.

ACL is pursuing validation and testing for a subset of the measures, 20. And that information is also included in your discussion guide.

CO-CHAIR GOLDEN: Any comments or questions on this one?

(Pause.)

CO-CHAIR GOLDEN: What's the next

item?

MS. GORHAM Number 30 in your discussion guide. This is the National Core Indicators Survey.

So, the first one, the one I just mentioned, 31, was the aging and disabilities. This one is the National Core Indicators. This is used more. This is used by 46 states.

And, again, the same things apply as reasonings for including the survey into the measure set.

CO-CHAIR GOLDEN: Any other comments or questions on this one?

Judy, are you up or is that -- you're just kind of behind. Okay.

Anything else?

(Pause.)

CO-CHAIR GOLDEN: Next item.

MS. GORHAM: All right. Number 40 in your discussion guide. I'll give you a minute to get there.

This is also a concept. And this is

the number and percent of waiver participants who had assessments completed by the MCO that included physical, behavioral and functional components to determine the member's need.

The TEP members felt that this mandated an assessment and was broad enough to be considered across the waiver population. So, including Ps (phonetic) disability, aging. And so, they thought this was a good concept.

CO-CHAIR GOLDEN: Comments, questions?

Judy.

MEMBER ZERZAN: I like this concept. I just don't like that it's only MCO and that it has to be done by the MCO.

There are states like us that are fee-for-service, but we're managed fee-for-service that I think this would apply to. And I think a lot of waivers are not in states that have managed care in the managed care, so I just want it to be broader since it seems, you know, like a made up measure, like a measure that isn't all the way finalized.

CO-CHAIR GOLDEN: Okay. Other comments, questions?

(Pause.)

CO-CHAIR GOLDEN: Next item.

MS. GORHAM: All right. Number 42. And that is Referral to Community-Based Health Resources. We also discussed this measure for BCN and PMH.

CO-CHAIR GOLDEN: So, this has already been approved?

MS. GORHAM: It did not pass --

CO-CHAIR GOLDEN: It did not pass.

MS. GORHAM: -- BCN.

CO-CHAIR MOORE: It was the one that flagged us about the denominator being population. If you recall, that was one of the ones that --

CO-CHAIR GOLDEN: So, I will take it that because it's failed the group that we've had a motion and a second to remove this item, do we need to have a vote about this item to keep it?

CO-CHAIR MOORE: So, you're saying that

because it's been removed from others, do we need to have the same with this one?

CO-CHAIR GOLDEN: Yeah. I was going to say we -- I would take it since the group has turned it down once or twice, that there's already been a motion and a second to extract.

So, do we need another vote? Do we want to do it formally? We should do another up or down vote.

And if you want to have additional conversation on this, let's have --

MEMBER WALLACE: (Speaking off mic.)

CO-CHAIR GOLDEN: Okay. That's fine.

(Speaking off mic.)

CO-CHAIR GOLDEN: I'm sorry, I can't hear you.

SPEAKER: I'm sorry, a clarification. This is a measure concept, right?

MEMBER WALLACE: Uh-huh.

SPEAKER: Okay. thank you.

MEMBER WALLACE: And I believe when it was considered before it was -- was it one of the

ones that was pulled -- that was referred to another group. And so, the CC was the only body that had, at that point, reviewed it.

Because we're going to be overturning the work of our TEP, I feel like it needs to have -- to be voted on.

CO-CHAIR GOLDEN: That's fine. So, is anyone disagreeing about -- extraction is on the table.

Do we want to have discussions about extraction and a move. Are we ready to vote?

CO-CHAIR MOORE: Do we need someone to do a motion?

CO-CHAIR GOLDEN: No, the motion is to remove it.

CO-CHAIR MOORE: Susan, that's your motion?

CO-CHAIR GOLDEN: No, I'm sorry. I -- the chair declared that there was a motion to remove the item since we've removed it from other TEPs.

So, we've already had a vote by the

members of the committee on multiple occasions on this. So, I just said on the table, I would assume that for the sake of consistency that, unless people want, I'm not going to do that.

So, are we ready to have a vote about removing this item? Okay.

MS. KUWAHARA: We are voting to remove measure number 42, Referral to Community-Based Health Resources, from the LTSS measure set. This will be an up or down vote.

If you would like to see this measure removed from the measure set, please raise your hand.

(Voting.)

MS. BUCHANAN: And participants on the phone, if you want to type in "vote to remove" or "not to remove" into the chat box?

(Voting.)

MS. KUWAHARA: So, I just want to clarify you are voting to remove it.

MEMBER GELZER: Yeah -- let me see. Hold on. This is for the community-based

resources one, yes.

MS. KUWAHARA: Yes. Okay.

And, Alvia, I just want to clarify you are voting not to remove it?

MEMBER SIDDIQI: Correct. So -- this is Alvia. And I guess what I'm curious about is when you're including this measure in this set, wouldn't the population be the long-term support service patient and, hence, there is a little bit more direction around who the population is for who this measure is being applied?

And so, yes, I vote to keep it.

MS. BUCHANAN: And those who would like to see the measure retained in the LTSS measure set, please raise your hand.

(Voting.)

MS. KUWAHARA: 17 members voted to remove the measure. Three members voted not to remove the measure. So, the measure will be removed from the LTSS measure set. And this is measure number 42, Referral to Community-Based Health Resources.

CO-CHAIR GOLDEN: Do we have any other items? We do?

MS. GORHAM: Yes.

CO-CHAIR GOLDEN: Okay.

MS. GORHAM: So, we have two more, actually.

If you would scroll to number 35 in your discussion guide, this is NQF 0647. And this is Transition Record With Specified Elements Received by Discharged Patients (Discharge is From an Inpatient Facility to Home Self-Care or Any Other Site of Care).

So, the TPEs thought that this was critical to provide LTSS. You need information when a person is released from an institution critical for the primary care and other LTSS providers to have information in order to provide appropriate services in the community.

DR. TERRY: Can I just ask the one that we voted on the other day, the transition care measure, was it this one, or was it for a --

CO-CHAIR GOLDEN: This is a different

measure.

DR. TERRY: It is. Okay.

CO-CHAIR GOLDEN: This is a different measure.

DR. TERRY: But this one also will probably lose endorsement, just so you know.

CO-CHAIR GOLDEN: So, this is -- and this is to be given to the patient, if I'm not -- is that what it states? So, this is to be given to the patient or the caregiver.

Comments, questions -- Allison.

MEMBER HAMBLIN: Yeah. I just have a question for anybody who knows these two measures. I would love to know why we're recommending one for one area and one for another.

So, if anybody has insight onto that, that would be great just so that we appear consistent.

CO-CHAIR MOORE: I guess the question is, did this TEP see both of them and review both of them?

MS. GORHAM: So, the LTSS TEP reviewed both of these measures, voted on both of these measures and decided that they were relevant for the LTSS population.

MEMBER HAMBLIN: Oh, I'm sorry. I meant the one below.

MEMBER HENNESSEY: Yeah. And I think the difference, if I recall, is that the one that we're looking at right now talks about giving the caregiver a record, if I'm understanding this correctly, whereas the one below it talks about giving -- or the patient or caregiver.

The one below it is talking about clinician-to-clinician communication. Thank you.

MEMBER HAMBLIN: Thank you. That's helpful.

CO-CHAIR GOLDEN: And if I am not mistaken, also the same steward -- the same measure steward. And the other measure had lost the NQF status only because it had not filed for retesting; isn't that correct?

DR. TERRY: They had not had -- all

the transition care measures that we saw and care coordination were -- are slated to lose endorsement not yet as they go through CSAC, but because there is no new performance data presented over the last three years since it was --

MS. GORHAM: Also have it known here that the same committee did not accept the reliability testing. And, therefore, did not recommend the measure for endorsement, but just another note.

CO-CHAIR GOLDEN: That was the core set, yeah.

MS. GORHAM: Well, this is the care coordination committee that Peg just referenced, but also this measure was formally on the adult core set and it was removed from the 2017 core set.

