

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
MIRANDA KUWAHARA, MPH, Project Analyst
ELISA MUNTHALI, MPH, Acting Senior Vice
President, Quality Measurement
TARA MURPHY, Project Manager, NQF
MARGARET (PEG) TERRY, PhD, MS, RN, Senior
Director

ALSO PRESENT:

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

BEVERLY LOFTON, Medication Innovation
Accelerator Program, Center for Medicaid
and CHIP Services, CMS

* 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

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

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

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

3 DR. TERRY: On surveys?

4 MEMBER MCCANN: On surveys and the
5 statements within surveys?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

20 MEMBER GELZER: No, that's helpful.

21 Thank you.

22 CO-CHAIR MOORE: Any other questions?

1 Oh, yes?

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

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

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

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

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

15 MEMBER MCCANN: Oh, I'm sorry.

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

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

6 DR. TERRY: To the decision logic?

7 CO-CHAIR GOLDEN: Right.

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

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

1 trying to say.

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

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

20 So I think - we were just going to do
21 a little summation of yesterday, if that's okay.

22 Or should we just move on and - I think we

1 should just finish SUDs.

2 CO-CHAIR GOLDEN: Okay. That's fine.

3 So yesterday we quit smoking.

4 (Laughter.)

5 CO-CHAIR GOLDEN: And today we start

6 drinking.

7 (Laughter.)

8 CO-CHAIR GOLDEN: So we were on the

9 last item on the second slide.

10 MS. MURPHY: Absolutely.

11 CO-CHAIR GOLDEN: Thank you.

12 MS. MURPHY: Good morning, everyone.

13 Just to jog everyone's memory, we're on this last

14 measure here. This is percent of patients

15 prescribed a medication for alcohol use disorder.

16 For reference, that is number sixty-three on your

17 discussion guide. The measure is not NQF-

18 endorsed, but came to us from ASAM.

19 The TEP unanimously voted - excuse me.

20 Wrong note. The TEP noted the significant

21 opportunity for improvement in the area that this

22 measure addresses, as patients are not routinely

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

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

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

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

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

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

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

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

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

3 MEMBER AMSTUTZ: Not in person.

4 CO-CHAIR GOLDEN: Okay, great.

5 (Simultaneous speaking.)

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

8 (Laughter.)

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

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

21 CO-CHAIR MOORE: Welcome.

22 MS. GORHAM: And just for our record

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

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

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

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

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

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

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

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

1 shouldn't be in there.

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

6 (Laughter.)

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

22 And because there's so little to do

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

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

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

22 DR. TERRY: I think it was on addiction

1 medication.

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

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

7 (Laughter.)

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

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

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

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

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

20 (Laughter.)

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

1 publically available information at least
2 specifies.

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

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

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

22 CO-CHAIR GOLDEN: So the other

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

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

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

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

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

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

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

22 CO-CHAIR GOLDEN: You dropped your

1 instrument.

2 (Laughter.)

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

14 CO-CHAIR GOLDEN: Deborah?

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

22 CO-CHAIR GOLDEN: Other comments,

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

3 MEMBER AMSTUTZ: It's Karen.

4 CO-CHAIR GOLDEN: Karen, sorry.

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

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

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

4 CO-CHAIR GOLDEN: David?

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

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

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

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

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

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

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

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

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

3 (Simultaneous speaking.)

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

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

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

22 CO-CHAIR GOLDEN: Final comments,

1 questions?

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

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

22 MS. MURPHY: Our next item is number

1 sixty-five on your discussion guide. Presence of
2 screening for psychiatric disorder. The TEP felt
3 that this measure concept - oh, and I should note
4 that this was recommended as a measure concept.

5 They felt that this concept addressed the
6 quality issue of screening for co-morbid
7 psychiatric conditions, which can often increase
8 difficulties with childhood treatment, adherence
9 to treatment, and other medical problems.

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

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

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

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

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

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

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

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

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

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

1 CO-CHAIR GOLDEN: Relabel the title?

2 MEMBER SCHIFF: Yeah.

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

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

10 MS. MURPHY: Next item -

11 MEMBER KELLEY: I have a comment.

12 CO-CHAIR GOLDEN: David?

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

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

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

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

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

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

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

16 MEMBER RYAN: Right. Right.

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

19 MEMBER RYAN: Yeah.

20 (Simultaneous speaking.)

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

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

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

10 MS. MURPHY: So I -

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

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

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

4 DR. TERRY: Say that again, please?

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

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

13 MS. MURPHY: Yes.

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

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

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

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

20 MEMBER RYAN: Can I just say?

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

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

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

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

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

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

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

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

5 (Laughter.)

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

8 (Laughter.)

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

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

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

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

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

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

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

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

6 CO-CHAIR GOLDEN: Deborah?

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

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

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

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

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

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

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

20 (Laughter.)

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

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

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

14 CO-CHAIR: Hello? Yes, Deborah.

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

1 that we already discussed?

2 MEMBER RYAN: Can I address that?

3 CO-CHAIR GOLDEN: Yes, please.

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

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

22 MEMBER HAMBLIN: Just to add for what

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

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

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

22 The TEP noted that this measure

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

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

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

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

9 CO-CHAIR GOLDEN: Anyone? Next item.

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

12 CO-CHAIR GOLDEN: One more slide there.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 Medicaid Innovation Accelerator Program?

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

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

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

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

11 MEMBER GELZER: And we're ready to
12 vote.

13 (Laughter.)

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

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

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

21 CO-CHAIR GOLDEN: Vote time.

22 MS. MURPHY: Please remember to select

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

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

4 MS. MURPHY: Okay. The measure set
5 passes.

6 CO-CHAIR GOLDEN: Okay.

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

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

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

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

22 MS. MURPHY: We need to do a public

1 comment time.

2 CO-CHAIR GOLDEN: Okay, public comment
3 time.

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

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

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

16 (Whereupon, the above-entitled matter
17 went off the record at 9:52 a.m. and resumed at
18 10:04 a.m.)

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

22 MS. BUCHANAN: Thank you, Jennifer.

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

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

16 (Laughter.)

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

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

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

14 (Laughter.)

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

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

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

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

18 DR. TERRY: Yeah. Thank you.

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

22 DR. TERRY: Keep going.

1 (Simultaneous speaking.)

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

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

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

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

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

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

4 MS. BUCHANAN: Thank you very much,
5 Maureen.

6 (Laughter.)

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

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

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

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

13 (Laughter.)

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

18 MS. BUCHANAN: It's a measure.

19 CO-CHAIR MOORE: Measure. Okay.

20 MS. BUCHANAN: Maureen?

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

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

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

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

4 MEMBER GELZER: Can you hear me?

5 CO-CHAIR MOORE: Yes, I can.

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

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

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

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

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

4 CO-CHAIR MOORE: Kathryn?

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

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

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

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

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

1 CO-CHAIR MOORE: Okay. Deborah?

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

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

12 CO-CHAIR MOORE: Okay.

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

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

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

4 (Laughter.)

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

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

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

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

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

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

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

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

13 MS. KUWAHARA: All right. This is
14 postpartum -

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

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

1 select two. Or low, please select three.

2 Polling is open.

3 MEMBER SIDDIQI: This is Alvia again.

4 I don't have online access right now. So I'm

5 just going to voice my vote, I'll wait a few

6 seconds. It's two.

7 MS. BUCHANAN: Two? Thank you very

8 much, Alvia.

9 MS. KUWAHARA: Ninety percent of the

10 twenty voting members selected high. Ten percent

11 selected medium, and zero percent selected low.

12 Moving on to the next step. To what extent will

13 this measure or measure concept address an

14 opportunity for improvement and/or significant

15 variation in change? For high, please select

16 one. Medium, select two. Or low, please select

17 three.

18 MEMBER SIDDIQI: This is Alvia. And I

19 would say two.

20 MS. BUCHANAN: Received, thank you.

21 MS. KUWAHARA: Seventy-five percent of

22 the twenty - we captured twenty. Seventy-five

1 percent of the twenty voting members selected
2 high. Twenty-five percent selected medium. And
3 no members voted low. To what extent does this
4 measure or measure concept demonstrate efficient
5 use of resources and/or contribute to alignment?
6 For high, please select one. Medium, select two.
7 Or low, please select three.

8 MEMBER SIDDIQI: Alvia, two.

9 MS. BUCHANAN: Thank you.

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

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

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

11 MEMBER SIDDIQI: Alvia, one.

12 MS. BUCHANAN: Thank you.

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

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

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

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

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

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

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

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

9 Voting is now open.

10 Alvia, say your vote?

11 MEMBER SIDDIQI: One.

12 MS. KUWAHARA: Thank you.

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

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

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

1 Medicaid agencies and other key stakeholders?

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

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

8 CO-CHAIR MOORE: Unless they changed.

9 MS. BUCHANAN: Unless they changed.

10 CO-CHAIR MOORE: We have to re-vote.

11 No, just this last one.

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

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

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

19 MS. KUWAHARA: We're missing one vote.

20 CO-CHAIR MOORE: Someone in the room?

21 Okay, everyone, hit your clicker one more time,
22 point it at Miranda.

1 MS. KUWAHARA: There it is.

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

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

9 For high, please raise your hand.

10 MEMBER SIDDIQI: Alvia, high.

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

13 For low, please raise your hand.

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

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

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

22 MS. GORHAM: We have the votes on the

1 phone.

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

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

7 MS. BUCHANAN: Great, thank you so
8 much.

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

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

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

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

22 And, the examples are psychosis,

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

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

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

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

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

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

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

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

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

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

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

14 CO-CHAIR MOORE: Bill?

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

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

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

4 MEMBER ZERZAN: I agree.

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

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

13 CO-CHAIR MOORE: Deborah?

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

16 MEMBER ZERZAN: Yes, it is.

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

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

22 CO-CHAIR MOORE: Okay. Any comments

1 on the phone?

2 David?

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

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

18 CO-CHAIR MOORE: Are we ready to vote?

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

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

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

7 Polling is now open.

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

10 MEMBER SIDDIQI: Sure, Alvia, two.

11 MS. BUCHANAN: Thank you.

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

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

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

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

1 Voting is now open.

2 MEMBER SIDDIQI: Alvia, three.

3 MS. BUCHANAN: Thank you, Alvia.

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

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

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

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

16 For high, please raise your hand.

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

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

21 And, for low, please raise your hand.

22 All right, we're missing one vote.

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

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

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

11 Please raise your hand for high.

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

16 MEMBER SIDDIQI: Sure, Alvia, three.

17 MS. BUCHANAN: Thank you.

18 MS. KUWAHARA: Medium, please raise
19 your hand.

20 And low.

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

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

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

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

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

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

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

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

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

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

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

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

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

17 So, is that a yes or a no?

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

22 I would expect that if we vote on it,

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

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

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

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

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

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

17 MEMBER WALLACE: Anyone want to save
18 it?

19 CO-CHAIR MOORE: I don't.

20 MEMBER HAMBLIN: And so, this is
21 Allison.

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

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

4 MS. BUCHANAN: Thank you.

5 MEMBER SIDDIQI: I agree. This is
6 Alvia.

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

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

17 And, I'll turn it over to Miranda.

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

22 MS. BUCHANAN: So, the discussion on

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

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

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

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

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

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

22 You reviewed it yesterday for BCN and,

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

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

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

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

11 MEMBER HENNESSEY: Thank you.

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

14 MEMBER HENNESSEY: Thank you for the
15 clarification.

16 MEMBER ZERZAN: So, I think with
17 Allison --

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

22 So, even aside from the measurement

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

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

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

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

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

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

18 MEMBER SIDDIQI: This is Alvia.

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

22 But, I do think, you know, at some

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

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

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

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

20 MS. BUCHANAN: That sounds great.

21 CO-CHAIR MOORE: Allison?

22 MEMBER SIDDIQI: And, I'll remove my

1 motion to vote on it today.

2 MEMBER HAMBLIN: Just one suggestion

3 --

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

7 MS. BUCHANAN: All right, thank you.

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

14 MS. BUCHANAN: Okay, thank you.

15 MEMBER MOHANTY: This is Sarita.

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

19 MS. BUCHANAN: Yes, so we --

20 MEMBER MOHANTY: -- how will those be

21 --

22 MS. BUCHANAN: We had discussed this

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

6 So, yes, thank you.

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

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

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

22 Because, a lot of times, the health

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

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

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

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

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

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

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

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

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

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

13 (Off microphone.)

14 MS. BUCHANAN: So --

15 (Off microphone.)

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

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

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

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

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

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

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

1 individuals who are served by Medicaid.

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

3 --

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

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

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

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

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

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

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

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

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

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

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

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

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

22 MS. BUCHANAN: It looks to be not a

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

3 CO-CHAIR MOORE: Okay.

4 MS. BUCHANAN: Because it's already
5 included.

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

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

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

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

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

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

22 MS. BUCHANAN: This is Number 89.

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

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

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

20 CO-CHAIR MOORE: But is NQF-endorsed?

21 MS. BUCHANAN: It is NQF-endorsed.

22 CO-CHAIR GOLDEN: So, just a question

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

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

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

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

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

17 CO-CHAIR MOORE: Got it.

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

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

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

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

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

9 MEMBER SIDDIQI: This is Alvia.

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

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

21 CO-CHAIR MOORE: Yes.

22 MEMBER PHELAN: So, just reading the

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

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

9 (LAUGHTER)

10 MEMBER SCHIFF: This is Jeff.

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

20 CO-CHAIR MOORE: Barbara?

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

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

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

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

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

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

1 of this Committee.

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

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

11 So, are we charged with a vote?

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

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

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

1 For high, please raise your hand.

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

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

6 (LAUGHTER)

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

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

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

15 Those who vote high, please raise your
16 hand.

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

20 MS. KUWAHARA: Medium, please raise
21 your hand.

22 And low.

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

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

7 For high, please raise your hand.

8 Medium, please raise your hand.

9 And, low.

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

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

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

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

20 For high, please raise your hand.

21 Medium.

22 And, low.

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

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

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

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

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

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

1 Anyone on the phone?

2 Hearing no opposition, we shall move
3 on.

4 MS. BUCHANAN: Wonderful, thank you.

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

10 And so, wanted to start with the first
11 two, though. And, the first one is NQF Number
12 2602, Controlling High Blood Pressure for People
13 with Serious Mental Illness. This is Number 97
14 on your discussion guide.

15 And, as you can see here, the
16 description is the percentage of patients 18 to
17 85 with serious mental illness who have a
18 diagnosis of hypertension whose blood pressure
19 was adequately controlled with the measurement
20 year.

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

1 chose not to include this one.

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

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

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

18 And, this measure was retained by
19 Cheryl Powell.

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

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

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

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

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

16 MEMBER SIDDIQI: And, this is Alvia.

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

22 And, I would say even for patients

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

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

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

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

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

21 So, Maureen?

22 MEMBER HENNESSEY: Yes, I would just

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

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

8 CO-CHAIR MOORE: Okay, thank you.
9 Karen?

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

15 And, I think this is important from
16 that perspective.

17 CO-CHAIR MOORE: Great.
18 John?

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

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

3 So, you can't use the two together.
4 You can't have a benchmark from 9 and apply it to
5 10. You can't have a time period that spans both
6 9 and 10. It has to be one or the other.

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

9 MEMBER SHAW: There was something
10 yesterday we --

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

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

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

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

5 CO-CHAIR MOORE: Okay, thank you.

6 Bill?

7 CO-CHAIR GOLDEN: Yes --

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

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

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

21 CO-CHAIR MOORE: Thank you.

22 Maureen?

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

4 CO-CHAIR MOORE: Okay, great.

5 Anyone on the phone?

6 All right, no one else in the room.

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

15 CO-CHAIR GOLDEN: I'll vote.

16 MS. BUCHANAN: Okay, anyone second?

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

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

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

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

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

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

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

12 MS. BUCHANAN: Wonderful, thank you so
13 much.

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

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

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

22 And so, the TEP said that, in their

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

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

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

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

14 They encouraged initiatives to look at
15 electronic development to capture data with
16 regard to not only screening for depression but
17 using a standardized instrument such as the PHQ-
18 9, but also the monitoring for depression in
19 terms of readmission.

20 And, I believe this was retained by
21 David Kelley.

22 MEMBER KELLEY: So, again, this is --

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

5 And, it really allows you, from a
6 population standpoint to have an understanding of
7 how effectively depression is being treated.

8 And, depression is very common in the Medicaid
9 population, probably under treated and under
10 assessed.

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

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

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

1 CO-CHAIR MOORE: Maureen?

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

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

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

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

19 Also, it looks at not only remission,
20 but also response. So, it has more subtlety in
21 terms of gradation and it also starts with age
22 12.

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

7 CO-CHAIR MOORE: That's really
8 helpful, thank you for adding that. We have some
9 --

10 MEMBER ZERZAN: So, that's number --

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

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

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

17 MEMBER ZERZAN: Okay.

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

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

22 CO-CHAIR MOORE: Okay, can we go to

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

3 MEMBER SIDDIQI: So, this is Alvia.

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

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

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

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

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

3 CO-CHAIR MOORE: All right, thank you.

4 Okay, Judy?

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

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

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

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

22 MEMBER ZERZAN: Got it.

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

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

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

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

18 CO-CHAIR MOORE: Okay, great.

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

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

1 you.

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

8 CO-CHAIR MOORE: Okay, thank you.

9 MEMBER HENNESSEY: Thank you.

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

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

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

22 And then, this measure actually looks

1 at whether or not --

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

7 Thanks.

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

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

17 CO-CHAIR MOORE: Okay.

18 MEMBER SCHIFF: This is Jeff.

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

21 CO-CHAIR MOORE: Okay, thank you.

22 MS. BUCHANAN: So, this is going to be

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

4 MEMBER KELLEY: I'll move.

5 MEMBER SIDDIQI: This is Alvia.

6 I vote to include this measure.

7 CO-CHAIR GOLDEN: I'll second.

8 MEMBER KELLEY: I would second.

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

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

15 CO-CHAIR GOLDEN: A procedural
16 question.

17 MS. BUCHANAN: Yes?

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

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

1 logic.

2 CO-CHAIR GOLDEN: Okay.

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

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

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

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

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

1 was not on the slide set.

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

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

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

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

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

14 (Simultaneous speaking.)

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

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

22 (Off microphone.)

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

3 MEMBER SIDDIQI: No, we can't hear.

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

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

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

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

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

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

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

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

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

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

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

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

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

22 So, I thought that was really

1 important.

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

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

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

19 CO-CHAIR MOORE: Okay, thank you.

20 Bill?

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

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

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

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

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

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

19 CO-CHAIR MOORE: Thank you.

20 David?

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

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

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

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

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

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

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

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

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

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

7 CO-CHAIR MOORE: Yes.

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

11 CO-CHAIR MOORE: Correct.

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

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

22 Obviously, we know that serious mental

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

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

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

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

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

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

22 So, just a matter of information since

1 it has been brought up.

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

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

11 Maureen?

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

18 CO-CHAIR MOORE: Thank you.

19 And, Sheryl?

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

1 those two with people.

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

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

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

13 Karen?

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

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

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

3 CO-CHAIR MOORE: Okay, thank you.

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

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

9 MEMBER SCHIFF: This is Jeff.

10 I move to add it.

11 MEMBER SIDDIQI: And this is Alvia.

12 I second.

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

15 MEMBER SCHIFF: Yes.

16 CO-CHAIR MOORE: -- list.

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

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

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

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

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

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

15 CO-CHAIR MOORE: Allison?

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

21 MEMBER SIDDIQI: This is Alvia.

22 And, I just wanted to make a comment

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

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

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

16 CO-CHAIR MOORE: Thank you.

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

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

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

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

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

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

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

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

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

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

1 open for at least 20 seconds.

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

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

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

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

18 CO-CHAIR MOORE: Thank you.

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

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

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

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

7 MS. BUCHANAN: Yes, we can.

8 DR. LUI: Great, thank you.

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

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

20 Thank you.

21 MS. BUCHANAN: Thank you very much.

22 Are there any other public comments?

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

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

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

7 MEMBER SIDDIQI: What time will we
8 reconvene?

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

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

15 MEMBER SIDDIQI: Thank you.

16 (Whereupon, the above-entitled matter
17 went off the record at 11:45 a.m. and resumed at
18 12:06 p.m.)