CO-CHAIR GOLDEN: Actually, it's the next measure. This one is a different measure.

MS. GORHAM: 0647 was formally on the adult core set and removed from the 2017 core

set. That is the measure we're looking at right now.

CO-CHAIR GOLDEN: Okay. Any motions for extraction?

MEMBER HENNESSEY: I had a question.

CO-CHAIR GOLDEN: Yes.

MEMBER HENNESSEY: Could you say a little bit about why the committee chose to keep the -- the panel chose to recommend these, please, despite the fact that there had been these lack of recommendation and there wasn't data -- new data. Thanks.

MEMBER MCCANN: Transitions remain the biggest issue for community-based services and receiving any information whatsoever.

So, we didn't understand why -- actually why it was so problematic, because the process in bundling ACOs, however you want to do it by payer, is trying to give either those that are discharged to self-care something from the facility. This crosses a nice range of facilities better than usual.

And then to also give it to the provider so you have a place to start for the assessment in the community. This is not common practice, unfortunately.

MEMBER HENNESSEY: Thank you.

CO-CHAIR GOLDEN: Anyone else? Comments, questions, motions for extraction?

(Pause.)

CO-CHAIR GOLDEN: Next item.

MS. GORHAM: All right. So, number 36 on your discussion guide, if you scroll down one, is NQF 0648. And that is the Timely Transmission of Transition Record (Discharge From an Inpatient Facility to Home/Self-Care and/or Other Site of Care).

For the same reasons as stated above for the previous measure, the TEPs were -- this measure was critical. Also, timeliness of one day of being discharged into the community was very important and it addresses health literacy.

This measure, if you remember, was considered yesterday for BCN and voted to remain

-- you all voted to keep it for BCN as well.

CO-CHAIR GOLDEN: Okay. So, we have -- we moved this from another set in --

MS. GORHAM: No, we kept it.

CO-CHAIR GOLDEN: I'm sorry, we kept it. Pardon me. Okay.

So, any other additional comments or questions on this item?

(Pause.)

CO-CHAIR GOLDEN: Next item.

MS. GORHAM: So, that concludes our discussion for the LTSS measure set.

CO-CHAIR GOLDEN: Super. We can take a break, I guess, at this point -- oh, public comment.

I will say, by the way, I have gotten an email from one of our phone participants. And this is Chip, who voted earlier.

(Laughter.)

CO-CHAIR GOLDEN: He has no conflicts of interest.

(Laughter.)

CO-CHAIR MOORE: In fact, I think the question -- the logic model about stakeholders, we should include Chip.

(Laughter.)

MS. BUCHANAN: We are now opening the lines for public comment. We invite anyone to comment either through phone, through chat box. Or if they're in person, there is a microphone available.

And so, Alvia, if you don't mind opening the lines, and I see that we have a comment in the room. So, we'll take that one first.

MS. DOBSON: Thank you. Good afternoon. Camille Dobson. I'm the deputy executive director at the National Association of States United for Aging and Disabilities.

We are the membership association sister to the Medicaid directors who represent the state aging and disability directors who deliver directly HCBS services to the more than three million individuals who get those services

every year.

And so, I was a member, an unofficial member of the LTSS TEP -- a nonvoting member of the LTSS TEP to bring some direct state experience to the TEP about -- as they look through the measures that were in front of them.

So, one, I'm very passionate -- we're very passionate about this work. That's all our members focus on is HCBS and they really spend a lot of time thinking about ways to deliver those services in the best manner that they can.

I would echo -- I really commend the committee for passing on as many measures as possible. As I think Cheryl and MaryBeth and a number of other people said, this is a really nascent area.

States are the innovators, because these services aren't delivered in the commercial space. And so, there's no -- there's nobody to build measures for us, for the states in the Medicaid space. They sort of make it up on their own.

So, they don't have the kind of validity and evidence testing, because, frankly, the states don't have the money to do that. They're delivering services to people.

So, but that doesn't mean that they're not any -- they're not any less valuable and useful and effective in helping states improve their program.

So, we appreciate the fact that there's a nice set that's being passed on to CMS for states to consider.

I will just note again for the report, and I mentioned this in the TEP, that there is still significant gaps. Lots of gaps.

I was a member of the NQF HCBS quality framework group. We identified 11 domains for measurement of assessment of quality and these measures might have -- might be in two or three.

And so, there are lots of gaps around choice and control for individuals, because, really, in the end, HCBS services are about living -- helping people live the most

independent and fulfilled lives that they can.

And so, there's very little about the delivery of services. If people don't get these services, they don't live, period. They can't get out of bed, they can't work.

And so, actually getting services to people is a really critical piece. No measures in here about how effectively those services get delivered to people.

And then last, but not least, around the workforce shortage, it is a massive and emerging crisis as our elderly population explodes. People are diagnosed with disabilities more and more frequently and there are not enough highly qualified staff out there to deliver services. And so, measures of quality and the delivery of services to individuals is still lacking.

So, I appreciate the work of the group. We're excited to have a nice set to pick from. But as you know, you know, there's 355 waiver programs out there. Another, I think,

five or six that just do those program through 1115 and they must have thousands of measures that they use today.

So, I think the states will continue to be laboratories for innovation, but appreciate the work of the committee today. Thank you.

MS. TRIANO: Good afternoon. My name is Sarah Triano, and I am the director of policy and innovation for Complex Care for Centene, which is a Medicaid managed care organization.

We actually have the largest number of managed LTSS members of any plan across the country. And we're also a member of the -- recently formed last year, National MLTSS Health Plan Association, which is made up of ten of the largest national health plans in the country that are serving members in long-term services and supports.

Christine Hawkins, who's actually a member of this body, had asked that I come and share just a little bit about the work that they're doing and comment on some of the measures

that you're about to vote on.

So, last year in 2016, there was a Medicaid final rule that came out. And there was a whole section in there, Section 438.330, that called on states to create measures specifically in this area by July of this year.

And they had -- they identified five key outcome areas. One was quality of life, community integration, rebalancing, transitional care, and then did the member actually receive the services that are in the care plan.

You had a lot of discussion about the care plan. All managed care organizations that provide LTSS have to provide a care plan for our members.

So, at that point, the states came to us, all of these health plans, and said, "Help, we need your help." There are literally thousands of measures out there that, you know, different states are implementing.

There's over 80 measures on the NCI-AD. There's over a hundred on the HCBS CAHPS.

There are over 160 that the NQF HCBS Committee came up with in their report. So, the states came to us and said, "Help"

So, what we did is last fall we rolled up our sleeves. We went to our members. We said, "What does quality LTSS mean to you?" We started there, but then we combed through, literally, the hundreds and hundreds of measures that are out there, because the states wanted to know from us, this is great, but what can you actually implement, right?

Because at the end of the day, some of the conversation that you've been having is about 78 percent of our members who receive LTSS are duals.

And if they're in a non-aligned Medicare plan, we do not have access to that data to be able to report it.

So, we sat down and we said, what are the measures that we can actually implement and that we can report very quickly?

We have assessment data already right

now today. We could report on this in as little as a month.

And so, we also met with the chairs of the NQF HCBS Committee and created a framework of 37 measures -- only 37 measures in five domains that actually match up with the 2016 regulation. And I wanted to just share a paper that we had put out a couple months ago that outlines those 37 measures for you.

So, I made copies, if I -- okay. And just to give you a piece of information, yesterday the association of all the health plan -- the ten health plans met with CMS' quality division. And we're going to be holding a workgroup to actually test -- we have broken the 37 measures out into three tiers of implementation that we're going to report and we're holding -- we're starting a workgroup to actually test some of these measures.

So, I -- the thing I would want to do is just tell you what I would like to see come out of this group is something that is aligned

with not just the work that we've done, but the work of the NQF HCBS Committee has done a lot of work in this area and has come up with some measures that we believe really reflect what is actually being done in long-term services and support service.

So, that four -- in the areas of quality of life, again, community integration, rebalancing, transitional care, and did the members receive services in the care plan.

The last thing I want to share with you is we did an analysis of the measures that you're about to vote on and how they are aligned or not aligned with the ones that we just put out in our paper. And so, I'd like to pass that out to you as well.

Some of them definitely are. So, for example, the HCBS CAHPS absolutely. But, again, as I mentioned, there are over a hundred measures in that measure set. To think that we are going to actually implement that, right, along with all of the other ones is -- it's just not realistic.

It's not going to happen.

So, I wanted to pass this out for you so that you have an analysis of where the measures align and where actually some of them really don't.

The white paper is available. If you go to www.mltss.org, the measure set is there. So, thank you for the opportunity to comment.

DR. BERSHADSKY: Hi. Julie Bershadsky from Human Services Research Institute out in Boston. My comment is actually going to be very short, promise, and very -- fairly narrow.

And that is I don't know how much of this is going to enter into the voting considerations today. But if it is, I would just like to, I guess, second a reminder that was voiced a little bit earlier.

And that is in terms of evidence of validity and reliability with the measures you were considering today, just because potentially something has not been submitted to NQF as evidence in the process of endorsement, it does

not mean that that evidence does not exist or that a measure is not valid or reliable.

So, I'm a methodologist by training and I just, you know, a lot of people don't care about that, but I do. So, that's all I had to contribute.

MS. BUCHANAN: Do we have any public comments on the phone?

THE OPERATOR: We have no public comments at this time.

MS. BUCHANAN: Thank you.

CO-CHAIR GOLDEN: Are we at the end here? We can take a break. Thank you all for hanging in there. It is now 2:20. How about 10 minutes?

CO-CHAIR MOORE: Do we have to vote on the whole set?

SPEAKER: Yes.

CO-CHAIR GOLDEN: I'm sorry. Okay. One more vote. Don't leave. Can't break. Emerson -- we have to be consistent. So, we have to vote about accepting the entire set.

So, all in favor of accepting --

MS. GORHAM: We will pull it up real fast just so you have it on the slide. And it includes the three measures that you decided on today to include in the measure set, and it excludes the measure that you decided to exclude.

So, the three measures that you included today was the NQF 0097, also the Percentage of Short-Stay Residents Who Were Successfully Discharged to the Community, as well as NQF 0419.

Those were the additions made and we decided to -- or you decided to remove measure number 42, on your discussion guide, which was referral to community-based resources.

And it has been removed, so now we will take a vote on the overall set.

MS. BUCHANAN: Participants on the phone, please type "yes" or "no."

CO-CHAIR GOLDEN: So, all in favor of the set as we have produced, please raise your hand.

(Voting.)

CO-CHAIR GOLDEN: Okay. And you can lower that. And anybody opposed, raise your hand, please.

(Voting.)

CO-CHAIR GOLDEN: Okay.

MS. KUWAHARA: 19 of the 19 voting members voted to recommend the LTSS measure set to CMS' Medicaid Innovation Accelerator Program.

CO-CHAIR GOLDEN: So, it's now 2:24. How about breaking to 2:35 -- yeah, 2:35. Fair enough?

(Whereupon, the proceedings went off the record at 2:25 p.m. and resumed at 2:36 p.m.)

CO-CHAIR MOORE: All right. Shaconna is going to take us through how we're going to spend the rest of the afternoon together.

MS. GORHAM: All right. So first of all, we thank you all for your participation thus far. We're going to go back, since we finished all of our programs areas except PMH; we're going to go back to the PMH program area.

We have our illustrious Chair of the PMH TEP back with us, and we are going to start with the PMH measures for reconsideration, because we did not go through the decision logic for those measures; they were reconsidered. So we'll have to go back through the decision logic for those measures.

After doing that, we will look at the PMH measure set as a whole, and then you all have the opportunity to remove any measures from the block and then we'll vote on the blocks.

What we are going to do because we recognize that there are a good number of members who have planes and trains and automobiles -- all that good stuff -- to catch, we are not going to finish our agenda today.

So after we finish the review of the PMH measure set, we will postpone the final review of all of the measure sets for our post-meeting webinar. Okay?

So with that, I will hand it over to Kate to go back to the program area.

CO-CHAIR MOORE: But if we do finish it today, do we get anything, you know, cupcakes?

(Laughter.)

CO-CHAIR MOORE: I'm really trying to work on this motivation piece. So yesterday, breaks, bathroom, cookies didn't work.

CO-CHAIR GOLDEN: And Chip will wag his tail.

MS. BUCHANAN: Okay. So we are going to be voting through number 97 on your discussion guide, NQF-2602; controlling high blood pressure for people with serious mental illness.

And so as you all pull that up, I will give you -- number 97 on the discussion guide. And I'll give people just a moment to get that. And then once people have it pulled up, I'll turn it over to Miranda to walk us through the decision logic.

CO-CHAIR MOORE: Can you remind us, for each of these -- not that a lot of time has passed, but -- how we had decided last time that we would go into it?

MS. BUCHANAN: Of course. So for this one, we voted on this morning, we did the straight up or down, we voted to include. But it did not go through the decision logic.

CO-CHAIR MOORE: Yes.

MS. BUCHANAN: So we just need to have it go through that now.

CO-CHAIR MOORE: Okay.

MS. BUCHANAN: And with that, I'll turn it over to Miranda.

MS. KUWAHARA: This is Measure Number 97, NQF Number 2062, controlling high blood pressure for people with serious mental illness. Again, we'll go to hand votes and take this through the decision logic.

So for our first vote, to what extent does this measure or measure concept address the CMS quality measurement domains, and/or program area key concepts?

For high, please raise your hand.

For medium, please raise your hand.

And low, please raise your hand.

MS. KUWAHARA: Okay. Sixteen members voted high, two members voted medium, and zero members voted low.

Moving on to the next step in the decision logic; to what extent will this measure address an opportunity for improvement and/or significant variation in care?

Those who vote high, please raise your hand.

MS. BUCHANAN: And we're just waiting for one more -- oh, no, we just got it. We have all the people on the phone, thank you.

MS. KUWAHARA: Medium, please raise your hand.

Sixteen members voted high, two members voted medium, and zero members voted low.

On to the next step; to what extent does this measure demonstrate efficient use of resources and/or contribute to alignment?

For high, please raise your hand.

Medium?

And low?

Thirteen members voted high, four members voted medium, and one member voted low.

Because this is an NQF-endorsed measure, we're now skipping to the last question in the decision logic. To what extent do you think this measure is important to state Medicaid agencies and other stakeholders?

For high, please raise your hand.

MS. BUCHANAN: Just waiting for one -- oh, just got it.

MS. KUWAHARA: Medium?

And low?

Okay. Eleven members voted high, eight members voted medium. This measure will be recommended in the PMH measure set. And again, this is Measure Number 97, NQF Number 2602, controlling high blood pressure for people with serious mental illness.

MS. BUCHANAN: Okay. And so we'll be moving on to measure 85 on your discussion guide. This is NQF-0710, depression remission at twelve months. And so once again that's number 85 on

your discussion guide. I will give you a moment to get there, and then Miranda will walk you through the voting.

CO-CHAIR MOORE: And can you remind us again how we decided?

MS. KUWAHARA: So this was a straight up or down; we voted to recommend. And so we just need to walk it through.

CO-CHAIR MOORE: Yes.

MS. KUWAHARA: Again, we're voting on Measure Number 85, NQF Number 0710; depression remission at twelve months.

The first vote; to what extent does this measure address the CMS quality measurement domains and/or key concepts?

For high, please raise your hand.

Medium?

MS. BUCHANAN: And Judy, it looks like you're now on your line. And so we're voting --

MEMBER ZERZAN: I am, I'm high.

MS. BUCHANAN: You're a high grade, thank you.

MS. KUWAHARA: And low?

Thirteen members voted high, five members voted medium, and one member voted low.

The next question; to what extent will this measure address an opportunity for improvement and/or significant variation in care?

Those who vote high, please raise your hand.

MS. BUCHANAN: And Judy, are you a high, middle, or low for this one?