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

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

2 So, let me turn it over to Shaconna.

3 MS. GORHAM: Thank you.

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

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

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

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

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

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

3 Let me go through the themes of these
4 measures, because I think they're critical.

5 There is an incredible lack of measures. And
6 many of the measures that you look at are medical
7 measures that are being adapted for people in
8 LTSS and HCBS.

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

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

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

22 There are no standards of practice

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

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

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

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

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

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

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

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

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

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

1 professional, personal remark. It's sad.

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

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

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

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

18 (Laughter.)

19 MEMBER MCCANN: -- in the process.

20 MS. GORHAM: All right. Next slide.

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

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

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

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

13 (Pause.)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 recommended list.

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

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

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

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

1 required to supervise once monthly.

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

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

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

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

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

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

10 MEMBER MCCANN: Yeah.

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

13 MEMBER MCCANN: Please.

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

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

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

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

22 The second question, though, is, in

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

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

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

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

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

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

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

1 MEMBER MCCANN: Uh-huh.

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

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

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

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

18 MEMBER MCCANN: Uh-huh. Waivers.

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

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

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

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

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

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

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

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

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

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

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

1 I would highly recommend that we keep this.

2 CO-CHAIR GOLDEN: Karen.

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

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

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

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

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

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

11 CO-CHAIR GOLDEN: Deborah.

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

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

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

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

7 CO-CHAIR GOLDEN: John.

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

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

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

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

1 time consumer for family, too.

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

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

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

15 CO-CHAIR GOLDEN: MaryBeth.

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

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

1 feasible.

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

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

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

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

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

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

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

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

9 (Laughter.)

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

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

20 MEMBER MCCANN: It is in the duals --

21 MEMBER POWELL: I thought so. Okay.

22 MEMBER MCCANN: -- demo, because we do

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

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

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

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

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

19 MEMBER WALLACE: I have a question.

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

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

6 MEMBER MCCANN: Yeah.

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

11 MEMBER MCCANN: It's on this list.

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

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

20 DR. TERRY: So, that would be easier
21 --

22 MEMBER MCCANN: Okay.

1 DR. TERRY: -- because it's already
2 gone through the process. So, I think we could
3 actually look at that measure as well, but --
4 unless somebody has any concerns, it's really
5 just another look at a measure that's gone
6 through in another program.

7 CO-CHAIR GOLDEN: So, we have 097 in
8 front of us, right, to talk about. And, again,
9 I'm just trying to get -- it was good to get a
10 little orientation here.

11 The denominator says, "All patients
12 who are discharged," which is not a functional
13 denominator definition.

14 Do we have enough specifications or
15 concept here to even apply it to LTSS, is my
16 question. And I'm a little bit --

17 MEMBER MCCANN: That was the reason
18 why our group had problems with it. We didn't
19 know where it was discharged from and that it
20 appears to be limited to the physician's office
21 at that point.

22 CO-CHAIR GOLDEN: Susan, you have

1 something you want to add? Are you --

2 MEMBER WALLACE: No.

3 CO-CHAIR GOLDEN: Oh, Cheryl. Yes.

4 MEMBER POWELL: I think, again,
5 looking at how a Medicaid agency might use it
6 with an HCBS program population, it would, by
7 definition, be limited to those who are in that
8 waiver program who are discharged from the
9 hospital.

10 So, it's probably one of those where
11 it wouldn't be used exactly like this. But given
12 the program that it's applied to, it would be
13 limited to the right population.

14 MEMBER MCCANN: And if I could
15 comment, it's the medication list in the
16 outpatient medical record. Now, this is a good
17 example of how we can't talk to each other.

18 In home and community-based services,
19 we would not think that that would apply to home
20 and community-based services and that we would
21 not have access to that. That would sit in a
22 physician or clinic office and that was the basis

1 upon which we voted no.

2 CO-CHAIR GOLDEN: Okay. Are we ready
3 to vote or ready to table this to happy hour, I
4 guess.

5 Anybody else have any comments?

6 (Pause.)

7 SPEAKER: Someone has to do a motion.

8 CO-CHAIR GOLDEN: Okay. We need --
9 first, we need a motion for reconsideration.

10 MS. GORHAM: We have it. It's being
11 reconsidered now --

12 CO-CHAIR GOLDEN: Okay.

13 MS. GORHAM: -- but we need a motion
14 to vote. And then a second to vote to include.

15 CO-CHAIR GOLDEN: Well, I mean, that's
16 the same thing, so we already have that. So --
17 and to do this, we would have to go through all
18 five steps?

19 MS. GORHAM: So, no. So, yesterday we
20 decided that if it already went through the
21 decision logic in another program area, that we
22 just had to take an up or down vote and just --

1 we have rationale, we've had plenty of
2 discussion, so we have good information for the
3 report as to why we want to --

4 CO-CHAIR GOLDEN: And this was
5 approved for the other set?

6 MS. GORHAM: Yes.

7 CO-CHAIR GOLDEN: Thank you. Okay.

8 Okay. Ready to vote?

9 All in favor, raise your hands.

10 MS. BUCHANAN: And so, also, people on
11 the phone, please type in "yes" or "no" and we
12 will capture your vote.

13 MS. GORHAM: And for record purposes,
14 we are voting for NQF 0097, measure of medication
15 reconciliation, which is number 32 on your
16 discussion guide.

17 MS. BUCHANAN: Okay. Those who vote
18 no, please raise your hand.

19 (Voting.)

20 SPEAKER: And I didn't vote, because
21 I can't figure out how to vote.

22 (Laughter.)

1 CO-CHAIR GOLDEN: I believe our charge
2 is you can't abstain.

3 MS. GORHAM: We have a quorum.

4 CO-CHAIR MOORE: I'll vote yes in
5 recognizing that all the comments that have been
6 made will be passed along.

7 MEMBER MCCANN: Can I make a
8 recommendation that it be noted that as part of
9 the challenge in the use of the measure, that
10 there's clarification between home and community-
11 based and outpatient.

12 CO-CHAIR GOLDEN: Yeah. I think that
13 this measure has -- the concept moving forward
14 will be given to the states for them to figure it
15 out.

16 MS. BUCHANAN: And, also, we just need
17 to, for record purposes, to have Tara and Miranda
18 say the votes.

19 MS. KUWAHARA: 18 members voted to
20 include this measure in the LTSS measure set.
21 Two voted no. So, this measure will be
22 recommended for inclusion in the LTSS measure

1 set.

2 CO-CHAIR GOLDEN: John.

3 MEMBER SHAW: Another note to put in
4 for use.

5 MS. BUCHANAN: Can you use your
6 microphone?

7 MEMBER SHAW: Oh, sorry. Another note
8 to put in for use is if we're looking at trends,
9 we've moving towards value-based payment and
10 bundling across settings over time that's patient
11 centered.

12 And so, some of the information
13 availability between different settings should
14 theoretically go away in that construct.

15 SPEAKER: Okay. That's a good point.

16 MS. GORHAM: So, I also think that
17 this would be a good place to -- Barbara
18 mentioned 0419, NQF measure 0419, which is number
19 83 on your discussion guide.

20 So, if we look at that --

21 SPEAKER: Can you hang on for one
22 second? We're having a little conference over

1 here.

2 (Pause.)

3 CO-CHAIR GOLDEN: So, there is a
4 request that we had already approved measure 83;
5 is that correct?

6 MS. GORHAM: No. So, number 83 is NQF
7 0419. And that is the measure that Barbara just
8 recommended.

9 That measure has been reviewed for the
10 PMH TEP and you all will decide whether or not it
11 should stay on the PMH measure set, but let's
12 leave that alone right now.

13 And so, right now we want to look at
14 --

15 CO-CHAIR GOLDEN: Well, I would
16 suggest that we -- when we look at it later on,
17 we then also consider it for both -- both sets.

18 MS. GORHAM: Okay.

19 CO-CHAIR GOLDEN: Okay. We'll just do
20 them both. I mean --

21 CO-CHAIR MOORE: Do you want to do it
22 now then?

1 MS. GORHAM: Yeah. I think because we
2 already are having discussion about it now and
3 because we will need rationale behind it, that we
4 have the discussion and just take that up or down
5 vote whether or not we want it in, but we do need
6 to have rationale behind it.

7 MEMBER SHAW: Another point is it's
8 part of the bloc for PMH. And so, we're really
9 not discussing it because of that. So, this is
10 the opportunity to discuss it.

11 MS. GORHAM: Exactly.

12 CO-CHAIR GOLDEN: Okay. So, what
13 number is it?

14 CO-CHAIR MOORE: 83.

15 MS. GORHAM: Number 83 on your
16 discussion guide. NQF 0419, Documentation of
17 Current Medications in the Medical Record.

18 So, we have had a motion to discuss
19 and a second. So, we can discuss and then we can
20 take a vote.

21 MEMBER MCCANN: I'll so move.

22 CO-CHAIR GOLDEN: So give me a second

1 here while I noodle through this. So,
2 technically -- I just want to make sure we know
3 where we are.

4 So, technically we have yet -- this is
5 yet to come up. This was approved by the other
6 TEP, correct?

7 MEMBER MCCANN: Right.

8 CO-CHAIR GOLDEN: So, it's only now to
9 be -- so, when it comes up later in the day, it
10 would be up for extraction if there was
11 objection. So, we won't have to go through the
12 five steps for this measure. Fine.

13 So, the measure -- the motion on the
14 table would be to include this, assuming it's
15 going to be approved for the other group.

16 Okay. That's fine. So, let's open up
17 for discussion.

18 Barbara, do you want to make any
19 comments about it?

20 MEMBER MCCANN: Yes. My comment is
21 this currently, actually, reflects the state of
22 practice in home health.

1 So, it would be typically done also
2 for Medicaid and it is broader and focuses on
3 what is known in the home. It's broader than
4 current prescribed medications.

5 CO-CHAIR GOLDEN: Okay. Other
6 comments or questions about this item?

7 (Pause.)

8 CO-CHAIR GOLDEN: All right. All in
9 favor of including this measure, raise your right
10 hand.

11 MS. BUCHANAN: And people on the
12 phone, please type in your vote on NQF 0419,
13 Documentation of Current Medications.

14 (Voting.)

15 MS. KUWAHARA: So, have zero nos.

16 CO-CHAIR GOLDEN: Okay.

17 MS. KUWAHARA: So, we have 18 yeses,
18 zero nos. So, this measure will be recommended
19 for inclusion in the LTSS measure set.

20 CO-CHAIR GOLDEN: What's next?

21 MS. GORHAM: Okay. So, the next
22 measure is Percentage of Short-Stay Residents Who

1 Were Successfully Discharged From the Community.
2 And that is number 41 on your discussion guide.

3 And let me just state the rationale
4 for not including, according to the LTSS TEP
5 meeting. While the TEP members again thought
6 this measure was critical, they did not think it
7 pertained to LTSS.

8 A stay over 30 days likely diminishes
9 the likelihood of folks returning to the
10 community. So, not a good measure -- this is not
11 a good measure, they felt, of quality
12 particularly for the younger population.

13 We had a few members of the CC who
14 wanted to discuss this, including Christine, who
15 is not here today, MaryBeth, Deborah, as well as
16 Cheryl. So, I will hand it over to either one of
17 you.

18 (Comments off record.)

19 CO-CHAIR GOLDEN: I'm sorry, so is it
20 Deborah or David? It's David. Okay.

21 MS. GORHAM: If one of you would like
22 to start the discussion?

1 MEMBER KELLEY: So, from my
2 standpoint, as a Medicaid program I think one of
3 the key elements that you really want to look at,
4 because these are typically waiver programs that
5 our friends at CMS always ask us to look for ways
6 of measuring and improving cost effectiveness as
7 per the waiver, I think this is an essential
8 metric in determining who actually moves back
9 into the community.

10 And whether that's long-term or short-
11 stay residents, the biggest concern is always
12 folks will leave -- these patients will leave an
13 acute care hospital or acute rehab, they'll land
14 in a SNF and they sit there.

15 And one of the -- supposedly one of
16 the key ways to not only save money, but actually
17 place patients where they really want to be, is
18 to move them out into the community, to rebalance
19 them into the community.

20 And some may question whether that is
21 cost effective. I believe it is, but it
22 certainly -- my mind is very member/patient-

1 centric, because most individuals really do not
2 want to be in a nursing home. Their goal is to
3 get home or into a safe community setting.

4 So, I thought that this even though
5 it's not a perfect measure, that it is certainly
6 a very important one to Medicaid long-term
7 support service managed care programs.

8 CO-CHAIR GOLDEN: So, David, who is
9 the accountable party that you're measuring here?
10 Is it the hospital? Is it the plan? Who would
11 be the unit that would be getting the data
12 feedback?

13 MEMBER KELLEY: So, I got booted out
14 of wifi. I was trying to pull up the spec. I
15 believe it is that we would expect our plans to
16 report this. And they would know, because there
17 would be -- in our model, there would be service
18 coordinators that would be working with these
19 individuals.

20 If they are, quote/unquote, nursing
21 home eligible, because now they've been dumped
22 into a nursing home because it's the path of

1 least resistance for many hospitals, there should
2 be service coordinators that would be working
3 with these individuals to find out what their
4 needs are, find out what they really want to have
5 happen to them, and then help move them back
6 safely into the community.

7 So, it would be the health plan that
8 would be measuring this activity and documenting
9 that, indeed, they have moved back into the
10 community and have remained there.

11 Not just moving them back, but there
12 is the whole idea of keeping them there since; A,
13 they're safe, but they don't bounce back into
14 either hospital or into -- back into a SNF
15 nursing facility.

16 CO-CHAIR MOORE: So, I'm going to
17 point out that it does state that there's a --
18 it's part of the five-star quality rating system.
19 So, it is the managed care plans.

20 (Simultaneous speaking.)

21 CO-CHAIR GOLDEN: So, David, again, on
22 the denominator. The way you're envisioning

1 this, are you talking about people who live in a
2 community, get admitted to the hospital and go
3 back to the community? Are you talking about --

4 SPEAKER: This is why clickers don't
5 work.

6 (Laughter.)

7 SPEAKER: For those on the phone, we
8 just had a major spill of water on the clickers.

9 CO-CHAIR GOLDEN: The measure, David,
10 is spec'd -- the measure is spec'd for people in
11 a nursing home, correct -- oh, who are not?

12 MEMBER SIDDIQI: This is Andrea. So,
13 these are individuals that perhaps were in an
14 acute care hospital and ended up in a nursing
15 home as a short stay.

16 And obviously we want to get them back
17 to the community rather than keeping them in
18 chronic care in a skilled facility, right? I
19 mean, is that the very basic idea of this
20 measure?

21 MEMBER AMSTUTZ: So, I think one of
22 the things -- this is Karen Amstutz -- that we

1 may be getting confused here, because the measure
2 actually talks about Medicare instead of Medicaid
3 --

4 CO-CHAIR GOLDEN: Yeah.

5 MEMBER AMSTUTZ: -- is that there's
6 sort of two ways that benefit -- skilled nursing
7 facility benefits are covered.

8 One is because it's medically
9 necessary under your Medicare benefit, and that's
10 a distinctly different situation than what we're
11 talking about in folks who have a nursing
12 facility benefit covered under the LTSS benefit.

13 MEMBER MCCANN: Great. If I can make
14 a comment, the -- under Community First, right,
15 Choice, there's certainly an emphasis to move
16 folks from the nursing home into the community.

17 The TEP struggled with this, because
18 it doesn't reference that they receive LTSS or
19 home and community-based services in the
20 numerator or denominator.

21 So, it would -- I guess it would have
22 to be reported based on any claim, not

1 necessarily for home and community-based
2 services, that occurs after discharge from the
3 SNF, in this case, or long-term -- that's when
4 you go into the Medicaid hospital, so nursing
5 home benefit. So, that's where we got lost.

6 So, it assumes -- you would hope that
7 if they went home on the waiver to get them home,
8 they would receive home and community-based
9 services to keep them there, but this doesn't
10 address that.

11 CO-CHAIR GOLDEN: MaryBeth.

12 MEMBER MUSUMECI: So, a couple of
13 technical things. First, for the original
14 reasoning about the 30 days versus the 90 days, I
15 completely agree that if you can get people home
16 sooner, it's more likely you're preserving your
17 community supports.

18 However, when money follows the
19 person, which is the demonstration grant to
20 transition people back was reauthorized in the
21 ACA, one of the changes was is that they changed
22 it from a 30-day stay to a 90-day stay. So,

1 they're recognizing that.

2 And I can tell you from years of
3 experience of sitting in these meetings and
4 trying to work with folks getting them home, 30
5 days goes by real fast and it's really hard to
6 get the services in place. So, to me, that
7 wouldn't be a reason to toss it out.

8 On the Medicare piece, many of these
9 people are duals, but not all of them are duals.
10 So, you could have a Medicaid-only person in this
11 situation.

12 And moreover, just -- this one is very
13 important to me for not only having something
14 about rebalancing, but also about the message
15 that we're sending overall.

16 You know, I've worked with folks on
17 the ground for about 17 years. And I would say
18 the number one thing that I hear, you know, you
19 can't say anything is a hundred percent.
20 Certainly there are folks where institutions are
21 preferable or needed, but across the board from
22 seniors to people with physical disabilities,

1 traumatic brain injuries, spinal cord injury,
2 IDD, what parents hope for their kids with
3 special needs, the number one thing is "I want to
4 be supported in the community and I want to get
5 back to the community."

6 And I felt like while this may not be
7 perfect, this is the only thing that's there.
8 And we are sending a message about what we're
9 valuing and measuring and sending a message to
10 beneficiaries about what plans and providers and
11 states should be looking at by recognizing this.

12 The other thing is I do know that
13 there are states, Tennessee and some other
14 states, who do look at their long-term care
15 balance and don't have that overlay of are you
16 getting -- I mean, I think it's assumed that
17 you're not going to be discharged to the
18 community unless you have appropriate services in
19 place to make it safe and give you the supports
20 that you need, but the measures are simply number
21 of people who leave institution and don't go
22 back, or amount of dollars spent in the

1 institution versus community. So those, to me,
2 aren't reasons to set this apart.

3 And then I just -- the overarching
4 comment is, as I said earlier, I just think it's
5 really important to note in the report that we
6 recognize that this is a gap area and this is
7 something that needs to be further developed.
8 Because the movement that we're seeing, you know,
9 it's not enough just to have a care plan.

10 That measure is not really
11 satisfactory for someone who is depending on
12 supports for very basic daily activities.

13 You could have a care plan and it
14 doesn't meet your needs and the power
15 differential sometimes in those care plan
16 meetings is not where it needs to be. So, I just
17 think that's an important area to recognize.

18 And the movement now, actually, is
19 towards people saying not only are we
20 rebalancing, but, also, what does that level of
21 community integration look like? Are people not
22 in isolated settings?

1 So, for all of those reasons, we have
2 convened an expert group and did a report at
3 Kaiser a couple of years ago on this that
4 included states' health plans, beneficiaries kind
5 of across the board, and this was -- the number
6 one focus was rebalancing measures.

7 CO-CHAIR GOLDEN: Okay. We're going
8 to have to wrap this up soon.

9 So, Karen, you have something?

10 MEMBER AMSTUTZ: Yeah. I'm going to
11 go back to saying I really think this measure is
12 about moving someone -- is about Medicare
13 patients and is not about long-term services and
14 supports patients, B.

15 So, and the challenge just to sort of
16 quote from the MedPAC report on skilled nursing
17 facility, is that the medically necessary
18 Medicare nursing -- skilled nursing facility
19 stays pay for a disproportionately larger amount
20 of revenue to the skilled nursing facilities than
21 do the number of days that someone stays in. So,
22 those patients are considered especially

1 valuable.

2 So, as someone is getting discharged
3 out of post-acute care and going into -- and,
4 remember, Medicare is only covering these for
5 people that need a medically necessary skilled
6 nursing facility. They're not covering long-term
7 services and supports. They're not covering the
8 situation that MaryBeth just talked about.

9 And so, because they're so valuable,
10 the skilled nursing, there has to be some
11 measures to really get the nursing homes focused
12 on getting these patients back to their --
13 whether they're going back to their custodial --
14 their LTSS benefit or whether they're actually
15 going back home, that's what the focus of this
16 measure is on.