MEMBER ZERZAN: I'm a high.

MS. BUCHANAN: Okay, thank you.

MS. KUWAHARA: Medium, please?

And low?

Nine members voted high, nine members voted medium, and one member voted low.

Moving on to the next step; to what extent does this measure demonstrate efficient use of resources and/or contribute to alignment?

High, please raise your hand.

I'll repeat the question. It was, to what extent does this measure demonstrate

efficient use of resources and/or contribute to alignment? Yes, this is for high.

MS. BUCHANAN: And Judy, are you a high, medium, or low?

MEMBER ZERZAN: I'll vote medium.

MS. BUCHANAN: Medium? Thank you.

MS. KUWAHARA: Medium?

And low?

Six members voted high, ten members voted medium, and two members voted low.

To the next and final step; to what extent do you think this measure is important to state Medicaid agencies and other key stakeholders?

For high, please raise your hand.

MS. BUCHANAN: And Judy, are you a high, medium, or low for this one? Stakeholders?

MEMBER ZERZAN: High.

MS. BUCHANAN: Okay.

MS. KUWAHARA: Medium?

And low?

Thirteen members voted high, five

members voted medium, and one member voted low. Measure Number 85, NQF Number 0710, depression remission at twelve months will be recommended for inclusion in the PMH measure set.

MS. BUCHANAN: And so we have one more; it's the behavioral health risk assessment for pregnant women. This is the one that was recommended; it's in the handout you have in front of you; or if you're participating remotely, it is the email that we sent.

Just a quick description again, just for people to familiarize themselves; it's percentage of patients, regardless of age, who gave birth during a 12-month period, seen at least once for prenatal care who received a behavioral health screening assessment that includes the following screening at first prenatal visit: depression, alcohol use, tobacco use, drug use, and intimate partner violence.

Originally, the committee did vote to include this, but it was an up or down.

MS. KUWAHARA: Again, this is Measure

Behavioral Health Risk Assessment for Pregnant Women. 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?

For those who vote high, please raise your hand.

MS. BUCHANAN: And Sarita, if you don't mind, is your yes a high, medium or low for this?

MEMBER SIDDIQI: Sorry about that.

MEMBER ZERZAN: This is Judy; I'm a high.

MS. BUCHANAN: Thank you, Judy.

MEMBER MOHANTY: I just submitted.

MS. BUCHANAN: Thank you, Sarita. Okay. Great.

MS. KUWAHARA: Medium?

Low?

Eighteen members voted high, one member voted medium, and no members voted low. The next step; to what extent will this measure

address an opportunity for improvement and/or significant variation in care?

Those who vote high, please raise your hand.

MS. BUCHANAN: And Judy, are you a high, medium, or low for this one?

MEMBER ZERZAN: I'm high.

MS. BUCHANAN: Wonderful, thank you.

MS. KUWAHARA: Medium?

And low.

Eighteen members voted high, one member voted medium, and no members voted low.

To what extent does this measure or measure concept demonstrate efficient use of resources and/or contribute to alignment?

Those who vote high, please raise your hand.

MS. BUCHANAN: And Judy, would you mind stating your vote?

MEMBER ZERZAN: Is this a high or a yes?

MS. BUCHANAN: This is a high, medium,

or low.

MEMBER ZERZAN: I'm medium.

MS. BUCHANAN: Thank you. And Alvia, I don't see anything from you yet.

MEMBER SIDDIQI: Sorry; high.

MS. BUCHANAN: Got it, thank you.

MS. KUWAHARA: Medium, please raise your hand.

And low?

MEMBER ZERZAN: I'm medium.

MS. BUCHANAN: Yes, got it. Thank you.

MS. KUWAHARA: Ten members voted high, eight members voted medium, and one member voted low. To what extent is this measure or measure concept ready for immediate use? And this is yes or no question. Those who vote yes, please raise your hand.

MEMBER ZERZAN: I'm a yes.

MS. BUCHANAN: Thank you, Judy.

MS. KUWAHARA: And no?

MS. MURPHY: I think -- Maureen, did

you vote yes?

MEMBER HENNESSEY: I voted yes.

MS. MURPHY: Oh, I'm sorry. I must have just missed your hand.

MS. KUWAHARA: Nineteen voted yes, zero votes for no. The last question; to what extent do you think this measure is important to state Medicaid agencies and other key stakeholders?

For high, please raise your hand.

MS. BUCHANAN: And Judy, this is a high, medium, or low one.

MEMBER ZERZAN: High.

MS. BUCHANAN: Thank you.

(Off mic question)

MS. BUCHANAN: Sure. We're at the last step, the stakeholder's question.

MS. KUWAHARA: Medium?

And low?

Eighteen members voted high, one member voted medium, and no members voted low. This Measure, Behavioral Health Risk Assessment

for Pregnant Women, will be recommended for inclusion in the PMH measure set.

MS. BUCHANAN: Wonderful. Thank you so much, Miranda. So we are now going to go to review the PMH measure set. And I am pulling it up now.

CO-CHAIR MOORE: And since we have 26 measures in an hour, we should be good.

MS. BUCHANAN: So the first measure is number 75 on your discussion guide. It's the combined behavioral health, physical health, and patient 30-day re-admission rate for individuals with FMI-eligible population denominator and numerator specifications.

Once again, that is number 75. I'm going to pull it up right now. And so I will provide a little rationale as to why the TEP chose to include it.

They recommended this as a promising measure concept. They said, although the measure concept is only in its first year of implementation in Pennsylvania, it directly

addresses the issue of mental health and physical health integration.

Specifically, the measure concept captured re-admissions within 30 days of anyone diagnosed with a behavioral health condition, so it's re-admission for either behavioral health or physical health conditions if they've been previously diagnosed with a mental health condition.

And we'll track whether or not we have any re-admission. So we felt this really hit to the crux of the program area, even though it's only in its first year, they did recommend it as a promising measure concept.

CO-CHAIR MOORE: Any comments, concerns, objections? Going once, going twice --

MEMBER GELZER: Hey, this is Andrea --

CO-CHAIR MOORE: Darn it all, Andrea.

(Laughter.)

CO-CHAIR MOORE: Just kidding.

MEMBER GELZER: No, I think this is a great measure. I'm just in a carve-out state.

Behavioral health patient admissions are going to be on the behavioral health side of things, and physical health are going to be in the physical health plan side of things.

So it's going to be the state that's going to be able to capture this data, because I guess readily we get the BHUM data ultimately. But there's a lag period. So I just -- Dave, can you comment on this?

MS. BUCHANAN: So Andrea, the question is how is it captured?

MEMBER GELZER: Yes. I'm just saying for example, Pennsylvania is a carve-out state for behavioral health. You have physical health plans, you have behavioral health plans. We're trying to coordinate data and have much better data transfer from behavioral health plans to physical health plans and vice versa.

That said, the data isn't real time available. I mean there's just a lag period in collecting it, and I just wanted to acknowledge that.

MS. BUCHANAN: Yes, and my recollection -- Maureen feel free to step in -- is that the person who recommended this from the State of Pennsylvania said it was going to be a large lift unless this was something we were really dedicated for. So I think it's reflecting your comment, Andrea.

MEMBER KELLEY: I'll speak to it from Pennsylvania, since this is a program that we're operationalizing. There are two things; one is that we require physical and behavioral health plans, the submit their encounters to us.

We have an EQRO and by law, every Medicaid program is supposed to their EQRO to develop quality metrics. We also require -- we give our EQRO all of our encounters.

So the EQRO is actually the one who pulls the physical health data and validates it. So that's how the metric gets especially validated by our EQRO, done by out EQRO and validated by our EQRO.

Another component of this program

that's not mentioned here is an electronic transmission for the most part, of inpatient stays within 24 hours. And they have to do it 90 percent of the time.

And I will tell you almost all of the MCOs were able to do that. And the only ones who weren't able to do that were because their lawyers couldn't agree on interpreting HIPPA.

Once they finally got them to agree to that, they met that threshold. But they're not going to get incentive payments because they weren't able to.

So the behavioral health plan is getting real time electronic -- within 24 hours up to 90 percent of the time, they're actually getting the admissions they should have. I mean, I have all the data, but they actually know, real time, almost, when that is happening.

CO-CHAIR MOORE: Andrea, does that answer your question?

MEMBER GELZER: Yes, thank you for that clarification. I think it's a very

important measure.

MEMBER HENNESSEY: Yes, and I would just say -- this is Maureen -- I would just say that the TEPs felt that we're talking about individuals with acute inpatient care. So we're talking a high level of acuity, and therefore even if it is a lift, this is the group that we should be particularly focusing on from an integration of health and behavioral health care perspective, and this measure helps to do that. Thank you.

CO-CHAIR MOORE: Thanks. MaryBeth, and then we will go to Karen.

MEMBER MUSUMECI: I just would add that Kaiser Family Foundation does a 50-state budget survey of all the Medicaid programs annually; and physical behavioral health integration is another trend that we've seen in recent years. So states are moving away from the historic carve-outs, and going towards carve-ins.

So to the extent that, as we discussed before, these aren't mandatory in putting things

in the tool kit, I think this reflects something useful for states as they move in that direction.

CO-CHAIR MOORE: Thanks. Karen?

MEMBER AMSTUTZ: Yes, just one last comment. I agree with all of what's been said, and I would add that, as a company that actually runs a health plan specific for patients who have serious mental illness, that is the qualifying event in part, in Florida.

The waits that you will see when you begin to manage this population will knock your socks off. And so it will be well worth every bit of agony that we all go through to integrate these data sources.

CO-CHAIR MOORE: Okay. I think we're ready to move on to the next one.

MS. BUCHANAN: Great. Thank you very much. So the next one is number 76 on your discussion guide; depression, remission, or response for adolescents and adults. And I will say that this is something that we've discussed earlier in the day.

This is a first year HEDIS Measure, and because of that, the TEP worried that the measure would not be an efficient use of resources, and cities are not sure how many individuals it may capture.

But the TEP voted to include it because it was an outcome measure that extends beyond screening for depression, and it looks at an individual's response to treatment. Additionally, members appreciated that the measure relies on patient reported data, since many of the measures they reviewed did not.

CO-CHAIR MOORE: Can you refresh our memory on how we voted on this one?

MS. BUCHANAN: Oh, we didn't vote on this one; we just discussed it.

CO-CHAIR MOORE: Just discussed it. Comments or concerns?

MEMBER HENNESSEY: This is the electronic quality grid measure that we spoke about. It also begins evaluation at age 12, so it has a larger numerator from that perspective.

CO-CHAIR MOORE: Okay. Great. Anyone on the phone? All right. Let's move to the next.

MS. BUCHANAN: Great. So next we're on to number 77 on your discussion guide; follow up after emergency department visit for mental illness.

And the TEP said, since the measure includes follow-up care provided by both behavioral health and non-behavioral health clinicians, it directly addresses the issue of integration of mental and physical health.

It is similar to another they reviewed, NQF-2605. And they voted that both of these measures did not include certain wraparound clinical services for individuals with serious mental illness and physical health conditions, such as assertive community treatment act, mobile crisis services or Lifeline.

But despite this concern, the TEP recommended to the CC for review. And I will say that this concern of wraparound services was seen

in several measures, and that the theme was that they just wanted more included.

CO-CHAIR MOORE: Additional comments or concerns that you wanted to voice? Karen?

MEMBER AMSTUTZ: I would just note that I think the challenge that we're going to have in Medicaid behavioral health with all of the benefits, is the fact that these benefits are very exclusive to Medicaid programs. So they're not found in commercial or Medicare.

And hence, the metrics that we develop really have to be very specific to not just the population, but also the benefit package. And likely, also from that, the provider types, since it's really a very different delivery system.

So I agree; let's get started, but note that those of us involved in Medicaid are going to have to actually carry the flag, here.

MS. BUCHANAN: Thank you for that; we'll note that in our report.

CO-CHAIR MOORE: Next item?

MS. BUCHANAN: Great, so number 78;

mental health service penetration. And the TEP said this measure is important because it allows programs to measure the effectiveness of behavioral health integration from a payer perspective.

The denominator of the measure, which is; all individuals in the eligible population with the mental health service need within the 24-month identification window.

So they felt that this denominator allows for population stratification, so that programs could utilize the measure to assess mental health service penetration among different sub-populations.

Further, the measure assesses care provided by behavioral health and non-behavioral health clinicians, and will capture a large population of people who receive services.

CO-CHAIR MOORE: Comments or concerns? Anyone on the phone? All right. Next one.

MS. BUCHANAN: So we are moving just one down to number 79, which is mental health

utilization; number and percentage of members receiving the following mental health services during the measurement year: any service, inpatient, intensive outpatient, or partial hospitalization, and outpatient or emergency department.

And so the TEP expressed concerns since the measure focuses on individuals' mental health issues as the primary diagnosis. In the ED, it may only capture a small sample of those co-occurring mental and physical health conditions.

And as Maureen and I talked about this morning, one of the issues is, it's not so much a knock on the measure as the way people provide care, and that it may not be able to capture everyone.

But since the measure is a HEDIS Measure, and NCQA-accredited programs, including commercial, Medicare and Medicaid programs will report on this, there is an opportunity to compare performance across programs.

CO-CHAIR GOLDEN: I guess I -- does anybody use this? Does this discriminate about anything? I mean, it's basically outpatient, inpatient, acute care, chronic care.

I'm not sure; I mean, it's sort of a utilization measure, but it's not much of a quality measure.

MEMBER HENNESSEY: Yes, this is Andrea. That's exactly what I was thinking. Is it a measure of acuity? I mean, having a high number of services, they might be good services for the population. It may indicate unmet needs, because there's no differentiation as to whether it's an outpatient or an inpatient, or professional service.

CO-CHAIR MOORE: Michael?

MEMBER PHELAN: I think a measure like this, though, would still be valuable to be able to share with either health systems or states to show that you've got a deficit of either beds or access. And they don't know if this measure discriminates between the different -- is there a

breakdown in this measure? Does anyone know, is there a breakdown between inpatient, outpatient, ED visits?

Because it would be really valuable to be able to look at that from a health systems point of view and say, maybe we don't have enough outpatient resources. Or maybe our inpatient bed needs to go up because there's a greater percentage. So I still like the measure included.

CO-CHAIR MOORE: Karen?

MEMBER AMSTUTZ: Yes, so just talking from the behavioral health business perspective and working with a lot of health plan customers; we use these measures extensively and they are really good crude indicators of sort of overall utilization. You'll see places, plans, they come in at only five percent of their individuals are receiving a mental health service.

And we just know that's grossly too low. So it really gives you a good starting point.

I think if I was going to add any distinction there, it's obviously missing the professional services, on the professional side to distinguish both total professional services, but both prescribers and non-prescribers, because the access to prescribers is clearly a huge issue.

CO-CHAIR MOORE: Thank you. Allison?

MEMBER HAMBLIN: Just on a similar vein, MaryBeth has noted the move towards integrated manager and integrated financing for physical and mental health benefits in Medicaid across the states, and I would say that this measure is an important one to monitor as that delivery system trend happens, to be able to identify if there are any changes in access to service, either for better or worse, and the nuances within that.

CO-CHAIR MOORE: All right. Any other comments on the phone? Oh, go ahead Maureen.

MEMBER HENNESSEY: Another comment, which is to say because you can stratify here,

you can also start to look for disparities in care, as well.

CO-CHAIR MOORE: Okay. Thank you. Karen, did you have one more comment? Okay. Great. All right, we're ready to move on.

MS. BUCHANAN: Great. Number 80 on your discussion guide, NQF Number 0097; medication reconciliation post discharge, as we have discussed this in numerous program areas.

And I won't rehash it too much, but the PMH TEP felt this was very important to be assessing the integration of physical and mental health services.