17 So, I think that the -- we need a
18 measure like this, though, that looks at once
19 you've qualified for LTSS benefits if you've been
20 put into a non-community setting, how fast does
21 it take us to move, you know, how fast does it
22 take the system to move you into the community?

1 So, we need that concept, it's just
2 not this measure.

3 CO-CHAIR GOLDEN: Deborah.

4 MEMBER KILSTEIN: Just a comment that
5 this is a little bit more difficult in terms of
6 administering this measure; one, because the
7 claims data and who holds it. And then, also;
8 two, some of the exceptions would require
9 probably an evaluation, either the chart or
10 something else in terms of whether it was an
11 unplanned admission. So, it's not just claims
12 data.

13 CO-CHAIR GOLDEN: Jennifer.

14 CO-CHAIR MOORE: This is very quick.

15 I just want to acknowledge, MaryBeth,
16 and thank you for bringing a very important point
17 to this discussion. And that is that we look at
18 measures that are meaningful to the Medicaid
19 beneficiary.

20 And I think that you made that point
21 very succinctly and I do appreciate you bringing
22 that to the conversation.

1 CO-CHAIR GOLDEN: Judy.

2 MEMBER ZERZAN: This measure includes
3 Medicare fee-for-service enrollees only in the
4 denominator.

5 So, I'm a little worried that while I
6 super agree rebalancing in this transition is
7 really important, I'm not sure this is the
8 measure.

9 CO-CHAIR GOLDEN: Okay. David, you
10 get the last one.

11 MEMBER KELLEY: So, when you look at
12 Medicaid fee-for-service, and, again, this is how
13 the metric is designed. However, once -- if we
14 put this on the island and CMS gives guidance,
15 they can say that this could be broadened.

16 So, within our waiver, our program
17 we're going to operationalize in January, we're
18 going to have duals, we're going to have people
19 that are in Medicare, fee-for-service Medicare
20 Advantage. Whether they're nursing home eligible
21 or not, they're going to be in the program.

22 That managed care plan is going to be

1 responsible for them. Whether or not they're in
2 fee-for-service, whether or not they're in
3 Medicare Advantage, they are -- they're getting
4 paid for them, they're going to be responsible
5 for them whether nursing home eligible or not.

6 So, there are waiver programs and
7 there are non-Medicare folks in those programs as
8 well that have other types of disabilities.

9 So, you know, I don't want to get
10 caught up on the Medicare fee-for-service.
11 That's what this says. But as with other
12 specifications, programs can look at this and
13 they can broaden the definition, if they want to,
14 or they can stick to the letter of the law, but
15 it's a nice example of looking at rebalancing and
16 actually measuring it.

17 And I would say that in our program,
18 the majority -- majority of folks that come into
19 a nursing home are -- Medicare is paying for them
20 prime. But if they sit there for a long time,
21 guess who ends up paying for them?

22 We, as a Medicaid program, get, you

1 know, I'll say -- we pick up the tab, shall we
2 say.

3 (Laughter.)

4 MEMBER KELLEY: So, this is a way to
5 make sure -- this is why we're doing our program
6 is that we don't want those folks sitting there
7 if they don't need to be there and they want to
8 be back in the community.

9 This is one way. It's not a perfect
10 measure, but it's one way of measuring that. And
11 our managed care plans can do variations on the
12 theme.

13 CO-CHAIR GOLDEN: So, I had declared
14 that David was the last word. So, I know there
15 may be other people wanting to come in on the
16 end, but I think we need to start the vote.

17 So, is it a five-step process? Yes?

18 (Comments off mic.)

19 CO-CHAIR GOLDEN: Okay, because it's
20 in -- what set is this in already?

21 MS. GORHAM: So, this was discussed
22 and voted on the LTSS. Remember, LTSS did not

1 want it included. So, it has already been
2 through the decision logic. So, we just need the
3 up or down vote.

4 CO-CHAIR GOLDEN: I'm sorry, so --

5 CO-CHAIR MOORE: The motion would be
6 to have it considered for inclusion after the TEP
7 had decided not to include it.

8 CO-CHAIR GOLDEN: Okay.

9 MS. GORHAM: So, we actually have
10 already had motions, because we have four --

11 CO-CHAIR GOLDEN: That's why I'm
12 confused. So, the TEP had said no, this is for
13 reconsideration, but I thought in previous voting
14 we had done the five steps as opposed to an up or
15 down vote.

16 MS. GORHAM: No.

17 CO-CHAIR GOLDEN: No.

18 MS. GORHAM: Because the last one we
19 didn't do five steps. We did up or down.

20 CO-CHAIR GOLDEN: Well, no, that's
21 because we had been approved by another
22 committee.

1 MS. GORHAM: Right. So, remember
2 yesterday we decided that for measures that have
3 already went through the decision logic, that we
4 would --

5 CO-CHAIR GOLDEN: Okay. I wasn't
6 aware that we had done the decision logic on this
7 measure here.

8 MS. GORHAM: The LTSS TEP did the
9 decision logic on this.

10 CO-CHAIR GOLDEN: Now, I'm confused,
11 because we had done reconsideration votes earlier
12 in this meeting and we went through the five
13 steps.

14 MS. GORHAM: We did for the first one,
15 BCN. And you all because of the time factor,
16 decided that as long as we -- if the measure has
17 already been through the decision logic, for
18 timing, that you would do an up or down vote --

19 CO-CHAIR GOLDEN: We did not decide
20 that.

21 We decided had it been through the
22 decision logic by the coordinating committee to

1 do an up or down vote, not if it had been through
2 a decision logic of the TEP.

3 That was how we had structured -- at
4 least that was my understanding as chair.

5 MS. GORHAM: No, because if it went
6 through the decision logic as a coordinating
7 committee, you wouldn't have to go back and
8 revote. So, it was only the measures who -- that
9 went through the decision logic with the TEP.

10 Because if it went through the
11 decision logic at the coordinating committee, we
12 don't have to go back and do an up or down vote.
13 It will go through the decision logic and either
14 pass or not pass.

15 CO-CHAIR GOLDEN: I'm sorry, I'm
16 having a hard time with this. We may have to --

17 DR. TERRY: Can I just ask -- so, I
18 know it's a bit of a time issue. So, let's just
19 -- yesterday we did decide, as I remember, those
20 who came up that we were going to take out after
21 everybody looked at it again and it's just an up
22 or down vote, because it already had been gone

1 through.

2 This is a little different. This is
3 one that did not get through and it's now being
4 asked to look at it again.

5 And so, I think yesterday we did take
6 these to the decision, if I can remember. But,
7 you know, anyway, we didn't do that earlier
8 because it was a little different situation.

9 MEMBER MUSUMECI: Could we go back and
10 look for a comparable -- in the record, the last
11 time we did one of these and see what kind of
12 vote we took?

13 DR. TERRY: Yeah. That would be
14 helpful, yeah.

15 MEMBER KILSTEIN: And can we find out
16 what of the five steps, where did it fail in the
17 -- when the LTSS TEP looked at it? Because it --
18 they may agree that it was important, but just,
19 you know, couldn't get it all the way through all
20 five steps.

21 CO-CHAIR GOLDEN: Well, I mean --
22 okay. Again, I'm just looking at when we did the

1 first tranche of measures, you know, the first
2 items we did was review of -- where am I here?
3 Gee whiz.

4 MS. MURPHY: So, you might remember
5 that when we started working --

6 CO-CHAIR GOLDEN: For reconsideration,
7 and we went through the five steps for all the
8 reconsideration votes.

9 MS. MURPHY: So, for the BCN program
10 area, which was the first one we did --

11 CO-CHAIR GOLDEN: Right.

12 MS. MURPHY: -- that's when we ran
13 into our time issue and realized that it was
14 going to take a substantial amount of time to
15 take all the reconsidered measures to the
16 decision logic.

17 And then we changed it to an up and
18 down vote depending on the committee for the
19 measures that were identified for
20 reconsideration.

21 If you'll recall, I made a statement
22 about how we asked for a detailed rationale that

1 would hopefully be based in the decision logic
2 and that was our kind of workaround for these
3 time constraints.

4 And just as an example --

5 CO-CHAIR GOLDEN: No, I'm sorry. I
6 disagree.

7 MS. MURPHY: Okay.

8 CO-CHAIR GOLDEN: I disagree. We did
9 the -- we went through the detailed discussion of
10 things that we extracted from the consent
11 calendar. We went through the five steps for the
12 reconsideration items.

13 MS. GORHAM: So, why don't I suggest
14 we take a break. And so, we can confer between
15 staff and chairs and come back in five minutes.

16 (Whereupon, the proceedings went off
17 the record at 1:04 p.m. for a brief recess and
18 went back on the record at 1:10 p.m.)

19 CO-CHAIR GOLDEN: All right. I think
20 we've come to an agreement that yesterday we went
21 -- all the reconsideration ideas went through the
22 five steps and the items that we pulled from the

1 consent calendar was an up and down vote.

2 So, to be consistent, we should put
3 this through the five steps and go from there.
4 And I would say let's go ahead and do the voting
5 now. And maybe we got into trouble, because we
6 got tired of raising our hands.

7 MS. BUCHANAN: Okay. So, Miranda,
8 would you mind taking us through NQF 0097?

9 MS. GORHAM: So, just to be clear,
10 because we're -- even though we talked about
11 percentage of short-stay residents and we were
12 about to vote on that, we're going to vote on
13 that, but we have to go back to 0097, because we
14 would need to take that to the decision logic as
15 well to be consistent.

16 So, just want to make sure everyone is
17 on the same page.

18 DR. TERRY: So, which one are we going
19 to do?

20 MS. GORHAM: So, we can -- because we
21 stopped at the Percentage of Short-Stay Residents
22 Who Are Successfully Discharged to the Community,

1 let's go to the decision logic for that, take a
2 vote, but we will have to go back to 0097 and
3 take a vote through the decision logic for that
4 as well.

5 MS. KUWAHARA: Again, this is for
6 measure number 32 on your discussion guide, NQF
7 number -- 41. 41, I'm sorry.

8 Apologies. This is measure number 41,
9 Percentage of Short-Stay Residents Who Were
10 Successfully Discharged to the Community. We're
11 going to do hand votes as the clickers are acting
12 up a little bit.

13 So, for the first question, to what
14 extent does this measure or concept address the
15 CMS quality measurement domains and/or program
16 area key concepts?

17 If you vote high, please raise your
18 hand.

19 MS. BUCHANAN: And people on the
20 phone, please just type in high, medium or low.

21 (Voting.)

22 MS. KUWAHARA: Medium, please raise

1 your hand.

2 (Voting.)

3 MS. KUWAHARA: And low.

4 (Voting.)

5 MS. KUWAHARA: 19 of the 19 voting
6 members voted high. So, this measure will be
7 recommended for -- I'm sorry, I -- let me get my
8 bearings a little bit and move to the next one.

9 The next question is: To what extent
10 will this measure or measure concept address an
11 opportunity for improvement and/or significant
12 variation in care?

13 Those who vote high, please raise your
14 hand.

15 (Voting.)

16 MS. KUWAHARA: Medium.

17 (Voting.)

18 MS. KUWAHARA: And low.

19 (Voting.)

20 MS. KUWAHARA: Okay. 18 members --
21 I'm sorry, 15 members voted high. And three
22 members voted medium. No members voted for low.

1 The next step is to what extent does
2 this measure or measure concept demonstrate
3 efficient use of resources and/or contribute to
4 alignment?

5 Those who vote high, please raise your
6 hand.

7 (Voting.)

8 MS. KUWAHARA: Medium.

9 (Voting.)

10 MS. KUWAHARA: And low.

11 (Voting.)

12 MS. KUWAHARA: Okay. Nine members
13 voted high. Four members voted medium. And five
14 voted low.

15 To what extent is the -- I'm sorry,
16 we're skipping this question, because this is --
17 no. To what extent is this measure and measure
18 concept ready for immediate use?

19 If you believe it's ready, please
20 raise your hand for yes.

21 (Voting.)

22 MS. KUWAHARA: And we're just waiting

1 for Jeff to type in "yes" or "no."

2 (Pause.)

3 MS. KUWAHARA: And no.

4 (Voting.)

5 MS. KUWAHARA: 13 voted yes. Six
6 voted no.

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

10 For high, please raise your hand.

11 (Voting.)

12 MS. KUWAHARA: Alvia, if you wouldn't
13 mind typing in "high," "medium," or "low" instead
14 of "yes" for this one?

15 (Pause.)

16 MS. KUWAHARA: Alvia, so right now we
17 have you as a "yes," but we need to know if it
18 was a high, medium or low. You can just verbally
19 respond.

20 MEMBER SIDDIQI: Sure. High, I'm
21 sorry.

22 MS. KUWAHARA: Good.

1 Medium.

2 (Voting.)

3 MS. KUWAHARA: And low.

4 (Voting.)

5 MS. KUWAHARA: Ten members voted high.

6 Five voted medium. And four voted low. So, this
7 measure will be recommended for inclusion in the
8 LTSS measure set.

9 CO-CHAIR GOLDEN: Thank you. And
10 thank you putting up for the vote. And Cheryl
11 stands corrected. It was not Samuel Johnson, it
12 was Ralph Waldo Emerson.

13 (Laughter.)

14 MS. GORHAM: Okay. So, let's go back
15 to NQF 0097, and that is number 32 on your
16 discussion guide. And we will take a vote
17 through the decision logic.

18 (Pause.)

19 CO-CHAIR GOLDEN: Hold on. So, was
20 this measure approved in another TEP -- another
21 program?

22 Yes. So, another TEP had approved

1 this measure, so we just moved it into this
2 measure. That's right.

3 That was the whole business -- that's
4 right. This does not need the five steps,
5 because it's in the consent calendar for the
6 other group. So, this is fine. We don't need to
7 do the five steps on this item.

8 CO-CHAIR MOORE: And we have voted on
9 it.

10 CO-CHAIR GOLDEN: Right. And an up
11 and down vote was appropriate, because it will be
12 on the consent calendar in the next group that
13 Jennifer will be doing when we finally get there.

14 So, we are in the journey to get there
15 and won't need a five-step vote. Okay. So, we
16 can move on.

17 CO-CHAIR MOORE: We may need a five-
18 step program after this.

19 (Laughter.)

20 CO-CHAIR GOLDEN: Hey. I've already
21 publicly talked about my dependencies here, so
22 that's not a problem. So, let's move on.

1 Next item, what do we have? Tara is
2 -- you're in. okay. So, we can move on. We
3 don't need to vote.

4 SPEAKER: So, on to the other TEP
5 measures.

6 (Pause.)

7 MEMBER SIDDIQI: Can't hear.

8 CO-CHAIR GOLDEN: No, we're just doing
9 a referee consultation here. It is a secret,
10 though.

11 MEMBER SIDDIQI: Thank you.

12 (Pause.)

13 MS. GORHAM: Okay. So, let's move on.

14 CO-CHAIR GOLDEN: There should be --
15 do we have any other measures in LTSS?

16 MS. GORHAM: Yes. We're not moving
17 the program area yet. We need to move --

18 CO-CHAIR GOLDEN: You need to move it
19 to --

20 MS. GORHAM: -- the rest of the
21 measures for LTSS.

22 CO-CHAIR GOLDEN: Correct. So,

1 whatever Barbara has on the agenda for us, right?

2 MS. GORHAM: No. That's moved out and
3 so there were no related measures in LTSS.

4 CO-CHAIR GOLDEN: Right.

5 MS. GORHAM: We just need to move our
6 slide.

7 CO-CHAIR GOLDEN: Next slide. That's
8 right.

9 MS. GORHAM: Okay.

10 CO-CHAIR GOLDEN: Okay. Now, we have
11 --

12 MS. GORHAM: So, now we're looking at
13 the measure set recommended by LTSS TEP members.

14 CO-CHAIR GOLDEN: Okay. So, we have
15 -- this is presented to you as a consent
16 calendar. So, again, like in other measures,
17 extract the ones you want to have further
18 discussion on or votes.

19 MS. GORHAM: So, what I'll do is go
20 down the list and tell you why the LTSS TEP
21 recommended the measure for the set.

22 You'll notice the first measure, the

1 Adult Access to Preventive/Ambulatory Care, was
2 also discussed yesterday for another set. It is
3 number 27 in your discussion guide.

4 And the reasons why the LTSS TEP
5 recommended this measure; one, as a proxy for --
6 do people get where they need to be and are the
7 services available?

8 It's not restricted to only dual-
9 eligible populations, but should cross all the
10 populations in the LTSS area.

11 It could also be effective concept for
12 other -- for the other three program areas, which
13 we've already discussed. It is a comprehensive
14 approach, access to preventive and ambulatory
15 care, identify long-term support needs and
16 connects to physical and wellness needs.

17 The next measure, NQF 0326, can be
18 found at number 34 in your discussion guide.

19 CO-CHAIR MOORE: So, can I interject
20 real quick as a procedural --

21 CO-CHAIR GOLDEN: Yes.

22 CO-CHAIR MOORE: So, yesterday after

1 each one of these, we asked if people had any
2 comments or concerns before we moved on.

3 CO-CHAIR GOLDEN: Right. That's
4 correct, but we had already approved this
5 measure. So, does anybody have any concerns?

6 MEMBER AMSTUTZ: Well, I just have --
7 I have sort of a concern/comment and I realize
8 this has been discussed extensively.

9 This -- the definition of this measure
10 is very broad. And it's probably broader -- it
11 basically was originally intended to say, you
12 know, patients in the commercial population that
13 they access care in any way.

14 So, it looks at, like, any specialty,
15 any urgent, any -- I think it may be -- it's
16 very, very broad and it's not very specific. And
17 so, I think it's great for saying, did the, you
18 know, adults engage in the healthcare in any way.

19 I'm not sure it gets at what we want
20 it to here.

21 CO-CHAIR GOLDEN: Yeah. I think
22 comments along those lines were made yesterday as

1 well. So, that should be in the record.

2 MEMBER AMSTUTZ: All right. Thank
3 you. I missed that.

4 CO-CHAIR GOLDEN: Okay.

5 MEMBER AMSTUTZ: All right.

6 CO-CHAIR GOLDEN: If nothing else,
7 let's go to the next item.

8 MS. GORHAM: The next measure could be
9 found at number 34 in your discussion guide, NQF
10 0326, Advance Care Plan.

11 For 65 and older, higher risk
12 population, needed so individual can maintain
13 personal choice, needed so the person can also
14 remain in their home in the community.
15 Individual can decide for themselves obviously is
16 a great benefit of this measure.

17 Also, the LTSS providers had advanced
18 directive discussions. So, it is consistent with
19 the personal -- person-centric care.

20 CO-CHAIR GOLDEN: So, a quick question
21 for Barbara in this.

22 Is the definition of an advanced care

1 plan clear in terms of what it means? I just --
2 I mean, the reason I ask is, when I saw the
3 title, I was thinking complex care management as
4 opposed to advanced directives and preferences in
5 --

6 MEMBER MCCANN: You know, and my
7 colleagues from CMS may have to help me on this.

8 CO-CHAIR GOLDEN: Yes.

9 MEMBER MCCANN: Advanced directives is
10 different, we understand, than advanced care
11 plan.

12 CO-CHAIR GOLDEN: Okay.

13 MEMBER MCCANN: So, this is more than
14 just advanced directives; do you agree?

15 CO-CHAIR GOLDEN: But is there a
16 definition of what an advanced care plan is?
17 There is?

18 SPEAKER: In the measure specs, you
19 mean?

20 CO-CHAIR GOLDEN: Well, just in
21 general, yeah. I mean, will people know what
22 this means?

1 MEMBER MCCANN: Yeah. It's --

2 CO-CHAIR GOLDEN: Okay.

3 MEMBER MCCANN: I don't know that it
4 was ever --

5 CO-CHAIR GOLDEN: MaryBeth.

6 MEMBER MUSUMECI: It looks like it's
7 in the notes. It says the aim of advanced care
8 planning is to ensure that care near the end of
9 life aligns with the patient's wishes, but I
10 thought there was something else in here that led
11 me to believe it was along those lines as opposed
12 to service planning.