CO-CHAIR MOORE: Any comments or concerns? Anyone on the phone? All right.

MS. BUCHANAN: So we're now on 81; NQF-0105; anti-depressant medication management. And the TEP included this measure because it assesses continuous treatment both in the short term -- so the first 90 days of the initiation of treatment -- as well as the longer term, six months after the initiation.

And so they liked that it addressed the two aspects of the care. Additionally, they liked that it is a HEDIS Measure, so it will be reported under numerous health plans, which will again allow for comparison.

CO-CHAIR MOORE: And it's also part of the Medicaid adult core set. Any comments or concerns? Anyone on the phone?

MEMBER AMSTUTZ: The comment that I would note from a clinical perspective, and it's something that we see when you institute much broader screening for depression, it doesn't take into account the first line treatment, which is you should really try cognitive behavioral therapy as an alternative, or mediation management but in mild cases, it's CBT first.

It doesn't accommodate that. So it's potentially pushing people toward medication.

MEMBER KELLEY: I think it only starts once a script has been filled. So you could have your cognitive behavioral therapy and never get that medication. So you would not be in the --

MEMBER AMSTUTZ: Oh, that has -- okay, so you have to see the prescription in order to have it continue? Okay. Then I'll make one other comment about it. There's still some problems with the measure clinically.

There's actually some pretty good published literature that about 52 percent of the time, the depression diagnosis made by primary care is not confirmed by a psychiatrist as having somebody actually have that diagnosis.

That problem's even worse in the Medicare population where the number is only 15 percent actually have a diagnosis of depression confirmed, when they've been started on an anti-depressant.

So this may be an issue we need to take up with NCQA.

CO-CHAIR GOLDEN: And that gets to my earlier comment about depression and OS. The measure is badly specified.

CO-CHAIR MOORE: Any other comments? Is there a desire to take this one off? Allison?

MEMBER HENNESSEY: It is part of the Medicaid adult core set.

CO-CHAIR MOORE: Yes. Allison?

MEMBER HAMBLIN: I'm just -- I think it was yesterday; my sense of time is little vague, here, but I think there was a comment yesterday about wherever we were making recommendations that included major depression there would be a note about the importance of noting what's included in that definition.

CO-CHAIR GOLDEN: And just a comment from CMS; our program does not use this measure because of the specifications.

CO-CHAIR MOORE: Okay. Thank you. Next?

MS. BUCHANAN: Okay, 82, which is NQF-0418; preventative care and screening; screening for clinical depression and follow-up plan.

And so several TEP members expressed concern about capture in the measure; in their experience, it's very labor-intensive and involved chart review.

But the TEP felt that the measure addressed key issues in the program area and is very important to stakeholders. So they did choose to recommend it. And it is part of the Medicaid adult core set.

CO-CHAIR MOORE: Comments or concerns? Anyone on the phone? All right. Next.

MS. BUCHANAN: So we are now on number 83 which is NQF-0419; documentation of current medications in the medical record, which is --

CO-CHAIR MOORE: Did we already do this one?

MS. BUCHANAN: For LTSS --

CO-CHAIR MOORE: Oh, okay.

MS. BUCHANAN: Yes. And the TEP recommended it because it allows for high opportunity for improvement in the integration of physical and mental health. They also noted that CMS has indicated that this is a high-priority for them, as they already include it in quality payment programs and many providers report on it.

CO-CHAIR MOORE: Okay. This is the

one we got -- any comments or concerns? Anyone on the phone? All right.

MS. BUCHANAN: All right. Number 84, NQF-0576; follow-up after hospitalization for mental illness. And so the TEP was concerned that since the measure only captured follow-up provided by behavioral health clinicians, it would exclude many people who had follow-ups after hospitalization provided by other clinicians.

They felt that this was especially true in areas of the country that had behavioral health provider shortages. Ultimately, they voted to recommend the measure to the CC because the measure is so important to the consumer, but they did have some concerns about it.

CO-CHAIR MOORE: And it is part of the Medicaid adult core set.

MEMBER HENNESSEY: Yes, and I would also add that we had a representative from NAMI who was on our TEP and she particularly thought this was an important measure for consumers from

the consumer stakeholder perspective. Thank you.

CO-CHAIR MOORE: Thank you. Any additional comments? Bill?

CO-CHAIR GOLDEN: As I mentioned last night to some folks; we use this measure but we have to change the specs, because local codes -- we have local code that if we didn't use the local code, it would under-report our measure by a factor of four. So this is a prime example I use for how states modify the code sets.

CO-CHAIR MOORE: Thank you. Additional comments? All right. Next one.

MS. BUCHANAN: Okay. So we are now on 86, which is NQF-1879; adherence to anti-psychotic medications for individuals with schizophrenia. We had a little confusion about this one earlier today, so this is the NQF Measure.

And the TEP voted to recommend because it is a HEDIS Measure and so allows comparisons. Additionally, members said it addresses key areas of the program area, including adherence to anti-

psychotic medications which is highly correlated with stability among individuals who suffer from schizophrenia.

CO-CHAIR MOORE: Any comments or concerns? Anyone from the phone? Okay.

MS. BUCHANAN: Moving right along to number 87, NQF-1880; adherence to mood stabilizers for individuals with bipolar 1 disorder.

And this is a similar rationale that the TEP used. Adherence to mood stabilizers is highly correlated to stability among individuals who suffer from bipolar 1 disorder, and so they voted to recommend.

CO-CHAIR MOORE: Comments or concerns? Anyone from the phone? Next?

MS. BUCHANAN: Okay. So the next one we have -- one moment -- is NQF-90 on the discussion guide. And actually the NQF TEP reviewed both NQF-1927, 90 on the discussion guide, as well as NQF-1933, number 92.

They had kind of similar reasons, so

it was for number 90; cardiovascular health screening for people with schizophrenia or bipolar disorder who are prescribed anti-psychotic medications.

And then number 92, which is NQF-1993; cardiovascular monitoring for people with cardiovascular disease in schizophrenia.

And so they recommended both because they are both highly accepted standards of care. And they agreed that they are effective use of resources, ready for immediate use and very important to stakeholders.

CO-CHAIR MOORE: So let's -- can we do them individually?

MS. BUCHANAN: Of course. Okay.

CO-CHAIR MOORE: So let's open it up to comment or concern for 90. Bill?

CO-CHAIR GOLDEN: I'm not fond of the title; we call this metabolic monitoring, which is what the usual literature refers to this as, because of the risk for diabetes and hyperlipidemia.

So it's not really cardiovascular screening, per se, but the induction of a metabolic syndrome. So while the measure is fine, the title is not really appropriate.

CO-CHAIR MOORE: And according to the discussion guide, Arkansas is using this measure?

CO-CHAIR GOLDEN: We use it. In fact, you cannot get a renewal of your anti-psychotics unless you're getting this done.

CO-CHAIR MOORE: Okay. Any other comments or concerns? On the phone? Okay, let's look at 93.

MS. BUCHANAN: Ninety-two.

CO-CHAIR MOORE: Oh, sorry, 92. Any comments or concerns about this one? And again, this is being used in Arkansas?

CO-CHAIR GOLDEN: Mm-hmm.

CO-CHAIR GOLDEN: And nothing on the phone? All right. Let's move on.

MS. BUCHANAN: Okay. So we are moving on to 91, which is NQF-1932; diabetes screening for people with schizophrenia or bipolar disorder

who are using anti-psychotic medications.

And the TEP voted to recommend because they felt it was relatively easy to capture, assesses its care integration through screening of individuals with mental illness for frequent co-occurring physical health conditions.

CO-CHAIR MOORE: And this is part of the Medicaid adult core set. Any comments or concerns?

CO-CHAIR GOLDEN: The only question I have is, I think these are all the same measure. I mean, I'm not sure these measures are different from each other.

CO-CHAIR MOORE: They're parsing it out, that's how I'm interpreting it. Any other comments or concerns on the phone? Okay.