13 CO-CHAIR GOLDEN: Very good.

14 MEMBER MCCANN: This is just a
15 practice, believe it or not, that does actually
16 occur across home care, yeah.

17 CO-CHAIR GOLDEN: Okay. Any other
18 comments, questions?

19 Okay. Next item.

20 MS. GORHAM: Number 39 on your
21 discussion guide. I will give you a minute to
22 get there. This is the Home and Community-Based

1 Services CAHPS measure.

2 So, it is part of the CAHPS suite
3 widely used. This is the first tool available
4 that accesses HCBS and focus on supports to live
5 independently.

6 The blind and low-vision population
7 may prefer phone -- and this is just a note from
8 one of the TEP members -- may prefer phone, while
9 other populations may find the survey a negative.

10 Overall the TEP felt that this was a
11 good measure for the set.

12 CO-CHAIR GOLDEN: Comments, questions.
13 Judy.

14 MEMBER ZERZAN: So, there's a fair --
15 I just want to note there's a lot of overlap,
16 like, about 70 percent between this set of
17 measures and the National Core Indicators set of
18 measures. I'm not sure that one is better than
19 the other.

20 Colorado piloted the CAHPS -- what is
21 now the CAHPS home and community services
22 measures, and now we're doing the National Core

1 Indicators.

2 I sort of think they do the same thing
3 and, in fact, we're doing a study that is going
4 to be presented in August that shows whether
5 they're different.

6 So, and one of the other sort of
7 things, some are in person, some are by phone,
8 some can be by mail, and we're also doing some
9 stuff about response rates for those.

10 I'm fine with all of these things
11 being on there, but I just sort of want to note I
12 hope that in the next few years we figure out
13 which one is best and then we can all do the same
14 thing, if we want to.

15 CO-CHAIR GOLDEN: Okay. Comments
16 noted.

17 Other comments, questions?

18 DR. TERRY: I just want to --

19 CO-CHAIR GOLDEN: Peg will go, and
20 then Jeff. Okay?

21 DR. TERRY: Oh, I'm sorry.

22 Yeah, I just wanted to say that on the

1 HCBS CAHPS one, the measures are actually relied
2 on, valid, they're measures that have been
3 tested. That is a little bit of a distinction at
4 this point in time.

5 So, that means it's not just the
6 survey that's been tested, but also the measures.
7 And I know we'll be -- I assume when we get to
8 the NCI one and NCI-AD, you can talk about that,
9 too, but those are -- I think they're in process
10 of doing testing of some of their measures --
11 some of their questions and measures. Just
12 wanted to make that comment.

13 CO-CHAIR GOLDEN: Jeff.

14 MEMBER ZERZAN: Jeff, either you can
15 respond or I will.

16 CO-CHAIR GOLDEN: Go ahead, Jeff.

17 MEMBER SCHIFF: I'm just going to --
18 maybe you can respond to that first, Judy. Is
19 that what you wanted to do, or whoever just said
20 that?

21 MEMBER ZERZAN: It is Judy, but I'm
22 giving you my time on the --

1 MEMBER SCHIFF: Okay. Great.

2 All right. I just -- I guess I was
3 going to say I think that one of the challenges
4 we have here is that the individual measures --
5 and sort of the validity and reliability of the
6 specific measures.

7 I think what we need to note in the
8 recommendation to CMS on this, is that NCI
9 creates sort of a suite of measures that go into
10 some background data that allows for cross-
11 analysis.

12 So, the challenge that we have is
13 we're taking individual measures, but we're not
14 able to look at the ability of, like the NCI
15 purports to do, to link the core set to
16 background indicators so you can cross-tabulate
17 the results across populations.

18 And I think we should make some note
19 of that as we recommend these to CMS.

20 CO-CHAIR GOLDEN: So, I gather that
21 there is not a desire to pull this for deletion,
22 but to make note that new measure sets and new,

1 potentially better tools are in development and
2 may be available soon.

3 How's that sound?

4 Other comments or questions?

5 (Pause.)

6 CO-CHAIR GOLDEN: Next item.

7 MS. GORHAM: All right.

8 MEMBER ZERZAN: Maybe I will say the
9 NCI ones while they are undergoing NQF
10 endorsement, have been around for a while,
11 especially the NCI-DD. It has been around for
12 decades and is very well validated. So, I think
13 they're both good surveys and have validated
14 measures.

15 And in the NCI-AD, there are the exact
16 same questions as in the CAHPS. So, I also think
17 that there's a fair bit of overlap in these two
18 different things. But as Jeff said, they're
19 slightly different.

20 CO-CHAIR GOLDEN: Okay. Next item.

21 MS. GORHAM: All right. In your
22 discussion guide, please scroll to 33. And we

1 are now looking at NQF 0101. And I'll give you a
2 minute. The name of that measure is Falls:
3 Screening for Fall Risk.

4 And, simply, the LTSS TEP thought that
5 this was a really critical issue for 65 plus.
6 The falls make a difference in staying in the
7 institution or actually coming home.

8 CO-CHAIR GOLDEN: Comments and
9 questions.

10 (Pause.)

11 CO-CHAIR GOLDEN: Next item.

12 MS. GORHAM: All right. So, in your
13 discussion guide, number 38, NQF 2483. This is
14 the PAM measure. We also discussed this in BCN
15 yesterday.

16 CO-CHAIR GOLDEN: And it was approved.

17 MS. GORHAM: And it was.

18 CO-CHAIR GOLDEN: Okay.

19 MS. GORHAM: The reasons why the LTSS
20 TEP preferred this for our measure set, it
21 answers how effective providers are engaging
22 folks in the process and facilitating activation.

1 Also, where a person is when they come
2 into LTSS and what the providers do to activate
3 them to manage health and remain independent.
4 So, we thought this was a good measure.

5 CO-CHAIR GOLDEN: Deborah.

6 MEMBER KILSTEIN: Yeah. I was trying
7 to get my hand up before. I hate to do this
8 going back --

9 DR. TERRY: Microphone, please.

10 MEMBER KILSTEIN: Going back to the
11 falls, screening for fall risk, can someone from
12 the committee talk about why we use this measure
13 and not the Medicare stars measure? Because now
14 you've seen, like, for health plans now they're
15 going to be reporting -- if they are a D-SNF,
16 they're going to be reporting on two different
17 measures.

18 MEMBER MCCANN: I can comment on home
19 care. It's screening that's done.

20 So, I don't -- I apologize, I don't
21 know which stars measure you're talking about.

22 MEMBER KILSTEIN: For Medicare health

1 plans they -- for the dual-eligible SNFs, they
2 have to report to Medicare on stars. And there
3 is a measure on falls, screening for falls.

4 MEMBER HENNESSEY: Yeah. It's NQF
5 number 0035.

6 MEMBER MCCANN: I think there's work
7 that's important work that's being done under the
8 IMPACT Act right now that will be not only
9 functional scoring that will be available across
10 all settings, as well as fall risk that will be
11 harmonized across all settings.

12 MEMBER KILSTEIN: Okay. Just a
13 concern about --

14 MEMBER MCCANN: I agree.

15 MEMBER KILSTEIN: -- alignment.

16 MEMBER HENNESSEY: I think I may be
17 able to clarify that. If I recall the screening
18 measure that your committee looked at is an
19 actual screening, so there is a record of whether
20 or not the patient has been screened for falls.

21 Whereas the -- reducing the risk for
22 falling, the star measure, NQF 0035 is actually a

1 health outcome survey measure. So, it is a
2 survey question given to consumers.

3 MEMBER KILSTEIN: Okay. Thank you.

4 MEMBER MCCANN: And just as a
5 clarification, home care is unique in that we're
6 not with them 24 hours, except with some
7 Medicaid, and that's rare now.

8 And home care -- people receiving home
9 and community-based services notoriously under
10 report falls at home because of their fear of
11 going to a nursing home.

12 CO-CHAIR GOLDEN: Okay. Any other
13 comments?

14 Any motions to withdraw the motion?

15 Okay. Next item.

16 MS. GORHAM: So, let's go back to 38.

17 And that is the PAM measure. And I already
18 stated the reason why the LTSS members
19 recommended this measure.

20 CO-CHAIR GOLDEN: And we've approved
21 it in another group.

22 MS. GORHAM: Uh-huh.

1 CO-CHAIR GOLDEN: Next item.

2 MS. GORHAM: All right. So, number 28
3 in your discussion guide.

4 MEMBER GELZER: Hey, excuse me.
5 Before we go on -- this is Andrea. With regard
6 to the PAM in the LTSS measure set --

7 CO-CHAIR GOLDEN: Sure.

8 MEMBER GELZER: -- and, again, this
9 may be beyond the scope of what we're supposed to
10 be doing here, but I do think it's an important
11 comment that in this population, the PAM scores
12 and the questionnaire, it may be just as
13 important to be giving that -- or doing that
14 scoring with the patient caregiver if the patient
15 themselves cannot accurately answer the
16 questions.

17 So, I don't know if that's an
18 expansion of the use of this tool or if this is
19 even a relevant comment, but I think it is
20 relevant that it's important that patient
21 caregivers also are involved with this segment of
22 the population. Thanks.

1 CO-CHAIR GOLDEN: I'll add that to the
2 comments. It's a method of collecting the data.
3 Okay.

4 MS. GORHAM: Okay. So, if you all are
5 at measure 28 in your discussion guide, that is
6 the Home and Community-Based Long-Term Services
7 and Supports Use Measure Definition.

8 So, this is a concept the TEPs voted
9 on. This is a concept useful for a system-level
10 perspective more suitable. So, we initially had
11 it in a domain and the TEPs thought it was better
12 for the access domain.

13 It is critical for the community and
14 it assesses states' efforts to rebalance, but
15 does not address quality. It addresses placement
16 from institution to the community, and it is a
17 strategy for states to understand performance.

18 CO-CHAIR GOLDEN: Comments, questions.

19 (Pause.)

20 CO-CHAIR GOLDEN: Next item.

21 MS. GORHAM: Okay. If you scroll down
22 one to number 29, Individualized Plan of Care

1 Completed, some of the comments made by the TEP
2 members: Individuals need a care plan. It is
3 important to align care preferences with care
4 plans and address individual lifestyle goals. It
5 is also important to communicate that this
6 measure -- so, it's also important to communicate
7 the measure in a way that non-medical laypersons
8 would understand the measure.

9 There was some communication and
10 discussion about the fact that the measure is
11 very technical. And when one looks at it, it may
12 not be understood by the layperson. And, also,
13 this aligns with CMS' mandatory person-centered
14 goals.

15 CO-CHAIR GOLDEN: This is listed as a
16 claims measure; is that correct?

17 MS. GORHAM: It is.

18 MEMBER MCCANN: I don't know how you
19 can pull this from claims.

20 CO-CHAIR GOLDEN: Yeah. There's some
21 odd things there, but okay.

22 MEMBER MCCANN: Yeah. Right.

1 CO-CHAIR GOLDEN: Jennifer.

2 CO-CHAIR MOORE: We're on number 29,
3 right?

4 MS. GORHAM: Yes.

5 CO-CHAIR MOORE: Okay. So, yesterday,
6 if I recall, when we saw a denominator that had a
7 generic population by zip code, by gender, et
8 cetera, is a group we were concerned about that.

9 I also want to note that there is not
10 a lot of information, so I feel in the dark about
11 this measure and would like a little bit more
12 context about how this was included in --

13 CO-CHAIR GOLDEN: Yeah. They said the
14 measure source was a TEP measure -- was a TEP
15 member and the staff notes retained by a TEP
16 member. So, this was sort of like, I have a good
17 idea during the meeting.

18 MS. GORHAM: So, a TEP member --
19 remember, we had recommendations come in from TEP
20 members, CCs and so forth.

21 CO-CHAIR GOLDEN: Uh-huh.

22 MS. GORHAM: And so, a TEP member

1 recommended this measure. When she recommended
2 the measure, she said that it was a very early
3 concept.

4 She saved the measure, because,
5 remember, TEP members had the opportunity to save
6 measures. So, she also saved the measure,
7 brought it back for conversation.

8 They discussed it and the TEP members,
9 as a whole, if I remember correctly, thought that
10 this was a really early concept, but they thought
11 it was important.

12 MEMBER MCCANN: The only thing I can
13 offer from the -- as a provider is in order to
14 deliver Medicaid, you have to be Medicare
15 certified.

16 As of, likely, January 2018, there
17 will have to be a person-centered plan of care
18 for every individual. And that becomes an issue
19 of actually remaining eligible for Medicare
20 payment.

21 So, as we talked about it on the TEP,
22 this is an emerging, if you will, measure, but is

1 essentially a basic requirement to remain in the
2 program at this point.

3 CO-CHAIR GOLDEN: It's right now in
4 the cloud somewhere; is that correct?

5 MEMBER MCCANN: Is that how you would
6 describe it? It is a -- the comment period just
7 closed, but it is a condition of participating --
8 continuing to participate in the Medicare
9 program.

10 CO-CHAIR GOLDEN: We have a phone
11 comment.

12 MEMBER SIDDIQI: Yeah. This is Alvia.

13 I was just going to say that, you
14 know, I like the idea that this was a measure
15 concept that was being supported.

16 Because, as we heard earlier with
17 long-term support patients, a lot of times,
18 unfortunately, their care needs are readjusted
19 when they're hospitalized.

20 And so, I do think that the approach
21 of having an ability to have a care plan across
22 the board accepted is very much applicable to

1 this population.

2 CO-CHAIR GOLDEN: We have another
3 phone comment.

4 MEMBER MOHANTY: Yeah. Hi. This is
5 Sarita.

6 I just wanted to add I agree with the
7 last comment. I do -- I was a little confused.
8 I know we've talked about the way the measure is
9 defined, but, you know, it also talks about those
10 with a high-risk score to have an individualized
11 care plan.

12 So, that doesn't seem to correlate
13 with what the denominator is describing. So, I
14 feel that the measure is not quite developed at
15 this point.

16 CO-CHAIR GOLDEN: Okay. And as we go
17 through this discussion, if you're uncomfortable,
18 you need to extract, if you want to do anything.
19 If not, you know.

20 So, I have a hand over there. Cheryl.

21 MEMBER POWELL: I just wanted to make
22 a comment in general that I'm hoping the report

1 can reflect the understanding that we have of the
2 nascence of the developmentive measures for long-
3 term care or for long-term services and supports.

4 They don't exist. This is -- we have
5 thousands of medical measures --

6 CO-CHAIR GOLDEN: And I believe the
7 chair of the TEP has made that comment as well.

8 MEMBER POWELL: Yeah. I just want to
9 highlight it cannot be stated strongly enough.
10 And, I mean, when it comes to measures for HCBS
11 and long-term services and supports, much less
12 trying to integrate them with anything else or
13 across each other, there's just so little there.

14 There are a couple of measures that
15 are emerging now. There are the National Core
16 Indicators, there are the CAHPS measures for
17 HCBS. But I think as a committee, it would be
18 wonderful if we could encourage experimentation
19 to find what works, but also continue the trend,
20 because there are a number emerging now not for
21 us.

22 They're too new, really, for us to

1 review here, but they are emerging and I think
2 that just started in the last couple of years.

3 And I would really like us to be able
4 to encourage that further development and
5 highlight how important that is and some of the
6 experimentation of measures and across so that we
7 can really measure this.

8 It's incredibly difficult. It hasn't
9 really been done. And I applaud the -- actually
10 the inclusion of the idea, because I think it
11 also highlights that nothing exists.

12 So, anyway, I just wanted to say I
13 hope in the -- I hope that we can do that and I
14 thank the TEP for looking at, like, the 20
15 measures, many of which actually relate to
16 clinical issues, for doing the best they could.

17 CO-CHAIR GOLDEN: So, again, does
18 anybody want to extract this measure?

19 CO-CHAIR MOORE: I would like to have
20 just --

21 CO-CHAIR GOLDEN: Do you have a
22 comment?

1 CO-CHAIR MOORE: Yeah.

2 CO-CHAIR GOLDEN: No. I want to know
3 if anybody wanted to extract.

4 CO-CHAIR MOORE: I am on the verge of
5 that.

6 CO-CHAIR GOLDEN: Okay.

7 CO-CHAIR MOORE: So, I don't want to
8 say "extraction" yet, but I want to make a
9 comment and hopefully there's clarification
10 before I go to that step.

11 CO-CHAIR GOLDEN: Okay.

12 CO-CHAIR MOORE: This seems like more
13 of a comment that should be reflected for the
14 record, because this isn't a concept that we have
15 a lot of information on or even a measure. It's
16 very -- I put this in the same category as the
17 comment about, you know, there's missing
18 pediatrics, there's missing this, there's missing
19 that.

20 I think in the spirit of what we've
21 been doing and the comments that we're providing,
22 I'm not sure that this gives enough information

1 to actually be meaningful as opposed to just
2 standing in as a comment that this is needed, the
3 community recognizes that this is needed, and
4 encouraging the development of this similarly to
5 the lack of pediatrics, lack of other pieces.

6 So, before I say "extraction," I'd
7 like to throw that out and then push for us to
8 consider that.

9 CO-CHAIR GOLDEN: Allison.

10 MEMBER HAMBLIN: So, I'm about to make
11 that motion and I'm going to make it on the basis
12 of equity with some of the other program areas
13 that we discussed where we had similarly relevant
14 concepts like referral to community resources
15 that I think we all agree is important, risk
16 stratification that we all agree is important,
17 but the measure wasn't developed in a meaningful
18 way.

19 And so, I would worry by making your
20 exception here for a very loosely defined measure
21 concept, we sort of give short shrift to some of
22 the decisions that we made --

1 CO-CHAIR GOLDEN: So, if you make that
2 motion, you would have to pick one of the four
3 steps -- five steps it would fail. So, that
4 would be helpful to think about.

5 MEMBER HAMBLIN: Okay.

6 CO-CHAIR GOLDEN: Barbara.

7 MEMBER MCCANN: Thank you. The
8 individualized plan of care which is now going to
9 be mandated for January, likely, is incredibly
10 prescriptive as to the content.

11 This would -- this is one of the few
12 measures that applies to every single population
13 in Medicaid. And the specificity may not exist
14 in the measure statement, but it exists in the
15 regulation.

16 CO-CHAIR MOORE: I think I should
17 clarify this isn't a measure right now.

18 MEMBER MCCANN: Right. Right.

19 CO-CHAIR MOORE: So --

20 MEMBER MCCANN: It's just like some
21 other things that we have --

22 CO-CHAIR MOORE: Yeah.

1 MEMBER MCCANN: -- going forward with
2 are not measures.

3 CO-CHAIR MOORE: But I -- but it's not
4 even a well-developed concept yet.

5 MEMBER MCCANN: No, I disagree. I do
6 believe the individualized patient plan of care
7 is a well-developed concept well enough for it to
8 be a regulation, which is certainly not my
9 preference.

10 I would also ask the group to think
11 about there is a total absence of standards of
12 practice in this particular area of Medicaid.

13 This establishes one basic standard of
14 practice. And if you do not do well on this in a
15 federal survey or an accreditation organization
16 survey, your ability to continue to bill is at
17 risk, which means you wouldn't remain Medicaid or
18 Medicare certified.

19 CO-CHAIR GOLDEN: Karen, you have some
20 comments at the end there?

21 MEMBER AMSTUTZ: So, I just wanted to
22 add that as you look at the whole concept and

1 have the discussion that you think about all of
2 the levels of LTSS, including sort of thinking
3 about the role of self-directed care.

4 I mean, the ultimate is an LTSS
5 program where the individual who's receiving the
6 services is really driving their care plan
7 development, hiring and working with facility
8 intermediary to find the folks they want to have
9 be their caregivers and employing them on the
10 schedule that they think is most appropriate
11 within the context of the sort of plan of care
12 needs. And there just hasn't been any discussion
13 on self-direction, so...

14 CO-CHAIR GOLDEN: David.

15 MEMBER KELLEY: Again, I think within
16 a lot of the current LTSS wavier programs,
17 individual plans of care are mandatory. At least
18 in Pennsylvania, ours, you know, there has to be
19 an individual care plan that is submitted. And
20 then we're actually going to be measuring that
21 care plan to see if something -- to see if it's
22 actually done.