MS. BUCHANAN: Okay, so then we are moving on to 93, NQF-1934; diabetes monitoring for people with diabetes and schizophrenia. And the TEP recommended since the measure captures a high risk population who have both physical and mental health life-threatening co-morbidities.

And additionally, the two procedures that the measure captures are accepted standards of care.

CO-CHAIR MOORE: Any comments or concerns? On the phone? And we move into the next.

MS. BUCHANAN: Okay. Number 94, NQF number 1937; follow-up after hospitalization for schizophrenia --

CO-CHAIR GOLDEN: Can I stop for a second?

CO-CHAIR MOORE: Yes, Bill.

CO-CHAIR GOLDEN: A comment also for CMS to reflect on. When I order, I order a lipid panel for somebody with metabolic syndrome who has Medicare. My Epic will not accept the order, saying Medicare will not pay for it, even though I put in metabolic monitoring, or I put in toxic drug or anti-psychotics.

So I'm not sure what the coverage data are, but I have to make up a diagnosis in order to get the metabolic monitoring paid for by

Medicare. So that's something to look into, but my EMR won't let me order a test as described by the measures.

MS. BUCHANAN: Okay. And so 94, which is NQF-1937. And as previously stated, the TEP had concerns about which wraparound services the measure included. They were concerned it didn't include an ACT team. But they voted to recommend, as the measure addresses an important element of physical and mental health integration, which is the follow-up care post-discharge.

CO-CHAIR MOORE: Any comments or concerns? Anyone from the phone? Okay, 95.

MS. BUCHANAN: So we move the slide one. Okay. So we are now on 95, NQF-2599; alcohol screening and follow-up for people with serious mental illness.

And the TEP noted that many providers who screen for alcohol in primary care settings do not bill the codes that reflect this interaction. Consequently, they were concerned

the measure may not capture enough data.

But despite this concern, they voted to recommend because of the high rate of alcohol abuse and lack of treatment for individuals with mental health illness.

CO-CHAIR MOORE: Is this a HEDIS Measure? Any other comments or concerns? Anyone on the phone? Okay.

MS. BUCHANAN: Wonderful, 96; going back to tobacco. And so NQF-2600; tobacco use screening and follow-up for people with serious mental illness or alcohol or other drug dependence.

And so the TEP noted that there was an under-utilization of screening and intervention with people with serious mental illness with regard to tobacco use. They said that behavioral health clinicians often do not provide screening and intervention, but this measure could stimulate them to do so.

The measure has the ability to promote parity in tobacco cessation services for people

with serious mental illness. They also said there are potential implementation issues of the measure, since behavioral health providers were not included in meaningful use.

And so that makes some challenges with the EHR, but they agreed that the measure is too important to allow these difficulties to prevent them from recommending it.

CO-CHAIR MOORE: Thank you. Any comments or concerns? Bill?

CO-CHAIR GOLDEN: The only comment is that smoking is like, double the rate of the population in this population.

CO-CHAIR MOORE: Any comments or concerns on the phone? All right, moving, I believe, to 98.

MS. BUCHANAN: Yes, you got it. This is 98; NQF-2603; diabetes care for people with serious mental illness; hemoglobin A1C (HbA1C); testing.

And so the TEP, as a theme that we had many times, were concerned that the definition of

serious mental illness was a little too narrow. Similar to many measures, it includes only individuals with schizophrenia, bipolar 1 disorder, or major depression.

But they noted that MTDs can easily capture this measure through claims data, and that it is important to stakeholders. So they recommended to include it.

CO-CHAIR MOORE: Okay. Any additional comments or concerns? Anyone from the phone? All right. Let's move on to 99. Now, it is striking that we are able to move through these quickly. But a lot of them are NQF when you look at the overall measure score, and they're exceeding too.

So I want to thank the TEP for doing due diligence on this very lengthy list; it's making the work of the committee easier, so thank you for that.

MS. BUCHANAN: Awesome. So we are on number 99 on the discussion guide, NQF-2604; diabetes care for people with serious mental

illness; medical attention for neuropathy.

And so similar to other measures, they thought the mental illness definition was too narrow, but they agreed to recommend it because it captures a widely accepted standard of care for a very high risk population.

CO-CHAIR MOORE: Opening up to comments or concerns. Anyone on the phone? All right, number 100.

MS. BUCHANAN: On 101 -- oh, 100, goodness. Keeping me on track, Jennifer.

CO-CHAIR GOLDEN: Yes, that's my job. That's why I'm Chair.

(Laughter.)

MS. BUCHANAN: So this is number 100, NQF-2605; follow-up after discharge from the emergency department for mental health or alcohol or other drug dependence.

And so the TEP expressed concern that the denominator of this measure lacked clarity and entities cannot easily discern the rate for follow up for individuals with mental illness as

compared to those with substance use disorders.

So if we look at the denominator, they just didn't feel that there was the ability to pull things out. And they were also unsure if the measure includes the new suicide billing code that captures individuals admitted for that reason.

Similar to other measures, edited to include all the wraparound services that they feel should be; but they decided to recommend it since it captures individuals with either a mental or a substance use diagnosis, and is more inclusive than many of the other measures that they reviewed.

CO-CHAIR MOORE: And it's part of the Medicaid adult core set. Any comments or concerns? Anyone from the phone? Now you can move to 101.

MS. BUCHANAN: Thank you. NQF-2607; diabetes care for people with serious mental illness; hemoglobin A1c (HbA1c); port control which is greater than nine percent.

And so although the TEP said that they were not sure that the measure would capture a large number of people, they agreed that there was a great opportunity for improvement as the population this measure captures is a high risk group that requires immediate medical intervention.

CO-CHAIR MOORE: And it's part of the Medicaid adult core set. Any comments or concerns? Come on, let's shake it up. Anyone on the phone? All right, 102.

MS. BUCHANAN: So 102, NQF-2609; diabetes care for people with serious mental illness; eye exam.

And the TEP really like that ACOs and other health care plans currently report on this measure. They believe that the measure directly addresses care integration, especially for behavioral health providers who are not part of the EHR meaningful use incentives.

CO-CHAIR GOLDEN: Before I comment I just want to look at the -- so I guess a question

for Karen and others; is the standard for diabetes eye exams now every year or every other year? I believe it's going to every other year.

MEMBER ZERZAN: I'm going to have to check the guideline, but I think you're right; it's every other year.

CO-CHAIR GOLDEN: My concern that this is overly -- it's on an old standard. I believe it's going to 18 months or two years. I don't know what to do with that. I like the concept of eye exams, but I believe the measure is out of date in terms of frequency.

CO-CHAIR MOORE: David?

MEMBER KELLEY: So I don't think NCQA put out their updates for next calendar year, which is right now, HEDIS 18, calendar year 17. So this might be an area where there might be a spec change that they may recommend. They should be putting that out. I think they usually do that in late July, and then they open it up for public comment.

CO-CHAIR GOLDEN: We'd recommend the

most current specification of this measure.

MEMBER HENNESSEY: Yes, what I would say is that typically once the standard is changed, then HEDIS -- NCQA-HEDIS, typically, from what I've seen, they update the specification or they put it out for public comment for everyone to talk about whether or not to update it.

CO-CHAIR MOORE: Thanks. Any comments or concerns on the phone? All right. Moving on to our last item in this group, 103. I knew I could count on you guys; I knew it.

MS. BUCHANAN: So this is a measure concept that the TEP recommended. And they discussed some of the limitations of this measure concept, including that the denominator only includes individuals who suffer from schizophrenia and not individuals who suffer from any other types of serious mental illness; and that the sole focus of the measure is the Program for Assertive Community Treatment, the PACT Intervention, since it is difficult for rural

areas to implement PAC teams.

But the TEP noted that re-admission rates for individuals with schizophrenia are incredibly high, and that PAC is an evidence-based program with demonstrated impact, so they voted to recommend this measure concept.

CO-CHAIR MOORE: Maureen, can you talk a little about the conversation? I noticed that there's -- it's not being used, or hasn't been identified where it's being used?