1 I would say that in Pennsylvania with
2 our current managed care plans with,
3 quote/unquote, "straight up Medicaid," we have a
4 program where our plans must report to us an
5 integrated care plan between physical and
6 behavioral health.

7 And actually posted on CHCS' website
8 from a pilot, actually there is a template of
9 what might encompass a good, integrated care plan
10 between physical health and behavioral health.
11 So, yes, we don't have all the formats.

12 I will also say that for our long-term
13 support services program, we and other states are
14 in discussions around making these -- the formats
15 of these plans electronically available so that
16 your earlier comment about being in the cloud,
17 our plan is to put these things in the cloud.

18 So, to say that -- I mean, for any
19 LTSS program for other populations, I mean,
20 individual plan of care is -- I don't know how
21 you operate without that.

22 CO-CHAIR GOLDEN: Okay. So, my

1 question here before we go too much further, does
2 anybody want to make a motion to extract?

3 CO-CHAIR MOORE: I do.

4 CO-CHAIR GOLDEN: We have a motion to
5 extract.

6 Any seconds?

7 Anybody second?

8 We have a second. Okay. We'll
9 continue discussing. And you would extract
10 because it fails which criteria?

11 CO-CHAIR MOORE: This measure is not
12 ready for immediate use.

13 CO-CHAIR GOLDEN: Okay. Thank you.
14 Judy.

15 MEMBER ZERZAN: So, I just got in my
16 inbox, a viewpoint from JAMA. "Personalized care
17 planning is a promising strategy to improve
18 person-centeredness and quality of care. Careful
19 attention must be paid as to how it's implemented
20 to ensure it adds value and to avoid having care
21 planning become yet another burden for patients
22 and clinicians that adds cost and complexity

1 without improving care."

2 I fully believe that everyone needs a
3 care plan in this situation, but I feel like
4 this, at risk of using the word "squishy," is not
5 ready for prime time and what makes a good care
6 plan is so important.

7 And given how we've voted on other
8 measures, I know this is an underutilized area,
9 but I think we've already given CMS that message
10 and I worry about this going forward.

11 CO-CHAIR GOLDEN: And I -- I'll get to
12 Deborah in a second. My concern, if there is one
13 here, is that the description is a better
14 statement of the denominator than the nominator.

15 The nominator, as written, is
16 completely not appropriate for the description of
17 the measure, but that's neither here nor there, I
18 guess.

19 Deborah.

20 MEMBER KILSTEIN: I would also say
21 that it's written to say that it's based on the
22 data source's claims. You know, I don't see how

1 that would happen. Maybe other supplementary
2 data sources that could be used, but it's not
3 going to be claims.

4 CO-CHAIR GOLDEN: So, we have a motion
5 and it's been seconded to extract to not forward.
6 And it's based on failure to be ready for
7 immediate use.

8 Okay. Any other discussions on the
9 item?

10 (Pause.)

11 CO-CHAIR GOLDEN: Are we ready to
12 vote?

13 Let's vote.

14 MS. KUWAHARA: So, this will be an up
15 or down hand vote. Again, this is measure number
16 29 on your discussion guide, Individualized Plan
17 of Care Completed.

18 If you would like to see this measure
19 removed from the LTSS measure set, please raise
20 your hand.

21 (Voting.)

22 MS. MURPHY: Alvia, to distribute the

1 question for you, it's to whether or not -- the
2 vote right now is to remove the measure from the
3 set.

4 MEMBER SIDDIQI: Okay. So -- okay.

5 MS. MURPHY: So, you -- yeah. Thank
6 you.

7 MS. KUWAHARA: And if you would like
8 to see this measure remain in the measure set,
9 please raise your hand.

10 (Voting.)

11 MS. KUWAHARA: There were 11 members
12 who would -- I'm sorry. 11 members voted to
13 remove this measure. Nine members voted to keep
14 it. And we did not reach the greater than 60, so
15 the measure will remain in the LTSS measure set.

16 CO-CHAIR GOLDEN: So, you were saying
17 it would take a 60 percent vote to remove
18 something?

19 MS. KUWAHARA: Greater than 60
20 percent.

21 DR. TERRY: You're overturning, so
22 it's going to be greater --

1 CO-CHAIR GOLDEN: Okay. I don't know.
2 I'm just tracking the rules here. Okay.

3 DR. TERRY: Right. You're trying to
4 keep us honest, I know.

5 CO-CHAIR GOLDEN: I thought it was 60
6 percent to approve as opposed to 60 percent to --

7 DR. TERRY: No.

8 CO-CHAIR GOLDEN: Okay. That's very
9 good.

10 MS. KUWAHARA: And for record
11 purposes, this was measure number 29 on the
12 discussion guide, Individualized Plan of Care
13 Completed.

14 CO-CHAIR GOLDEN: And I think, though,
15 just the staff or CMS, I think attention needs to
16 be given to the description of the measure,
17 because it's not accurately recorded as what the
18 measure should be measuring. So, I think it
19 needs some work. So, I suggest some editing on
20 this before it gets sent around.

21 Okay. Next item.

22 MS. GORHAM: All right. So, let's

1 look at number 31 in your discussion guide. And
2 that is the National Core Indicators - Aging and
3 Disability Survey. I'll give you a minute to get
4 there.

5 And some reasons why the TEP decided
6 to include this measure -- or concept, measure
7 concept is what they actually voted on, this is
8 currently used in states, 14 to be exact, it is
9 critical importance to -- it is of critical
10 importance to disability and aging populations.

11 It focuses on elements important to
12 quality of life. It's parallel to other
13 hospital-based surveys. This too allows for the
14 voice of individuals to be heard.

15 ACL is pursuing validation and testing
16 for a subset of the measures, 20. And that
17 information is also included in your discussion
18 guide.

19 CO-CHAIR GOLDEN: Any comments or
20 questions on this one?

21 (Pause.)

22 CO-CHAIR GOLDEN: What's the next

1 item?

2 MS. GORHAM Number 30 in your
3 discussion guide. This is the National Core
4 Indicators Survey.

5 So, the first one, the one I just
6 mentioned, 31, was the aging and disabilities.
7 This one is the National Core Indicators. This
8 is used more. This is used by 46 states.

9 And, again, the same things apply as
10 reasonings for including the survey into the
11 measure set.

12 CO-CHAIR GOLDEN: Any other comments
13 or questions on this one?

14 Judy, are you up or is that -- you're
15 just kind of behind. Okay.

16 Anything else?

17 (Pause.)

18 CO-CHAIR GOLDEN: Next item.

19 MS. GORHAM: All right. Number 40 in
20 your discussion guide. I'll give you a minute to
21 get there.

22 This is also a concept. And this is

1 the number and percent of waiver participants who
2 had assessments completed by the MCO that
3 included physical, behavioral and functional
4 components to determine the member's need.

5 The TEP members felt that this
6 mandated an assessment and was broad enough to be
7 considered across the waiver population. So,
8 including Ps (phonetic) disability, aging. And
9 so, they thought this was a good concept.

10 CO-CHAIR GOLDEN: Comments, questions?

11 Judy.

12 MEMBER ZERZAN: I like this concept.

13 I just don't like that it's only MCO and that it
14 has to be done by the MCO.

15 There are states like us that are fee-
16 for-service, but we're managed fee-for-service
17 that I think this would apply to. And I think a
18 lot of waivers are not in states that have
19 managed care in the managed care, so I just want
20 it to be broader since it seems, you know, like a
21 made up measure, like a measure that isn't all
22 the way finalized.

1 CO-CHAIR GOLDEN: Okay. Other
2 comments, questions?

3 (Pause.)

4 CO-CHAIR GOLDEN: Next item.

5 MS. GORHAM: All right. Number 42.

6 And that is Referral to Community-Based Health
7 Resources. We also discussed this measure for
8 BCN and PMH.

9 CO-CHAIR GOLDEN: So, this has already
10 been approved?

11 MS. GORHAM: It did not pass --

12 CO-CHAIR GOLDEN: It did not pass.

13 MS. GORHAM: -- BCN.

14 CO-CHAIR MOORE: It was the one that
15 flagged us about the denominator being
16 population. If you recall, that was one of the
17 ones that --

18 CO-CHAIR GOLDEN: So, I will take it
19 that because it's failed the group that we've had
20 a motion and a second to remove this item, do we
21 need to have a vote about this item to keep it?

22 CO-CHAIR MOORE: So, you're saying that

1 because it's been removed from others, do we need
2 to have the same with this one?

3 CO-CHAIR GOLDEN: Yeah. I was going
4 to say we -- I would take it since the group has
5 turned it down once or twice, that there's
6 already been a motion and a second to extract.

7 So, do we need another vote? Do we
8 want to do it formally? We should do another up
9 or down vote.

10 And if you want to have additional
11 conversation on this, let's have --

12 MEMBER WALLACE: (Speaking off mic.)

13 CO-CHAIR GOLDEN: Okay. That's fine.
14 (Speaking off mic.)

15 CO-CHAIR GOLDEN: I'm sorry, I can't
16 hear you.

17 SPEAKER: I'm sorry, a clarification.
18 This is a measure concept, right?

19 MEMBER WALLACE: Uh-huh.

20 SPEAKER: Okay. thank you.

21 MEMBER WALLACE: And I believe when it
22 was considered before it was -- was it one of the

1 ones that was pulled -- that was referred to
2 another group. And so, the CC was the only body
3 that had, at that point, reviewed it.

4 Because we're going to be overturning
5 the work of our TEP, I feel like it needs to have
6 -- to be voted on.

7 CO-CHAIR GOLDEN: That's fine. So, is
8 anyone disagreeing about -- extraction is on the
9 table.

10 Do we want to have discussions about
11 extraction and a move. Are we ready to vote?

12 CO-CHAIR MOORE: Do we need someone to
13 do a motion?

14 CO-CHAIR GOLDEN: No, the motion is to
15 remove it.

16 CO-CHAIR MOORE: Susan, that's your
17 motion?

18 CO-CHAIR GOLDEN: No, I'm sorry. I --
19 the chair declared that there was a motion to
20 remove the item since we've removed it from other
21 TEPs.

22 So, we've already had a vote by the

1 members of the committee on multiple occasions on
2 this. So, I just said on the table, I would
3 assume that for the sake of consistency that,
4 unless people want, I'm not going to do that.

5 So, are we ready to have a vote about
6 removing this item? Okay.

7 MS. KUWAHARA: We are voting to remove
8 measure number 42, Referral to Community-Based
9 Health Resources, from the LTSS measure set.
10 This will be an up or down vote.

11 If you would like to see this measure
12 removed from the measure set, please raise your
13 hand.

14 (Voting.)

15 MS. BUCHANAN: And participants on the
16 phone, if you want to type in "vote to remove" or
17 "not to remove" into the chat box?

18 (Voting.)

19 MS. KUWAHARA: So, I just want to
20 clarify you are voting to remove it.

21 MEMBER GELZER: Yeah -- let me see.
22 Hold on. This is for the community-based

1 resources one, yes.

2 MS. KUWAHARA: Yes. Okay.

3 And, Alvia, I just want to clarify you
4 are voting not to remove it?

5 MEMBER SIDDIQI: Correct. So -- this
6 is Alvia. And I guess what I'm curious about is
7 when you're including this measure in this set,
8 wouldn't the population be the long-term support
9 service patient and, hence, there is a little bit
10 more direction around who the population is for
11 who this measure is being applied?

12 And so, yes, I vote to keep it.

13 MS. BUCHANAN: And those who would
14 like to see the measure retained in the LTSS
15 measure set, please raise your hand.

16 (Voting.)

17 MS. KUWAHARA: 17 members voted to
18 remove the measure. Three members voted not to
19 remove the measure. So, the measure will be
20 removed from the LTSS measure set. And this is
21 measure number 42, Referral to Community-Based
22 Health Resources.

1 CO-CHAIR GOLDEN: Do we have any other
2 items? We do?

3 MS. GORHAM: Yes.

4 CO-CHAIR GOLDEN: Okay.

5 MS. GORHAM: So, we have two more,
6 actually.

7 If you would scroll to number 35 in
8 your discussion guide, this is NQF 0647. And
9 this is Transition Record With Specified Elements
10 Received by Discharged Patients (Discharge is
11 From an Inpatient Facility to Home Self-Care or
12 Any Other Site of Care).

13 So, the TPEs thought that this was
14 critical to provide LTSS. You need information
15 when a person is released from an institution
16 critical for the primary care and other LTSS
17 providers to have information in order to provide
18 appropriate services in the community.

19 DR. TERRY: Can I just ask the one
20 that we voted on the other day, the transition
21 care measure, was it this one, or was it for a --

22 CO-CHAIR GOLDEN: This is a different

1 measure.

2 DR. TERRY: It is. Okay.

3 CO-CHAIR GOLDEN: This is a different
4 measure.

5 DR. TERRY: But this one also will
6 probably lose endorsement, just so you know.

7 CO-CHAIR GOLDEN: So, this is -- and
8 this is to be given to the patient, if I'm not --
9 is that what it states? So, this is to be given
10 to the patient or the caregiver.

11 Comments, questions -- Allison.

12 MEMBER HAMBLIN: Yeah. I just have a
13 question for anybody who knows these two
14 measures. I would love to know why we're
15 recommending one for one area and one for
16 another.

17 So, if anybody has insight onto that,
18 that would be great just so that we appear
19 consistent.

20 CO-CHAIR MOORE: I guess the question
21 is, did this TEP see both of them and review both
22 of them?

1 MS. GORHAM: So, the LTSS TEP reviewed
2 both of these measures, voted on both of these
3 measures and decided that they were relevant for
4 the LTSS population.

5 MEMBER HAMBLIN: Oh, I'm sorry. I
6 meant the one below.

7 MEMBER HENNESSEY: Yeah. And I think
8 the difference, if I recall, is that the one that
9 we're looking at right now talks about giving the
10 caregiver a record, if I'm understanding this
11 correctly, whereas the one below it talks about
12 giving -- or the patient or caregiver.

13 The one below it is talking about
14 clinician-to-clinician communication. Thank you.

15 MEMBER HAMBLIN: Thank you. That's
16 helpful.

17 CO-CHAIR GOLDEN: And if I am not
18 mistaken, also the same steward -- the same
19 measure steward. And the other measure had lost
20 the NQF status only because it had not filed for
21 retesting; isn't that correct?

22 DR. TERRY: They had not had -- all

1 the transition care measures that we saw and care
2 coordination were -- are slated to lose
3 endorsement not yet as they go through CSAC, but
4 because there is no new performance data
5 presented over the last three years since it was
6 --

7 MS. GORHAM: Also have it known here
8 that the same committee did not accept the
9 reliability testing. And, therefore, did not
10 recommend the measure for endorsement, but just
11 another note.

12 CO-CHAIR GOLDEN: That was the core
13 set, yeah.

14 MS. GORHAM: Well, this is the care
15 coordination committee that Peg just referenced,
16 but also this measure was formally on the adult
17 core set and it was removed from the 2017 core
18 set.

19 CO-CHAIR GOLDEN: Actually, it's the
20 next measure. This one is a different measure.

21 MS. GORHAM: 0647 was formally on the
22 adult core set and removed from the 2017 core

1 set. That is the measure we're looking at right
2 now.

3 CO-CHAIR GOLDEN: Okay. Any motions
4 for extraction?

5 MEMBER HENNESSEY: I had a question.

6 CO-CHAIR GOLDEN: Yes.

7 MEMBER HENNESSEY: Could you say a
8 little bit about why the committee chose to keep
9 the -- the panel chose to recommend these,
10 please, despite the fact that there had been
11 these lack of recommendation and there wasn't
12 data -- new data. Thanks.

13 MEMBER MCCANN: Transitions remain the
14 biggest issue for community-based services and
15 receiving any information whatsoever.

16 So, we didn't understand why --
17 actually why it was so problematic, because the
18 process in bundling ACOs, however you want to do
19 it by payer, is trying to give either those that
20 are discharged to self-care something from the
21 facility. This crosses a nice range of
22 facilities better than usual.

1 And then to also give it to the
2 provider so you have a place to start for the
3 assessment in the community. This is not common
4 practice, unfortunately.

5 MEMBER HENNESSEY: Thank you.

6 CO-CHAIR GOLDEN: Anyone else?
7 Comments, questions, motions for extraction?

8 (Pause.)

9 CO-CHAIR GOLDEN: Next item.

10 MS. GORHAM: All right. So, number 36
11 on your discussion guide, if you scroll down one,
12 is NQF 0648. And that is the Timely Transmission
13 of Transition Record (Discharge From an Inpatient
14 Facility to Home/Self-Care and/or Other Site of
15 Care).

16 For the same reasons as stated above
17 for the previous measure, the TEPs were -- this
18 measure was critical. Also, timeliness of one
19 day of being discharged into the community was
20 very important and it addresses health literacy.

21 This measure, if you remember, was
22 considered yesterday for BCN and voted to remain

1 -- you all voted to keep it for BCN as well.

2 CO-CHAIR GOLDEN: Okay. So, we have

3 -- we moved this from another set in --

4 MS. GORHAM: No, we kept it.

5 CO-CHAIR GOLDEN: I'm sorry, we kept

6 it. Pardon me. Okay.

7 So, any other additional comments or

8 questions on this item?

9 (Pause.)

10 CO-CHAIR GOLDEN: Next item.

11 MS. GORHAM: So, that concludes our

12 discussion for the LTSS measure set.

13 CO-CHAIR GOLDEN: Super. We can take

14 a break, I guess, at this point -- oh, public

15 comment.

16 I will say, by the way, I have gotten

17 an email from one of our phone participants. And

18 this is Chip, who voted earlier.

19 (Laughter.)

20 CO-CHAIR GOLDEN: He has no conflicts

21 of interest.

22 (Laughter.)

1 CO-CHAIR MOORE: In fact, I think the
2 question -- the logic model about stakeholders,
3 we should include Chip.

4 (Laughter.)

5 MS. BUCHANAN: We are now opening the
6 lines for public comment. We invite anyone to
7 comment either through phone, through chat box.
8 Or if they're in person, there is a microphone
9 available.

10 And so, Alvia, if you don't mind
11 opening the lines, and I see that we have a
12 comment in the room. So, we'll take that one
13 first.

14 MS. DOBSON: Thank you. Good
15 afternoon. Camille Dobson. I'm the deputy
16 executive director at the National Association of
17 States United for Aging and Disabilities.

18 We are the membership association
19 sister to the Medicaid directors who represent
20 the state aging and disability directors who
21 deliver directly HCBS services to the more than
22 three million individuals who get those services

1 every year.

2 And so, I was a member, an unofficial
3 member of the LTSS TEP -- a nonvoting member of
4 the LTSS TEP to bring some direct state
5 experience to the TEP about -- as they look
6 through the measures that were in front of them.

7 So, one, I'm very passionate -- we're
8 very passionate about this work. That's all our
9 members focus on is HCBS and they really spend a
10 lot of time thinking about ways to deliver those
11 services in the best manner that they can.

12 I would echo -- I really commend the
13 committee for passing on as many measures as
14 possible. As I think Cheryl and MaryBeth and a
15 number of other people said, this is a really
16 nascent area.

17 States are the innovators, because
18 these services aren't delivered in the commercial
19 space. And so, there's no -- there's nobody to
20 build measures for us, for the states in the
21 Medicaid space. They sort of make it up on their
22 own.

1 So, they don't have the kind of
2 validity and evidence testing, because, frankly,
3 the states don't have the money to do that.
4 They're delivering services to people.

5 So, but that doesn't mean that they're
6 not any -- they're not any less valuable and
7 useful and effective in helping states improve
8 their program.

9 So, we appreciate the fact that
10 there's a nice set that's being passed on to CMS
11 for states to consider.

12 I will just note again for the report,
13 and I mentioned this in the TEP, that there is
14 still significant gaps. Lots of gaps.

15 I was a member of the NQF HCBS quality
16 framework group. We identified 11 domains for
17 measurement of assessment of quality and these
18 measures might have -- might be in two or three.

19 And so, there are lots of gaps around
20 choice and control for individuals, because,
21 really, in the end, HCBS services are about
22 living -- helping people live the most

1 independent and fulfilled lives that they can.

2 And so, there's very little about the
3 delivery of services. If people don't get these
4 services, they don't live, period. They can't
5 get out of bed, they can't work.

6 And so, actually getting services to
7 people is a really critical piece. No measures
8 in here about how effectively those services get
9 delivered to people.

10 And then last, but not least, around
11 the workforce shortage, it is a massive and
12 emerging crisis as our elderly population
13 explodes. People are diagnosed with disabilities
14 more and more frequently and there are not enough
15 highly qualified staff out there to deliver
16 services. And so, measures of quality and the
17 delivery of services to individuals is still
18 lacking.

19 So, I appreciate the work of the
20 group. We're excited to have a nice set to pick
21 from. But as you know, you know, there's 355
22 waiver programs out there. Another, I think,

1 five or six that just do those program through
2 1115 and they must have thousands of measures
3 that they use today.

4 So, I think the states will continue
5 to be laboratories for innovation, but appreciate
6 the work of the committee today. Thank you.

7 MS. TRIANO: Good afternoon. My name
8 is Sarah Triano, and I am the director of policy
9 and innovation for Complex Care for Centene,
10 which is a Medicaid managed care organization.

11 We actually have the largest number of
12 managed LTSS members of any plan across the
13 country. And we're also a member of the --
14 recently formed last year, National MLTSS Health
15 Plan Association, which is made up of ten of the
16 largest national health plans in the country that
17 are serving members in long-term services and
18 supports.

19 Christine Hawkins, who's actually a
20 member of this body, had asked that I come and
21 share just a little bit about the work that
22 they're doing and comment on some of the measures

1 that you're about to vote on.

2 So, last year in 2016, there was a
3 Medicaid final rule that came out. And there was
4 a whole section in there, Section 438.330, that
5 called on states to create measures specifically
6 in this area by July of this year.

7 And they had -- they identified five
8 key outcome areas. One was quality of life,
9 community integration, rebalancing, transitional
10 care, and then did the member actually receive
11 the services that are in the care plan.

12 You had a lot of discussion about the
13 care plan. All managed care organizations that
14 provide LTSS have to provide a care plan for our
15 members.

16 So, at that point, the states came to
17 us, all of these health plans, and said, "Help,
18 we need your help." There are literally
19 thousands of measures out there that, you know,
20 different states are implementing.

21 There's over 80 measures on the NCI-
22 AD. There's over a hundred on the HCBS CAHPS.

1 There are over 160 that the NQF HCBS Committee
2 came up with in their report. So, the states
3 came to us and said, "Help"

4 So, what we did is last fall we rolled
5 up our sleeves. We went to our members. We
6 said, "What does quality LTSS mean to you?" We
7 started there, but then we combed through,
8 literally, the hundreds and hundreds of measures
9 that are out there, because the states wanted to
10 know from us, this is great, but what can you
11 actually implement, right?

12 Because at the end of the day, some of
13 the conversation that you've been having is about
14 78 percent of our members who receive LTSS are
15 duals.

16 And if they're in a non-aligned
17 Medicare plan, we do not have access to that data
18 to be able to report it.

19 So, we sat down and we said, what are
20 the measures that we can actually implement and
21 that we can report very quickly?

22 We have assessment data already right

1 now today. We could report on this in as little
2 as a month.

3 And so, we also met with the chairs of
4 the NQF HCBS Committee and created a framework of
5 37 measures -- only 37 measures in five domains
6 that actually match up with the 2016 regulation.
7 And I wanted to just share a paper that we had
8 put out a couple months ago that outlines those
9 37 measures for you.

10 So, I made copies, if I -- okay. And
11 just to give you a piece of information,
12 yesterday the association of all the health plan
13 -- the ten health plans met with CMS' quality
14 division. And we're going to be holding a
15 workgroup to actually test -- we have broken the
16 37 measures out into three tiers of
17 implementation that we're going to report and
18 we're holding -- we're starting a workgroup to
19 actually test some of these measures.

20 So, I -- the thing I would want to do
21 is just tell you what I would like to see come
22 out of this group is something that is aligned

1 with not just the work that we've done, but the
2 work of the NQF HCBS Committee has done a lot of
3 work in this area and has come up with some
4 measures that we believe really reflect what is
5 actually being done in long-term services and
6 support service.

7 So, that four -- in the areas of
8 quality of life, again, community integration,
9 rebalancing, transitional care, and did the
10 members receive services in the care plan.

11 The last thing I want to share with
12 you is we did an analysis of the measures that
13 you're about to vote on and how they are aligned
14 or not aligned with the ones that we just put out
15 in our paper. And so, I'd like to pass that out
16 to you as well.

17 Some of them definitely are. So, for
18 example, the HCBS CAHPS absolutely. But, again,
19 as I mentioned, there are over a hundred measures
20 in that measure set. To think that we are going
21 to actually implement that, right, along with all
22 of the other ones is -- it's just not realistic.

1 It's not going to happen.

2 So, I wanted to pass this out for you
3 so that you have an analysis of where the
4 measures align and where actually some of them
5 really don't.

6 The white paper is available. If you
7 go to www.mltss.org, the measure set is there.
8 So, thank you for the opportunity to comment.

9 DR. BERSHADSKY: Hi. Julie Bershadsky
10 from Human Services Research Institute out in
11 Boston. My comment is actually going to be very
12 short, promise, and very -- fairly narrow.

13 And that is I don't know how much of
14 this is going to enter into the voting
15 considerations today. But if it is, I would just
16 like to, I guess, second a reminder that was
17 voiced a little bit earlier.

18 And that is in terms of evidence of
19 validity and reliability with the measures you
20 were considering today, just because potentially
21 something has not been submitted to NQF as
22 evidence in the process of endorsement, it does

1 not mean that that evidence does not exist or
2 that a measure is not valid or reliable.

3 So, I'm a methodologist by training
4 and I just, you know, a lot of people don't care
5 about that, but I do. So, that's all I had to
6 contribute.

7 MS. BUCHANAN: Do we have any public
8 comments on the phone?

9 THE OPERATOR: We have no public
10 comments at this time.

11 MS. BUCHANAN: Thank you.

12 CO-CHAIR GOLDEN: Are we at the end
13 here? We can take a break. Thank you all for
14 hanging in there. It is now 2:20. How about 10
15 minutes?

16 CO-CHAIR MOORE: Do we have to vote on
17 the whole set?

18 SPEAKER: Yes.

19 CO-CHAIR GOLDEN: I'm sorry. Okay.

20 One more vote. Don't leave. Can't break.

21 Emerson -- we have to be consistent. So, we have
22 to vote about accepting the entire set.

1 So, all in favor of accepting --

2 MS. GORHAM: We will pull it up real
3 fast just so you have it on the slide. And it
4 includes the three measures that you decided on
5 today to include in the measure set, and it
6 excludes the measure that you decided to exclude.

7 So, the three measures that you
8 included today was the NQF 0097, also the
9 Percentage of Short-Stay Residents Who Were
10 Successfully Discharged to the Community, as well
11 as NQF 0419.

12 Those were the additions made and we
13 decided to -- or you decided to remove measure
14 number 42, on your discussion guide, which was
15 referral to community-based resources.

16 And it has been removed, so now we
17 will take a vote on the overall set.

18 MS. BUCHANAN: Participants on the
19 phone, please type "yes" or "no."

20 CO-CHAIR GOLDEN: So, all in favor of
21 the set as we have produced, please raise your
22 hand.

1 (Voting.)

2 CO-CHAIR GOLDEN: Okay. And you can
3 lower that. And anybody opposed, raise your
4 hand, please.

5 (Voting.)

6 CO-CHAIR GOLDEN: Okay.

7 MS. KUWAHARA: 19 of the 19 voting
8 members voted to recommend the LTSS measure set
9 to CMS' Medicaid Innovation Accelerator Program.

10 CO-CHAIR GOLDEN: So, it's now 2:24.
11 How about breaking to 2:35 -- yeah, 2:35. Fair
12 enough?

13 (Whereupon, the proceedings went off
14 the record at 2:25 p.m. and resumed at 2:36 p.m.)

15 CO-CHAIR MOORE: All right. Shaconna
16 is going to take us through how we're going to
17 spend the rest of the afternoon together.

18 MS. GORHAM: All right. So first of
19 all, we thank you all for your participation thus
20 far. We're going to go back, since we finished
21 all of our programs areas except PMH; we're going
22 to go back to the PMH program area.

1 We have our illustrious Chair of the
2 PMH TEP back with us, and we are going to start
3 with the PMH measures for reconsideration,
4 because we did not go through the decision logic
5 for those measures; they were reconsidered. So
6 we'll have to go back through the decision logic
7 for those measures.

8 After doing that, we will look at the
9 PMH measure set as a whole, and then you all have
10 the opportunity to remove any measures from the
11 block and then we'll vote on the blocks.

12 What we are going to do because we
13 recognize that there are a good number of members
14 who have planes and trains and automobiles -- all
15 that good stuff -- to catch, we are not going to
16 finish our agenda today.

17 So after we finish the review of the
18 PMH measure set, we will postpone the final
19 review of all of the measure sets for our post-
20 meeting webinar. Okay?

21 So with that, I will hand it over to
22 Kate to go back to the program area.

1 CO-CHAIR MOORE: But if we do finish
2 it today, do we get anything, you know, cupcakes?

3 (Laughter.)

4 CO-CHAIR MOORE: I'm really trying to
5 work on this motivation piece. So yesterday,
6 breaks, bathroom, cookies didn't work.

7 CO-CHAIR GOLDEN: And Chip will wag
8 his tail.

9 MS. BUCHANAN: Okay. So we are going
10 to be voting through number 97 on your discussion
11 guide, NQF-2602; controlling high blood pressure
12 for people with serious mental illness.

13 And so as you all pull that up, I will
14 give you -- number 97 on the discussion guide.
15 And I'll give people just a moment to get that.
16 And then once people have it pulled up, I'll turn
17 it over to Miranda to walk us through the
18 decision logic.

19 CO-CHAIR MOORE: Can you remind us,
20 for each of these -- not that a lot of time has
21 passed, but -- how we had decided last time that
22 we would go into it?

1 MS. BUCHANAN: Of course. So for this
2 one, we voted on this morning, we did the
3 straight up or down, we voted to include. But it
4 did not go through the decision logic.

5 CO-CHAIR MOORE: Yes.

6 MS. BUCHANAN: So we just need to have
7 it go through that now.

8 CO-CHAIR MOORE: Okay.

9 MS. BUCHANAN: And with that, I'll
10 turn it over to Miranda.

11 MS. KUWAHARA: This is Measure Number
12 97, NQF Number 2062, controlling high blood
13 pressure for people with serious mental illness.
14 Again, we'll go to hand votes and take this
15 through the decision logic.

16 So for our first vote, to what extent
17 does this measure or measure concept address the
18 CMS quality measurement domains, and/or program
19 area key concepts?

20 For high, please raise your hand.

21 For medium, please raise your hand.

22 And low, please raise your hand.

1 MS. KUWAHARA: Okay. Sixteen members
2 voted high, two members voted medium, and zero
3 members voted low.

4 Moving on to the next step in the
5 decision logic; to what extent will this measure
6 address an opportunity for improvement and/or
7 significant variation in care?

8 Those who vote high, please raise your
9 hand.

10 MS. BUCHANAN: And we're just waiting
11 for one more -- oh, no, we just got it. We have
12 all the people on the phone, thank you.

13 MS. KUWAHARA: Medium, please raise
14 your hand.

15 Sixteen members voted high, two
16 members voted medium, and zero members voted low.

17 On to the next step; to what extent
18 does this measure demonstrate efficient use of
19 resources and/or contribute to alignment?

20 For high, please raise your hand.

21 Medium?

22 And low?

1 Thirteen members voted high, four
2 members voted medium, and one member voted low.

3 Because this is an NQF-endorsed
4 measure, we're now skipping to the last question
5 in the decision logic. To what extent do you
6 think this measure is important to state Medicaid
7 agencies and other stakeholders?

8 For high, please raise your hand.

9 MS. BUCHANAN: Just waiting for one --
10 oh, just got it.

11 MS. KUWAHARA: Medium?

12 And low?

13 Okay. Eleven members voted high,
14 eight members voted medium. This measure will be
15 recommended in the PMH measure set. And again,
16 this is Measure Number 97, NQF Number 2602,
17 controlling high blood pressure for people with
18 serious mental illness.

19 MS. BUCHANAN: Okay. And so we'll be
20 moving on to measure 85 on your discussion guide.
21 This is NQF-0710, depression remission at twelve
22 months. And so once again that's number 85 on

1 your discussion guide. I will give you a moment
2 to get there, and then Miranda will walk you
3 through the voting.

4 CO-CHAIR MOORE: And can you remind us
5 again how we decided?

6 MS. KUWAHARA: So this was a straight
7 up or down; we voted to recommend. And so we
8 just need to walk it through.

9 CO-CHAIR MOORE: Yes.

10 MS. KUWAHARA: Again, we're voting on
11 Measure Number 85, NQF Number 0710; depression
12 remission at twelve months.

13 The first vote; to what extent does
14 this measure address the CMS quality measurement
15 domains and/or key concepts?

16 For high, please raise your hand.

17 Medium?

18 MS. BUCHANAN: And Judy, it looks like
19 you're now on your line. And so we're voting --

20 MEMBER ZERZAN: I am, I'm high.

21 MS. BUCHANAN: You're a high grade,
22 thank you.

1 MS. KUWAHARA: And low?

2 Thirteen members voted high, five
3 members voted medium, and one member voted low.

4 The next question; to what extent will
5 this measure address an opportunity for
6 improvement and/or significant variation in care?

7 Those who vote high, please raise your
8 hand.

9 MS. BUCHANAN: And Judy, are you a
10 high, middle, or low for this one?

11 MEMBER ZERZAN: I'm a high.

12 MS. BUCHANAN: Okay, thank you.

13 MS. KUWAHARA: Medium, please?

14 And low?

15 Nine members voted high, nine members
16 voted medium, and one member voted low.

17 Moving on to the next step; to what
18 extent does this measure demonstrate efficient
19 use of resources and/or contribute to alignment?

20 High, please raise your hand.

21 I'll repeat the question. It was, to
22 what extent does this measure demonstrate

1 efficient use of resources and/or contribute to
2 alignment? Yes, this is for high.

3 MS. BUCHANAN: And Judy, are you a
4 high, medium, or low?

5 MEMBER ZERZAN: I'll vote medium.

6 MS. BUCHANAN: Medium? Thank you.

7 MS. KUWAHARA: Medium?

8 And low?

9 Six members voted high, ten members
10 voted medium, and two members voted low.

11 To the next and final step; to what
12 extent do you think this measure is important to
13 state Medicaid agencies and other key
14 stakeholders?

15 For high, please raise your hand.

16 MS. BUCHANAN: And Judy, are you a
17 high, medium, or low for this one? Stakeholders?

18 MEMBER ZERZAN: High.

19 MS. BUCHANAN: Okay.

20 MS. KUWAHARA: Medium?

21 And low?

22 Thirteen members voted high, five

1 members voted medium, and one member voted low.
2 Measure Number 85, NQF Number 0710, depression
3 remission at twelve months will be recommended
4 for inclusion in the PMH measure set.

5 MS. BUCHANAN: And so we have one
6 more; it's the behavioral health risk assessment
7 for pregnant women. This is the one that was
8 recommended; it's in the handout you have in
9 front of you; or if you're participating
10 remotely, it is the email that we sent.

11 Just a quick description again, just
12 for people to familiarize themselves; it's
13 percentage of patients, regardless of age, who
14 gave birth during a 12-month period, seen at
15 least once for prenatal care who received a
16 behavioral health screening assessment that
17 includes the following screening at first
18 prenatal visit: depression, alcohol use, tobacco
19 use, drug use, and intimate partner violence.

20 Originally, the committee did vote to
21 include this, but it was an up or down.

22 MS. KUWAHARA: Again, this is Measure

1 Behavioral Health Risk Assessment for Pregnant
2 Women. For the first vote; to what extent does
3 this measure or measure concept address the CMS
4 quality measurement domains and/or program area
5 key concepts?

6 For those who vote high, please raise
7 your hand.

8 MS. BUCHANAN: And Sarita, if you
9 don't mind, is your yes a high, medium or low for
10 this?

11 MEMBER SIDDIQI: Sorry about that.

12 MEMBER ZERZAN: This is Judy; I'm a
13 high.

14 MS. BUCHANAN: Thank you, Judy.

15 MEMBER MOHANTY: I just submitted.

16 MS. BUCHANAN: Thank you, Sarita.
17 Okay. Great.

18 MS. KUWAHARA: Medium?

19 Low?

20 Eighteen members voted high, one
21 member voted medium, and no members voted low.
22 The next step; to what extent will this measure

1 address an opportunity for improvement and/or
2 significant variation in care?

3 Those who vote high, please raise your
4 hand.

5 MS. BUCHANAN: And Judy, are you a
6 high, medium, or low for this one?

7 MEMBER ZERZAN: I'm high.

8 MS. BUCHANAN: Wonderful, thank you.

9 MS. KUWAHARA: Medium?
10 And low.

11 Eighteen members voted high, one
12 member voted medium, and no members voted low.

13 To what extent does this measure or
14 measure concept demonstrate efficient use of
15 resources and/or contribute to alignment?

16 Those who vote high, please raise your
17 hand.

18 MS. BUCHANAN: And Judy, would you
19 mind stating your vote?

20 MEMBER ZERZAN: Is this a high or a
21 yes?

22 MS. BUCHANAN: This is a high, medium,

1 or low.

2 MEMBER ZERZAN: I'm medium.

3 MS. BUCHANAN: Thank you. And Alvia,
4 I don't see anything from you yet.

5 MEMBER SIDDIQI: Sorry; high.

6 MS. BUCHANAN: Got it, thank you.

7 MS. KUWAHARA: Medium, please raise
8 your hand.

9 And low?

10 MEMBER ZERZAN: I'm medium.

11 MS. BUCHANAN: Yes, got it. Thank
12 you.

13 MS. KUWAHARA: Ten members voted high,
14 eight members voted medium, and one member voted
15 low. To what extent is this measure or measure
16 concept ready for immediate use? And this is yes
17 or no question. Those who vote yes, please raise
18 your hand.

19 MEMBER ZERZAN: I'm a yes.

20 MS. BUCHANAN: Thank you, Judy.

21 MS. KUWAHARA: And no?

22 MS. MURPHY: I think -- Maureen, did

1 you vote yes?

2 MEMBER HENNESSEY: I voted yes.

3 MS. MURPHY: Oh, I'm sorry. I must
4 have just missed your hand.

5 MS. KUWAHARA: Nineteen voted yes,
6 zero votes for no. The last question; to what
7 extent do you think this measure is important to
8 state Medicaid agencies and other key
9 stakeholders?

10 For high, please raise your hand.

11 MS. BUCHANAN: And Judy, this is a
12 high, medium, or low one.

13 MEMBER ZERZAN: High.

14 MS. BUCHANAN: Thank you.

15 (Off mic question)

16 MS. BUCHANAN: Sure. We're at the
17 last step, the stakeholder's question.

18 MS. KUWAHARA: Medium?

19 And low?

20 Eighteen members voted high, one
21 member voted medium, and no members voted low.
22 This Measure, Behavioral Health Risk Assessment

1 for Pregnant Women, will be recommended for
2 inclusion in the PMH measure set.

3 MS. BUCHANAN: Wonderful. Thank you
4 so much, Miranda. So we are now going to go to
5 review the PMH measure set. And I am pulling it
6 up now.

7 CO-CHAIR MOORE: And since we have 26
8 measures in an hour, we should be good.

9 MS. BUCHANAN: So the first measure is
10 number 75 on your discussion guide. It's the
11 combined behavioral health, physical health, and
12 patient 30-day re-admission rate for individuals
13 with FMI-eligible population denominator and
14 numerator specifications.

15 Once again, that is number 75. I'm
16 going to pull it up right now. And so I will
17 provide a little rationale as to why the TEP
18 chose to include it.

19 They recommended this as a promising
20 measure concept. They said, although the measure
21 concept is only in its first year of
22 implementation in Pennsylvania, it directly

1 addresses the issue of mental health and physical
2 health integration.