MEMBER HENNESSEY: Yes. The reason for this is that the use of PACT is considered to be from an evidence-based perspective, one of the more emerging and important kinds of intervention for individuals who are living with schizophrenia, particularly focusing more now on early intervention; so some of the programs like Ray's that you're seeing are the types of programs that provide a more comprehensive, wraparound kind of service.

And what they've seen from an evidence-based perspective is a decline in

admissions fairly substantially. So that's why the TEP was very interested in this, recognizing it's not a full-blown measure at this point, but it's really a concept that we think is important for CMS to consider.

CO-CHAIR MOORE: Okay. Great. Any other comments or concerns? Anyone on the phone? Whoa, that's a wrap.

MS. BUCHANAN: Okay. So we are going to move on to voting en block to recommend the PMH Measure Set. And as you can see, the new measures that you all included today are reflected on this. And so we do have all the measures and we'll be voting now to recommend this measure set to CMS's IAP. Now I'll turn it over to Miranda.

MS. KUWAHARA: Again, this will be an up or down hand vote. If you would like to recommend the PMH Measure Set to CMS's Medicaid Innovation Accelerator Program, please raise your hand.

MS. BUCHANAN: And Judy and Karen, if

you wouldn't mind saying yes or no on the line.

MEMBER AMSTUTZ: Yes.

MS. BUCHANAN: One yes. And then it looks like -- and I think Alvia's the only person we don't have a response for yet, who is texting.

CO-CHAIR MOORE: Were we required to open up for public comment before we did the --

MS. BUCHANAN: After. And Alvia -- got it, thank you. But I don't think Judy's on the line right now. Just want to double-check that. No. So we did get Karen's vote though.

MEMBER ZERZAN: Did you just me? I just got through security.

MS. BUCHANAN: Judy, we're voting on whether or not to --

MEMBER ZERZAN: I was just wondering if I heard my name.

MS. BUCHANAN: Yes. We were voting en block to recommend the physical and mental health integration measure set to CMS.

(Simultaneous speaking)

MS. BUCHANAN: Yes, got it. Okay.

Thank you.

MS. KUWAHARA: Are there any recommendations not to recommend the measure set? Okay, 18 of our 18 voting members voted to recommend the PMH Measure Set to CMS's Medicaid Innovation Accelerator Program.

MS. BUCHANAN: Okay. So now we are moving on to an opportunity for public comment. Operator, if you wouldn't mind opening the lines. Additionally, anyone who would like to type a public comment in, staff can read. We'll be holding the line open for about 20 seconds; and we are ready now.

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

(Pause for phone line.)

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

MS. BUCHANAN: Thank you so much. On to next steps. So we will all convene again June 20th for a web meeting to discuss the overall

measure sets in their entirety.

Then we will work diligently to capture all the recommendations put forth by the technical expert panels and by the Coordinating Committee and capture that in a draft report, which we will submit for public comment July 21st to August 21st. Then we will submit a final report to CMS no later than September 14th.

Next slide, please. We have our contact information on this page. We also have our committee SharePoint and project web page. You can find all meeting materials on either of those sites, and as always, please feel free to reach out to the Medicaid Accelerator team at any point in time.

I'll turn it back over to Bill and Jennifer for closing remarks.

CO-CHAIR GOLDEN: Wow; the only thing I would say is, Thank you, everybody, for hanging in there and doing, first of all, all the TEPs for doing all of the work, and for everybody to have good and focused conversations. And I think

that's been very good.

You know, I guess in some ways, I don't know if Karen wants to make any comments about what you're hearing or other kinds of information. I'd be kind of curious.

MS. LLANOS: Yes, this is, again I echo the thanks and I think the TEP committees, which were also very intensive in nature, so I'm just listening and trying not to comment.

But it's been fantastic to hear all of the time and expertise you have all brought to the past two days, and I know the homework that went into this, as well. So a giant thank you, obviously, to the NQF staff, as well.

In terms of what I'm hearing; I think it's really nice to hear some areas being validated, that I think we hoping you all would find and resonate with, as well. And in terms of the gaps, again, very familiar territory. But it's really nice to have a broader group say that, as well.

And then again, I think some of the

nuances in terms of your experiences on particular measures and reporting, I think are going to be really helpful for states as they also think about this. As someone remarked, We're just trying to add to the toolbox and have resources through these types of measures.

But also know that it's a starting point and that there's much more to do in terms of measurement development. So very consistent with where I think we'd like to head with this project, so thank you all.

CO-CHAIR GOLDEN: Thank you, Karen. And I'll just speak as a member of the Medicaid medical director network, as some of my colleagues are; these areas are of -- it's something that the Medicaid medical directors think about all the time.

And we are pleased that we get tools. Different states have different capacities to get data, so I think it's still an emerging and learning process. Unfortunately, I think it's more for each state to figure out how to start to

implement and change and transform their systems.

The data consistency across states is still a work in progress, I think. And I think that you and others would agree with that, and that's just the way it is. But I think the more useful stuff we can give to our colleagues, the more we can work with the provider community to make a difference.

So thank you for all your work, and thank you, Karen and CMS for sponsoring this and getting the NQF staff to be able to do this valuable work for us.

DR. TERRY: I just have a few words. Oh, Jennifer, yes.

CO-CHAIR MOORE: I don't want to hold everybody up, but I want to echo the sentiment that I really do appreciate everybody's hard work. They both said it exceptionally well, so there's -- I won't repeat that.

But I was hoping, Karen, not getting into the political climate that we're in, but recognizing all of the work that everybody has

put into this and the excitement we have in this project, can you give us a sense of the two different scenarios, so one path would be that additional funding is not available.

What happens at that point with the work that has been done in this space? And then secondly, if funding is available, what are your thoughts at this point in where this might go as a next phase?

MS. LLANOS: About this particular project? So I think regardless of funding, we wanted to be able to work on putting something like this together and sharing it with all states. So I think in many ways, that's a huge accomplishment on its own.

In terms of what would happen next, it does sound more of a development respecification type of project, which we already have ongoing and that's going to continue on; it's on a different glide path.

But this has been really helpful to inform that parallel project, so that we're

building some of this feedback into the measures that we're currently working on, that also reflect these four program areas.

So we have our contracting representative from that project that has been listening in over the past two days, and our contracting team from our pipeline work, as well.

As we are starting to identify measure concepts for development for our final year, we thought it would be really nice to connect these two efforts together and have them hear directly from all of you in terms of some key gap areas.

CO-CHAIR MOORE: Thank you for that. I really do appreciate that.

CO-CHAIR GOLDEN: Is this project part of CMMI or CMS? I'm just --

MS. LLANOS: IAP is a CMMI model that was in CMCS, so it's a Medicaid-led effort. And our center leads it, as well, but with CMMI funding.

DR. TERRY: And I just wanted to add a few more words. First of all, I want to thank

everybody; just to echo what everybody said, I'm always impressed when people come together and they have such wonderful backgrounds and deep knowledge, because it's really what makes this work. So thank you, everybody, for your work and for your dedication, flying through these many, many measures.

And in particular, I want to thank our co-chairs, Jennifer and Bill, for really keeping us on target, getting us through this. You know, really making this work. And so thank you very much. And to the public and the people who stayed on the calls and the people who made comments; and to Chip.

CO-CHAIR MOORE: To Chip.

(Laughter.)

MEMBER SIDDIQI: Thank you everybody.

MEMBER HENNESSEY: Thank you to NQF, not only for taking us through the process here for the past two days, but really taking the TEPs, all of us, each of us chairs through this process as well. It's been a longer, more

extended period, and you guys have been terrific. Thank you.

(Applause.)

MS. BUCHANAN: Thank you to everyone who joined us on the phone. We will be signing off.

MEMBER SIDDIQI: Thank you, safe travels everyone.

MEMBER GELZER: Thank you.

(Whereupon, the above-entitled matter was adjourned at 3:44 p.m.)

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C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Medicaid Innovation Accelerator Project Coordinating Committee

Before: NQF

Date: 06-08-17

Place: Washington, DC

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

Neal R Gross

Court Reporter