3 Specifically, the measure concept
4 captured re-admissions within 30 days of anyone
5 diagnosed with a behavioral health condition, so
6 it's re-admission for either behavioral health or
7 physical health conditions if they've been
8 previously diagnosed with a mental health
9 condition.

10 And we'll track whether or not we have
11 any re-admission. So we felt this really hit to
12 the crux of the program area, even though it's
13 only in its first year, they did recommend it as
14 a promising measure concept.

15 CO-CHAIR MOORE: Any comments,
16 concerns, objections? Going once, going twice --

17 MEMBER GELZER: Hey, this is Andrea --

18 CO-CHAIR MOORE: Darn it all, Andrea.

19 (Laughter.)

20 CO-CHAIR MOORE: Just kidding.

21 MEMBER GELZER: No, I think this is a
22 great measure. I'm just in a carve-out state.

1 Behavioral health patient admissions are going to
2 be on the behavioral health side of things, and
3 physical health are going to be in the physical
4 health plan side of things.

5 So it's going to be the state that's
6 going to be able to capture this data, because I
7 guess readily we get the BHUM data ultimately.
8 But there's a lag period. So I just -- Dave, can
9 you comment on this?

10 MS. BUCHANAN: So Andrea, the question
11 is how is it captured?

12 MEMBER GELZER: Yes. I'm just saying
13 for example, Pennsylvania is a carve-out state
14 for behavioral health. You have physical health
15 plans, you have behavioral health plans. We're
16 trying to coordinate data and have much better
17 data transfer from behavioral health plans to
18 physical health plans and vice versa.

19 That said, the data isn't real time
20 available. I mean there's just a lag period in
21 collecting it, and I just wanted to acknowledge
22 that.

1 MS. BUCHANAN: Yes, and my
2 recollection -- Maureen feel free to step in --
3 is that the person who recommended this from the
4 State of Pennsylvania said it was going to be a
5 large lift unless this was something we were
6 really dedicated for. So I think it's reflecting
7 your comment, Andrea.

8 MEMBER KELLEY: I'll speak to it from
9 Pennsylvania, since this is a program that we're
10 operationalizing. There are two things; one is
11 that we require physical and behavioral health
12 plans, the submit their encounters to us.

13 We have an EQRO and by law, every
14 Medicaid program is supposed to their EQRO to
15 develop quality metrics. We also require -- we
16 give our EQRO all of our encounters.

17 So the EQRO is actually the one who
18 pulls the physical health data and validates it.
19 So that's how the metric gets especially
20 validated by our EQRO, done by out EQRO and
21 validated by our EQRO.

22 Another component of this program

1 that's not mentioned here is an electronic
2 transmission for the most part, of inpatient
3 stays within 24 hours. And they have to do it 90
4 percent of the time.

5 And I will tell you almost all of the
6 MCOs were able to do that. And the only ones who
7 weren't able to do that were because their
8 lawyers couldn't agree on interpreting HIPPA.

9 Once they finally got them to agree to
10 that, they met that threshold. But they're not
11 going to get incentive payments because they
12 weren't able to.

13 So the behavioral health plan is
14 getting real time electronic -- within 24 hours
15 up to 90 percent of the time, they're actually
16 getting the admissions they should have. I mean,
17 I have all the data, but they actually know, real
18 time, almost, when that is happening.

19 CO-CHAIR MOORE: Andrea, does that
20 answer your question?

21 MEMBER GELZER: Yes, thank you for
22 that clarification. I think it's a very

1 important measure.

2 MEMBER HENNESSEY: Yes, and I would
3 just say -- this is Maureen -- I would just say
4 that the TEPs felt that we're talking about
5 individuals with acute inpatient care. So we're
6 talking a high level of acuity, and therefore
7 even if it is a lift, this is the group that we
8 should be particularly focusing on from an
9 integration of health and behavioral health care
10 perspective, and this measure helps to do that.
11 Thank you.

12 CO-CHAIR MOORE: Thanks. MaryBeth,
13 and then we will go to Karen.

14 MEMBER MUSUMECI: I just would add
15 that Kaiser Family Foundation does a 50-state
16 budget survey of all the Medicaid programs
17 annually; and physical behavioral health
18 integration is another trend that we've seen in
19 recent years. So states are moving away from the
20 historic carve-outs, and going towards carve-ins.

21 So to the extent that, as we discussed
22 before, these aren't mandatory in putting things

1 in the tool kit, I think this reflects something
2 useful for states as they move in that direction.

3 CO-CHAIR MOORE: Thanks. Karen?

4 MEMBER AMSTUTZ: Yes, just one last
5 comment. I agree with all of what's been said,
6 and I would add that, as a company that actually
7 runs a health plan specific for patients who have
8 serious mental illness, that is the qualifying
9 event in part, in Florida.

10 The waits that you will see when you
11 begin to manage this population will knock your
12 socks off. And so it will be well worth every
13 bit of agony that we all go through to integrate
14 these data sources.

15 CO-CHAIR MOORE: Okay. I think we're
16 ready to move on to the next one.

17 MS. BUCHANAN: Great. Thank you very
18 much. So the next one is number 76 on your
19 discussion guide; depression, remission, or
20 response for adolescents and adults. And I will
21 say that this is something that we've discussed
22 earlier in the day.

1 This is a first year HEDIS Measure,
2 and because of that, the TEP worried that the
3 measure would not be an efficient use of
4 resources, and cities are not sure how many
5 individuals it may capture.

6 But the TEP voted to include it
7 because it was an outcome measure that extends
8 beyond screening for depression, and it looks at
9 an individual's response to treatment.
10 Additionally, members appreciated that the
11 measure relies on patient reported data, since
12 many of the measures they reviewed did not.

13 CO-CHAIR MOORE: Can you refresh our
14 memory on how we voted on this one?

15 MS. BUCHANAN: Oh, we didn't vote on
16 this one; we just discussed it.

17 CO-CHAIR MOORE: Just discussed it.
18 Comments or concerns?

19 MEMBER HENNESSEY: This is the
20 electronic quality grid measure that we spoke
21 about. It also begins evaluation at age 12, so
22 it has a larger numerator from that perspective.

1 CO-CHAIR MOORE: Okay. Great. Anyone
2 on the phone? All right. Let's move to the
3 next.

4 MS. BUCHANAN: Great. So next we're
5 on to number 77 on your discussion guide; follow
6 up after emergency department visit for mental
7 illness.

8 And the TEP said, since the measure
9 includes follow-up care provided by both
10 behavioral health and non-behavioral health
11 clinicians, it directly addresses the issue of
12 integration of mental and physical health.

13 It is similar to another they
14 reviewed, NQF-2605. And they voted that both of
15 these measures did not include certain wraparound
16 clinical services for individuals with serious
17 mental illness and physical health conditions,
18 such as assertive community treatment act, mobile
19 crisis services or Lifeline.

20 But despite this concern, the TEP
21 recommended to the CC for review. And I will say
22 that this concern of wraparound services was seen

1 in several measures, and that the theme was that
2 they just wanted more included.

3 CO-CHAIR MOORE: Additional comments
4 or concerns that you wanted to voice? Karen?

5 MEMBER AMSTUTZ: I would just note
6 that I think the challenge that we're going to
7 have in Medicaid behavioral health with all of
8 the benefits, is the fact that these benefits are
9 very exclusive to Medicaid programs. So they're
10 not found in commercial or Medicare.

11 And hence, the metrics that we develop
12 really have to be very specific to not just the
13 population, but also the benefit package. And
14 likely, also from that, the provider types, since
15 it's really a very different delivery system.

16 So I agree; let's get started, but
17 note that those of us involved in Medicaid are
18 going to have to actually carry the flag, here.

19 MS. BUCHANAN: Thank you for that;
20 we'll note that in our report.

21 CO-CHAIR MOORE: Next item?

22 MS. BUCHANAN: Great, so number 78;

1 mental health service penetration. And the TEP
2 said this measure is important because it allows
3 programs to measure the effectiveness of
4 behavioral health integration from a payer
5 perspective.

6 The denominator of the measure, which
7 is; all individuals in the eligible population
8 with the mental health service need within the
9 24-month identification window.

10 So they felt that this denominator
11 allows for population stratification, so that
12 programs could utilize the measure to assess
13 mental health service penetration among different
14 sub-populations.

15 Further, the measure assesses care
16 provided by behavioral health and non-behavioral
17 health clinicians, and will capture a large
18 population of people who receive services.

19 CO-CHAIR MOORE: Comments or concerns?
20 Anyone on the phone? All right. Next one.

21 MS. BUCHANAN: So we are moving just
22 one down to number 79, which is mental health

1 utilization; number and percentage of members
2 receiving the following mental health services
3 during the measurement year: any service,
4 inpatient, intensive outpatient, or partial
5 hospitalization, and outpatient or emergency
6 department.

7 And so the TEP expressed concerns
8 since the measure focuses on individuals' mental
9 health issues as the primary diagnosis. In the
10 ED, it may only capture a small sample of those
11 co-occurring mental and physical health
12 conditions.

13 And as Maureen and I talked about this
14 morning, one of the issues is, it's not so much a
15 knock on the measure as the way people provide
16 care, and that it may not be able to capture
17 everyone.

18 But since the measure is a HEDIS
19 Measure, and NCQA-accredited programs, including
20 commercial, Medicare and Medicaid programs will
21 report on this, there is an opportunity to
22 compare performance across programs.

1 CO-CHAIR GOLDEN: I guess I -- does
2 anybody use this? Does this discriminate about
3 anything? I mean, it's basically outpatient,
4 inpatient, acute care, chronic care.

5 I'm not sure; I mean, it's sort of a
6 utilization measure, but it's not much of a
7 quality measure.

8 MEMBER HENNESSEY: Yes, this is
9 Andrea. That's exactly what I was thinking. Is
10 it a measure of acuity? I mean, having a high
11 number of services, they might be good services
12 for the population. It may indicate unmet needs,
13 because there's no differentiation as to whether
14 it's an outpatient or an inpatient, or
15 professional service.

16 CO-CHAIR MOORE: Michael?

17 MEMBER PHELAN: I think a measure like
18 this, though, would still be valuable to be able
19 to share with either health systems or states to
20 show that you've got a deficit of either beds or
21 access. And they don't know if this measure
22 discriminates between the different -- is there a

1 breakdown in this measure? Does anyone know, is
2 there a breakdown between inpatient, outpatient,
3 ED visits?

4 Because it would be really valuable to
5 be able to look at that from a health systems
6 point of view and say, maybe we don't have enough
7 outpatient resources. Or maybe our inpatient bed
8 needs to go up because there's a greater
9 percentage. So I still like the measure
10 included.

11 CO-CHAIR MOORE: Karen?

12 MEMBER AMSTUTZ: Yes, so just talking
13 from the behavioral health business perspective
14 and working with a lot of health plan customers;
15 we use these measures extensively and they are
16 really good crude indicators of sort of overall
17 utilization. You'll see places, plans, they come
18 in at only five percent of their individuals are
19 receiving a mental health service.

20 And we just know that's grossly too
21 low. So it really gives you a good starting
22 point.

1 I think if I was going to add any
2 distinction there, it's obviously missing the
3 professional services, on the professional side
4 to distinguish both total professional services,
5 but both prescribers and non-prescribers, because
6 the access to prescribers is clearly a huge
7 issue.

8 CO-CHAIR MOORE: Thank you. Allison?

9 MEMBER HAMBLIN: Just on a similar
10 vein, MaryBeth has noted the move towards
11 integrated manager and integrated financing for
12 physical and mental health benefits in Medicaid
13 across the states, and I would say that this
14 measure is an important one to monitor as that
15 delivery system trend happens, to be able to
16 identify if there are any changes in access to
17 service, either for better or worse, and the
18 nuances within that.

19 CO-CHAIR MOORE: All right. Any other
20 comments on the phone? Oh, go ahead Maureen.

21 MEMBER HENNESSEY: Another comment,
22 which is to say because you can stratify here,

1 you can also start to look for disparities in
2 care, as well.

3 CO-CHAIR MOORE: Okay. Thank you.
4 Karen, did you have one more comment? Okay.
5 Great. All right, we're ready to move on.

6 MS. BUCHANAN: Great. Number 80 on
7 your discussion guide, NQF Number 0097;
8 medication reconciliation post discharge, as we
9 have discussed this in numerous program areas.

10 And I won't rehash it too much, but
11 the PMH TEP felt this was very important to be
12 assessing the integration of physical and mental
13 health services.

14 CO-CHAIR MOORE: Any comments or
15 concerns? Anyone on the phone? All right.

16 MS. BUCHANAN: So we're now on 81;
17 NQF-0105; anti-depressant medication management.
18 And the TEP included this measure because it
19 assesses continuous treatment both in the short
20 term -- so the first 90 days of the initiation of
21 treatment -- as well as the longer term, six
22 months after the initiation.

1 And so they liked that it addressed
2 the two aspects of the care. Additionally, they
3 liked that it is a HEDIS Measure, so it will be
4 reported under numerous health plans, which will
5 again allow for comparison.

6 CO-CHAIR MOORE: And it's also part of
7 the Medicaid adult core set. Any comments or
8 concerns? Anyone on the phone?

9 MEMBER AMSTUTZ: The comment that I
10 would note from a clinical perspective, and it's
11 something that we see when you institute much
12 broader screening for depression, it doesn't take
13 into account the first line treatment, which is
14 you should really try cognitive behavioral
15 therapy as an alternative, or mediation
16 management but in mild cases, it's CBT first.

17 It doesn't accommodate that. So it's
18 potentially pushing people toward medication.

19 MEMBER KELLEY: I think it only starts
20 once a script has been filled. So you could have
21 your cognitive behavioral therapy and never get
22 that medication. So you would not be in the --

1 MEMBER AMSTUTZ: Oh, that has -- okay,
2 so you have to see the prescription in order to
3 have it continue? Okay. Then I'll make one
4 other comment about it. There's still some
5 problems with the measure clinically.

6 There's actually some pretty good
7 published literature that about 52 percent of the
8 time, the depression diagnosis made by primary
9 care is not confirmed by a psychiatrist as having
10 somebody actually have that diagnosis.

11 That problem's even worse in the
12 Medicare population where the number is only 15
13 percent actually have a diagnosis of depression
14 confirmed, when they've been started on an anti-
15 depressant.

16 So this may be an issue we need to
17 take up with NCQA.

18 CO-CHAIR GOLDEN: And that gets to my
19 earlier comment about depression and OS. The
20 measure is badly specified.

21 CO-CHAIR MOORE: Any other comments?
22 Is there a desire to take this one off? Allison?

1 MEMBER HENNESSEY: It is part of the
2 Medicaid adult core set.

3 CO-CHAIR MOORE: Yes. Allison?

4 MEMBER HAMBLIN: I'm just -- I think
5 it was yesterday; my sense of time is little
6 vague, here, but I think there was a comment
7 yesterday about wherever we were making
8 recommendations that included major depression
9 there would be a note about the importance of
10 noting what's included in that definition.

11 CO-CHAIR GOLDEN: And just a comment
12 from CMS; our program does not use this measure
13 because of the specifications.

14 CO-CHAIR MOORE: Okay. Thank you.
15 Next?

16 MS. BUCHANAN: Okay, 82, which is NQF-
17 0418; preventative care and screening; screening
18 for clinical depression and follow-up plan.

19 And so several TEP members expressed
20 concern about capture in the measure; in their
21 experience, it's very labor-intensive and
22 involved chart review.

1 But the TEP felt that the measure
2 addressed key issues in the program area and is
3 very important to stakeholders. So they did
4 choose to recommend it. And it is part of the
5 Medicaid adult core set.

6 CO-CHAIR MOORE: Comments or concerns?
7 Anyone on the phone? All right. Next.

8 MS. BUCHANAN: So we are now on number
9 83 which is NQF-0419; documentation of current
10 medications in the medical record, which is --

11 CO-CHAIR MOORE: Did we already do
12 this one?

13 MS. BUCHANAN: For LTSS --

14 CO-CHAIR MOORE: Oh, okay.

15 MS. BUCHANAN: Yes. And the TEP
16 recommended it because it allows for high
17 opportunity for improvement in the integration of
18 physical and mental health. They also noted that
19 CMS has indicated that this is a high-priority
20 for them, as they already include it in quality
21 payment programs and many providers report on it.

22 CO-CHAIR MOORE: Okay. This is the

1 one we got -- any comments or concerns? Anyone
2 on the phone? All right.

3 MS. BUCHANAN: All right. Number 84,
4 NQF-0576; follow-up after hospitalization for
5 mental illness. And so the TEP was concerned
6 that since the measure only captured follow-up
7 provided by behavioral health clinicians, it
8 would exclude many people who had follow-ups
9 after hospitalization provided by other
10 clinicians.

11 They felt that this was especially
12 true in areas of the country that had behavioral
13 health provider shortages. Ultimately, they
14 voted to recommend the measure to the CC because
15 the measure is so important to the consumer, but
16 they did have some concerns about it.

17 CO-CHAIR MOORE: And it is part of the
18 Medicaid adult core set.

19 MEMBER HENNESSEY: Yes, and I would
20 also add that we had a representative from NAMI
21 who was on our TEP and she particularly thought
22 this was an important measure for consumers from

1 the consumer stakeholder perspective. Thank you.

2 CO-CHAIR MOORE: Thank you. Any
3 additional comments? Bill?

4 CO-CHAIR GOLDEN: As I mentioned last
5 night to some folks; we use this measure but we
6 have to change the specs, because local codes --
7 we have local code that if we didn't use the
8 local code, it would under-report our measure by
9 a factor of four. So this is a prime example I
10 use for how states modify the code sets.

11 CO-CHAIR MOORE: Thank you.
12 Additional comments? All right. Next one.

13 MS. BUCHANAN: Okay. So we are now on
14 86, which is NQF-1879; adherence to anti-
15 psychotic medications for individuals with
16 schizophrenia. We had a little confusion about
17 this one earlier today, so this is the NQF
18 Measure.

19 And the TEP voted to recommend because
20 it is a HEDIS Measure and so allows comparisons.
21 Additionally, members said it addresses key areas
22 of the program area, including adherence to anti-

1 psychotic medications which is highly correlated
2 with stability among individuals who suffer from
3 schizophrenia.

4 CO-CHAIR MOORE: Any comments or
5 concerns? Anyone from the phone? Okay.

6 MS. BUCHANAN: Moving right along to
7 number 87, NQF-1880; adherence to mood
8 stabilizers for individuals with bipolar 1
9 disorder.

10 And this is a similar rationale that
11 the TEP used. Adherence to mood stabilizers is
12 highly correlated to stability among individuals
13 who suffer from bipolar 1 disorder, and so they
14 voted to recommend.

15 CO-CHAIR MOORE: Comments or concerns?
16 Anyone from the phone? Next?

17 MS. BUCHANAN: Okay. So the next one
18 we have -- one moment -- is NQF-90 on the
19 discussion guide. And actually the NQF TEP
20 reviewed both NQF-1927, 90 on the discussion
21 guide, as well as NQF-1933, number 92.

22 They had kind of similar reasons, so

1 it was for number 90; cardiovascular health
2 screening for people with schizophrenia or
3 bipolar disorder who are prescribed anti-
4 psychotic medications.

5 And then number 92, which is NQF-1993;
6 cardiovascular monitoring for people with
7 cardiovascular disease in schizophrenia.

8 And so they recommended both because
9 they are both highly accepted standards of care.
10 And they agreed that they are effective use of
11 resources, ready for immediate use and very
12 important to stakeholders.

13 CO-CHAIR MOORE: So let's -- can we do
14 them individually?

15 MS. BUCHANAN: Of course. Okay.

16 CO-CHAIR MOORE: So let's open it up
17 to comment or concern for 90. Bill?

18 CO-CHAIR GOLDEN: I'm not fond of the
19 title; we call this metabolic monitoring, which
20 is what the usual literature refers to this as,
21 because of the risk for diabetes and
22 hyperlipidemia.

1 So it's not really cardiovascular
2 screening, per se, but the induction of a
3 metabolic syndrome. So while the measure is
4 fine, the title is not really appropriate.

5 CO-CHAIR MOORE: And according to the
6 discussion guide, Arkansas is using this measure?

7 CO-CHAIR GOLDEN: We use it. In fact,
8 you cannot get a renewal of your anti-psychotics
9 unless you're getting this done.

10 CO-CHAIR MOORE: Okay. Any other
11 comments or concerns? On the phone? Okay, let's
12 look at 93.

13 MS. BUCHANAN: Ninety-two.

14 CO-CHAIR MOORE: Oh, sorry, 92. Any
15 comments or concerns about this one? And again,
16 this is being used in Arkansas?

17 CO-CHAIR GOLDEN: Mm-hmm.

18 CO-CHAIR GOLDEN: And nothing on the
19 phone? All right. Let's move on.

20 MS. BUCHANAN: Okay. So we are moving
21 on to 91, which is NQF-1932; diabetes screening
22 for people with schizophrenia or bipolar disorder

1 who are using anti-psychotic medications.

2 And the TEP voted to recommend because
3 they felt it was relatively easy to capture,
4 assesses its care integration through screening
5 of individuals with mental illness for frequent
6 co-occurring physical health conditions.

7 CO-CHAIR MOORE: And this is part of
8 the Medicaid adult core set. Any comments or
9 concerns?

10 CO-CHAIR GOLDEN: The only question I
11 have is, I think these are all the same measure.
12 I mean, I'm not sure these measures are different
13 from each other.

14 CO-CHAIR MOORE: They're parsing it
15 out, that's how I'm interpreting it. Any other
16 comments or concerns on the phone? Okay.

17 MS. BUCHANAN: Okay, so then we are
18 moving on to 93, NQF-1934; diabetes monitoring
19 for people with diabetes and schizophrenia. And
20 the TEP recommended since the measure captures a
21 high risk population who have both physical and
22 mental health life-threatening co-morbidities.

1 And additionally, the two procedures
2 that the measure captures are accepted standards
3 of care.

4 CO-CHAIR MOORE: Any comments or
5 concerns? On the phone? And we move into the
6 next.

7 MS. BUCHANAN: Okay. Number 94, NQF
8 number 1937; follow-up after hospitalization for
9 schizophrenia --

10 CO-CHAIR GOLDEN: Can I stop for a
11 second?

12 CO-CHAIR MOORE: Yes, Bill.

13 CO-CHAIR GOLDEN: A comment also for
14 CMS to reflect on. When I order, I order a lipid
15 panel for somebody with metabolic syndrome who
16 has Medicare. My Epic will not accept the order,
17 saying Medicare will not pay for it, even though
18 I put in metabolic monitoring, or I put in toxic
19 drug or anti-psychotics.

20 So I'm not sure what the coverage data
21 are, but I have to make up a diagnosis in order
22 to get the metabolic monitoring paid for by

1 Medicare. So that's something to look into, but
2 my EMR won't let me order a test as described by
3 the measures.

4 MS. BUCHANAN: Okay. And so 94, which
5 is NQF-1937. And as previously stated, the TEP
6 had concerns about which wraparound services the
7 measure included. They were concerned it didn't
8 include an ACT team. But they voted to
9 recommend, as the measure addresses an important
10 element of physical and mental health
11 integration, which is the follow-up care post-
12 discharge.

13 CO-CHAIR MOORE: Any comments or
14 concerns? Anyone from the phone? Okay, 95.

15 MS. BUCHANAN: So we move the slide
16 one. Okay. So we are now on 95, NQF-2599;
17 alcohol screening and follow-up for people with
18 serious mental illness.

19 And the TEP noted that many providers
20 who screen for alcohol in primary care settings
21 do not bill the codes that reflect this
22 interaction. Consequently, they were concerned

1 the measure may not capture enough data.

2 But despite this concern, they voted
3 to recommend because of the high rate of alcohol
4 abuse and lack of treatment for individuals with
5 mental health illness.

6 CO-CHAIR MOORE: Is this a HEDIS
7 Measure? Any other comments or concerns? Anyone
8 on the phone? Okay.

9 MS. BUCHANAN: Wonderful, 96; going
10 back to tobacco. And so NQF-2600; tobacco use
11 screening and follow-up for people with serious
12 mental illness or alcohol or other drug
13 dependence.

14 And so the TEP noted that there was an
15 under-utilization of screening and intervention
16 with people with serious mental illness with
17 regard to tobacco use. They said that behavioral
18 health clinicians often do not provide screening
19 and intervention, but this measure could
20 stimulate them to do so.

21 The measure has the ability to promote
22 parity in tobacco cessation services for people

1 with serious mental illness. They also said
2 there are potential implementation issues of the
3 measure, since behavioral health providers were
4 not included in meaningful use.

5 And so that makes some challenges with
6 the EHR, but they agreed that the measure is too
7 important to allow these difficulties to prevent
8 them from recommending it.

9 CO-CHAIR MOORE: Thank you. Any
10 comments or concerns? Bill?

11 CO-CHAIR GOLDEN: The only comment is
12 that smoking is like, double the rate of the
13 population in this population.

14 CO-CHAIR MOORE: Any comments or
15 concerns on the phone? All right, moving, I
16 believe, to 98.

17 MS. BUCHANAN: Yes, you got it. This
18 is 98; NQF-2603; diabetes care for people with
19 serious mental illness; hemoglobin A1C (HbA1C);
20 testing.

21 And so the TEP, as a theme that we had
22 many times, were concerned that the definition of

1 serious mental illness was a little too narrow.
2 Similar to many measures, it includes only
3 individuals with schizophrenia, bipolar 1
4 disorder, or major depression.

5 But they noted that MTDs can easily
6 capture this measure through claims data, and
7 that it is important to stakeholders. So they
8 recommended to include it.

9 CO-CHAIR MOORE: Okay. Any additional
10 comments or concerns? Anyone from the phone?
11 All right. Let's move on to 99. Now, it is
12 striking that we are able to move through these
13 quickly. But a lot of them are NQF when you look
14 at the overall measure score, and they're
15 exceeding too.

16 So I want to thank the TEP for doing
17 due diligence on this very lengthy list; it's
18 making the work of the committee easier, so thank
19 you for that.

20 MS. BUCHANAN: Awesome. So we are on
21 number 99 on the discussion guide, NQF-2604;
22 diabetes care for people with serious mental

1 illness; medical attention for neuropathy.

2 And so similar to other measures, they
3 thought the mental illness definition was too
4 narrow, but they agreed to recommend it because
5 it captures a widely accepted standard of care
6 for a very high risk population.

7 CO-CHAIR MOORE: Opening up to
8 comments or concerns. Anyone on the phone? All
9 right, number 100.

10 MS. BUCHANAN: On 101 -- oh, 100,
11 goodness. Keeping me on track, Jennifer.

12 CO-CHAIR GOLDEN: Yes, that's my job.
13 That's why I'm Chair.

14 (Laughter.)

15 MS. BUCHANAN: So this is number 100,
16 NQF-2605; follow-up after discharge from the
17 emergency department for mental health or alcohol
18 or other drug dependence.

19 And so the TEP expressed concern that
20 the denominator of this measure lacked clarity
21 and entities cannot easily discern the rate for
22 follow up for individuals with mental illness as

1 compared to those with substance use disorders.

2 So if we look at the denominator, they
3 just didn't feel that there was the ability to
4 pull things out. And they were also unsure if
5 the measure includes the new suicide billing code
6 that captures individuals admitted for that
7 reason.

8 Similar to other measures, edited to
9 include all the wraparound services that they
10 feel should be; but they decided to recommend it
11 since it captures individuals with either a
12 mental or a substance use diagnosis, and is more
13 inclusive than many of the other measures that
14 they reviewed.

15 CO-CHAIR MOORE: And it's part of the
16 Medicaid adult core set. Any comments or
17 concerns? Anyone from the phone? Now you can
18 move to 101.

19 MS. BUCHANAN: Thank you. NQF-2607;
20 diabetes care for people with serious mental
21 illness; hemoglobin A1c (HbA1c); port control
22 which is greater than nine percent.

1 And so although the TEP said that they
2 were not sure that the measure would capture a
3 large number of people, they agreed that there
4 was a great opportunity for improvement as the
5 population this measure captures is a high risk
6 group that requires immediate medical
7 intervention.

8 CO-CHAIR MOORE: And it's part of the
9 Medicaid adult core set. Any comments or
10 concerns? Come on, let's shake it up. Anyone on
11 the phone? All right, 102.

12 MS. BUCHANAN: So 102, NQF-2609;
13 diabetes care for people with serious mental
14 illness; eye exam.

15 And the TEP really like that ACOs and
16 other health care plans currently report on this
17 measure. They believe that the measure directly
18 addresses care integration, especially for
19 behavioral health providers who are not part of
20 the EHR meaningful use incentives.

21 CO-CHAIR GOLDEN: Before I comment I
22 just want to look at the -- so I guess a question

1 for Karen and others; is the standard for
2 diabetes eye exams now every year or every other
3 year? I believe it's going to every other year.

4 MEMBER ZERZAN: I'm going to have to
5 check the guideline, but I think you're right;
6 it's every other year.

7 CO-CHAIR GOLDEN: My concern that this
8 is overly -- it's on an old standard. I believe
9 it's going to 18 months or two years. I don't
10 know what to do with that. I like the concept of
11 eye exams, but I believe the measure is out of
12 date in terms of frequency.

13 CO-CHAIR MOORE: David?

14 MEMBER KELLEY: So I don't think NCQA
15 put out their updates for next calendar year,
16 which is right now, HEDIS 18, calendar year 17.
17 So this might be an area where there might be a
18 spec change that they may recommend. They should
19 be putting that out. I think they usually do
20 that in late July, and then they open it up for
21 public comment.

22 CO-CHAIR GOLDEN: We'd recommend the

1 most current specification of this measure.

2 MEMBER HENNESSEY: Yes, what I would
3 say is that typically once the standard is
4 changed, then HEDIS -- NCQA-HEDIS, typically,
5 from what I've seen, they update the
6 specification or they put it out for public
7 comment for everyone to talk about whether or not
8 to update it.

9 CO-CHAIR MOORE: Thanks. Any comments
10 or concerns on the phone? All right. Moving on
11 to our last item in this group, 103. I knew I
12 could count on you guys; I knew it.

13 MS. BUCHANAN: So this is a measure
14 concept that the TEP recommended. And they
15 discussed some of the limitations of this measure
16 concept, including that the denominator only
17 includes individuals who suffer from
18 schizophrenia and not individuals who suffer from
19 any other types of serious mental illness; and
20 that the sole focus of the measure is the Program
21 for Assertive Community Treatment, the PACT
22 Intervention, since it is difficult for rural

1 areas to implement PAC teams.

2 But the TEP noted that re-admission
3 rates for individuals with schizophrenia are
4 incredibly high, and that PAC is an evidence-
5 based program with demonstrated impact, so they
6 voted to recommend this measure concept.

7 CO-CHAIR MOORE: Maureen, can you talk
8 a little about the conversation? I noticed that
9 there's -- it's not being used, or hasn't been
10 identified where it's being used?

11 MEMBER HENNESSEY: Yes. The reason
12 for this is that the use of PACT is considered to
13 be from an evidence-based perspective, one of the
14 more emerging and important kinds of intervention
15 for individuals who are living with
16 schizophrenia, particularly focusing more now on
17 early intervention; so some of the programs like
18 Ray's that you're seeing are the types of
19 programs that provide a more comprehensive,
20 wraparound kind of service.

21 And what they've seen from an
22 evidence-based perspective is a decline in

1 admissions fairly substantially. So that's why
2 the TEP was very interested in this, recognizing
3 it's not a full-blown measure at this point, but
4 it's really a concept that we think is important
5 for CMS to consider.

6 CO-CHAIR MOORE: Okay. Great. Any
7 other comments or concerns? Anyone on the phone?
8 Whoa, that's a wrap.

9 MS. BUCHANAN: Okay. So we are going
10 to move on to voting en block to recommend the
11 PMH Measure Set. And as you can see, the new
12 measures that you all included today are
13 reflected on this. And so we do have all the
14 measures and we'll be voting now to recommend
15 this measure set to CMS's IAP. Now I'll turn it
16 over to Miranda.

17 MS. KUWAHARA: Again, this will be an
18 up or down hand vote. If you would like to
19 recommend the PMH Measure Set to CMS's Medicaid
20 Innovation Accelerator Program, please raise your
21 hand.

22 MS. BUCHANAN: And Judy and Karen, if

1 you wouldn't mind saying yes or no on the line.

2 MEMBER AMSTUTZ: Yes.

3 MS. BUCHANAN: One yes. And then it
4 looks like -- and I think Alvia's the only person
5 we don't have a response for yet, who is texting.

6 CO-CHAIR MOORE: Were we required to
7 open up for public comment before we did the --

8 MS. BUCHANAN: After. And Alvia --
9 got it, thank you. But I don't think Judy's on
10 the line right now. Just want to double-check
11 that. No. So we did get Karen's vote though.

12 MEMBER ZERZAN: Did you just me? I
13 just got through security.

14 MS. BUCHANAN: Judy, we're voting on
15 whether or not to --

16 MEMBER ZERZAN: I was just wondering
17 if I heard my name.

18 MS. BUCHANAN: Yes. We were voting en
19 block to recommend the physical and mental health
20 integration measure set to CMS.

21 (Simultaneous speaking)

22 MS. BUCHANAN: Yes, got it. Okay.

1 Thank you.

2 MS. KUWAHARA: Are there any
3 recommendations not to recommend the measure set?
4 Okay, 18 of our 18 voting members voted to
5 recommend the PMH Measure Set to CMS's Medicaid
6 Innovation Accelerator Program.

7 MS. BUCHANAN: Okay. So now we are
8 moving on to an opportunity for public comment.
9 Operator, if you wouldn't mind opening the lines.
10 Additionally, anyone who would like to type a
11 public comment in, staff can read. We'll be
12 holding the line open for about 20 seconds; and
13 we are ready now.

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

17 (Pause for phone line.)

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

20 MS. BUCHANAN: Thank you so much. On
21 to next steps. So we will all convene again June
22 20th for a web meeting to discuss the overall

1 measure sets in their entirety.

2 Then we will work diligently to
3 capture all the recommendations put forth by the
4 technical expert panels and by the Coordinating
5 Committee and capture that in a draft report,
6 which we will submit for public comment July 21st
7 to August 21st. Then we will submit a final
8 report to CMS no later than September 14th.

9 Next slide, please. We have our
10 contact information on this page. We also have
11 our committee SharePoint and project web page.
12 You can find all meeting materials on either of
13 those sites, and as always, please feel free to
14 reach out to the Medicaid Accelerator team at any
15 point in time.

16 I'll turn it back over to Bill and
17 Jennifer for closing remarks.

18 CO-CHAIR GOLDEN: Wow; the only thing
19 I would say is, Thank you, everybody, for hanging
20 in there and doing, first of all, all the TEPs
21 for doing all of the work, and for everybody to
22 have good and focused conversations. And I think

1 that's been very good.

2 You know, I guess in some ways, I
3 don't know if Karen wants to make any comments
4 about what you're hearing or other kinds of
5 information. I'd be kind of curious.

6 MS. LLANOS: Yes, this is, again I
7 echo the thanks and I think the TEP committees,
8 which were also very intensive in nature, so I'm
9 just listening and trying not to comment.

10 But it's been fantastic to hear all of
11 the time and expertise you have all brought to
12 the past two days, and I know the homework that
13 went into this, as well. So a giant thank you,
14 obviously, to the NQF staff, as well.

15 In terms of what I'm hearing; I think
16 it's really nice to hear some areas being
17 validated, that I think we hoping you all would
18 find and resonate with, as well. And in terms of
19 the gaps, again, very familiar territory. But
20 it's really nice to have a broader group say
21 that, as well.

22 And then again, I think some of the

1 nuances in terms of your experiences on
2 particular measures and reporting, I think are
3 going to be really helpful for states as they
4 also think about this. As someone remarked,
5 We're just trying to add to the toolbox and have
6 resources through these types of measures.

7 But also know that it's a starting
8 point and that there's much more to do in terms
9 of measurement development. So very consistent
10 with where I think we'd like to head with this
11 project, so thank you all.

12 CO-CHAIR GOLDEN: Thank you, Karen.
13 And I'll just speak as a member of the Medicaid
14 medical director network, as some of my
15 colleagues are; these areas are of -- it's
16 something that the Medicaid medical directors
17 think about all the time.

18 And we are pleased that we get tools.
19 Different states have different capacities to get
20 data, so I think it's still an emerging and
21 learning process. Unfortunately, I think it's
22 more for each state to figure out how to start to

1 implement and change and transform their systems.

2 The data consistency across states is
3 still a work in progress, I think. And I think
4 that you and others would agree with that, and
5 that's just the way it is. But I think the more
6 useful stuff we can give to our colleagues, the
7 more we can work with the provider community to
8 make a difference.

9 So thank you for all your work, and
10 thank you, Karen and CMS for sponsoring this and
11 getting the NQF staff to be able to do this
12 valuable work for us.

13 DR. TERRY: I just have a few words.
14 Oh, Jennifer, yes.

15 CO-CHAIR MOORE: I don't want to hold
16 everybody up, but I want to echo the sentiment
17 that I really do appreciate everybody's hard
18 work. They both said it exceptionally well, so
19 there's -- I won't repeat that.

20 But I was hoping, Karen, not getting
21 into the political climate that we're in, but
22 recognizing all of the work that everybody has

1 put into this and the excitement we have in this
2 project, can you give us a sense of the two
3 different scenarios, so one path would be that
4 additional funding is not available.

5 What happens at that point with the
6 work that has been done in this space? And then
7 secondly, if funding is available, what are your
8 thoughts at this point in where this might go as
9 a next phase?

10 MS. LLANOS: About this particular
11 project? So I think regardless of funding, we
12 wanted to be able to work on putting something
13 like this together and sharing it with all
14 states. So I think in many ways, that's a huge
15 accomplishment on its own.

16 In terms of what would happen next, it
17 does sound more of a development respecification
18 type of project, which we already have ongoing
19 and that's going to continue on; it's on a
20 different glide path.

21 But this has been really helpful to
22 inform that parallel project, so that we're

1 building some of this feedback into the measures
2 that we're currently working on, that also
3 reflect these four program areas.

4 So we have our contracting
5 representative from that project that has been
6 listening in over the past two days, and our
7 contracting team from our pipeline work, as well.

8 As we are starting to identify measure
9 concepts for development for our final year, we
10 thought it would be really nice to connect these
11 two efforts together and have them hear directly
12 from all of you in terms of some key gap areas.

13 CO-CHAIR MOORE: Thank you for that.
14 I really do appreciate that.

15 CO-CHAIR GOLDEN: Is this project part
16 of CMMI or CMS? I'm just --

17 MS. LLANOS: IAP is a CMMI model that
18 was in CMCS, so it's a Medicaid-led effort. And
19 our center leads it, as well, but with CMMI
20 funding.

21 DR. TERRY: And I just wanted to add
22 a few more words. First of all, I want to thank

1 everybody; just to echo what everybody said, I'm
2 always impressed when people come together and
3 they have such wonderful backgrounds and deep
4 knowledge, because it's really what makes this
5 work. So thank you, everybody, for your work and
6 for your dedication, flying through these many,
7 many measures.

8 And in particular, I want to thank our
9 co-chairs, Jennifer and Bill, for really keeping
10 us on target, getting us through this. You know,
11 really making this work. And so thank you very
12 much. And to the public and the people who
13 stayed on the calls and the people who made
14 comments; and to Chip.

15 CO-CHAIR MOORE: To Chip.

16 (Laughter.)

17 MEMBER SIDDIQI: Thank you everybody.

18 MEMBER HENNESSEY: Thank you to NQF,
19 not only for taking us through the process here
20 for the past two days, but really taking the
21 TEPs, all of us, each of us chairs through this
22 process as well. It's been a longer, more

1 extended period, and you guys have been terrific.
2 Thank you.

3 (Applause.)

4 MS. BUCHANAN: Thank you to everyone
5 who joined us on the phone. We will be signing
6 off.

7 MEMBER SIDDIQI: Thank you, safe
8 travels everyone.

9 MEMBER GELZER: Thank you.

10 (Whereupon, the above-entitled matter
11 was adjourned at 3:44 p.m.)
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